Centers for Medicare & Medicaid Services
Federally Facilitated Exchange
Contract HHSM-500-2016-00003I / 75FCMC21F0002

Marketplace Plan Management System Issuer User Guide

Version 7.1
09/05/2024

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1 Introduction

This document provides an overview and step-by-step guide on how to use the Marketplace Plan Management System (MPMS).

MPMS is a web application where users can validate plan data, as well as submit their Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) to the Centers for Medicare and Medicaid Services (CMS) for review and certification.

1.1 User Guide Notes

This document provides screenshots and corresponding narrative to describe how to use MPMS. Buttons requiring action are indicated by "apostrophes". Links requiring action are indicated by underlined blue text. The term "user" is used throughout this document to refer to an individual with access to MPMS.

2 Getting Started

To ensure that the user is able access MPMS, this section describes the recommended setup for the user's web browser, as well as recommendations to access and navigate the system. The web page design aligns to the CMS.gov web brand and is Section 508 compliant.

2.1 Supported Browsers and Browser Settings

To optimize user experience within MPMS:

1. Disable pop-up blockers prior to accessing MPMS.
2. Use one of the following browsers (latest version available for supported operating systems as of 3/1/2024):
    - Edge 122
    - Firefox 123
    - Chrome 122
3. Request the URL be added to the company's whitelist

Note: The system complies with Health and Human Services (HHS) design standards: all associated webpages are designed for viewing at a minimum screen resolution of 1280 x 1024.

2.2 User Role

All users must have a CMS Enterprise Portal Identifier (ID) and HIOS user role to access the system. Users may select 1 of the 4 user roles for each unique HIOS Issuer ID they need access to:

- PM Issuer Viewer - Grants user access to use Plan Preview, but read-only access to the rest of MPMS.
- PM Issuer Validator - Grants user full access to the Plan Validation Workspace and Plan Preview, but read-only access to other areas of MPMS.
- PM Network Validator - Grants user access to use the Plan Validation Workspace, Plan Preview, and edit the Network ID, Essential Community Providers (ECP), and Network

Adequacy sections in the QHP application. User will have read-only access to the rest of the QHP application, as well as to other areas of MPMS.

- PM Issuer Submitter - Grants the user full access to all areas of MPMS.

Note: In order to complete a QHP application, at least 1 user in the Issuers organization must have the PM Issuer Submitter role. The other 3 roles are optional and may be used to help separate user access within the Issuers organization.

State users must have a PM State Reviewer role to access MPMS. For further details on how to establish a CMS Enterprise Portal ID, refer to the Enterprise Portal User Guide. For further details on how to request a PM Issuer Submitter role, please refer to the Identity Management User Guide.

2.3 Accessing the System

Login steps for accessing MPMS:

1. Navigate to the CMS Enterprise Portal Login page
2. Enter User ID and Password into the field
3. Select the 'I agree to the Terms & Conditions' check box
4. Select the green 'Login' button
5. In My Portal Select the HIOS icon
6. Select 'Overview'
7. Select the 'Access HIOS' link
8. Select the green 'Launch This Module' button for the Marketplace Plan Management Module
9. Select 'Access the Marketplace Plan Management System module' link

2.4 Exiting the System

To exit MPMS, select the Logout link located in the top right corner of the page header. *See Figure 2-1*

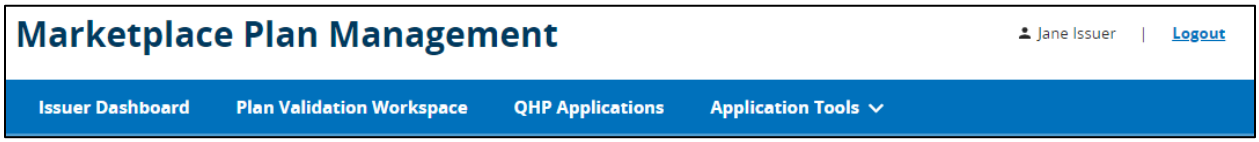


Figure 2-1. Logout

3 MPMS Functionality Overview

MPMS consists of the Issuer Dashboard, the Plan Validation Workspace, QHP Applications, and Application Tools.

1. **Issuer Dashboard:** The Issuer Dashboard is the first screen users see when navigating to MPMS. It provides the user with the ability to view announcements pertaining to their

applications, metrics about any QHP Applications they may have started for the current plan year, and easy navigation to other areas of the system.

2. **Plan Validation Workspace:** The Plan Validation Workspace is used to upload and validate QHP templates. Users may upload one or more templates at a time for validation, as well as cross validate the current templates uploaded in the system for a given Issuer ID and Plan Year.
3. **QHP Application:** The QHP Application screens are used to create or edit an existing application. Users may link valid QHP templates they uploaded in the Plan Validation Workspace to their QHP Application, complete attestations and justifications, and provide supplemental documentation relating to their submission. Users may also view any review results provided by CMS regarding their QHP Application.
4. **Application Tools**: Issuers can access additional tools that may support their QHP application submission, including Application Materials to download pre-populated templates with content from the prior plan year, access to maintain Machine-Readable URLs, and Plan Preview to validate rating scenarios.

The following sections provide instructions about using the various functions and features of MPMS.

4 Issuer Dashboard

The Issuer Dashboard is the first page users see when navigating to MPMS and is also the Main Navigation screen. It provides the user with the ability to navigate to the Plan Validation Workspace, QHP Applications and the Application Tools, as well as shows metrics for any applications the user has access to. *See Figure 4-1.*

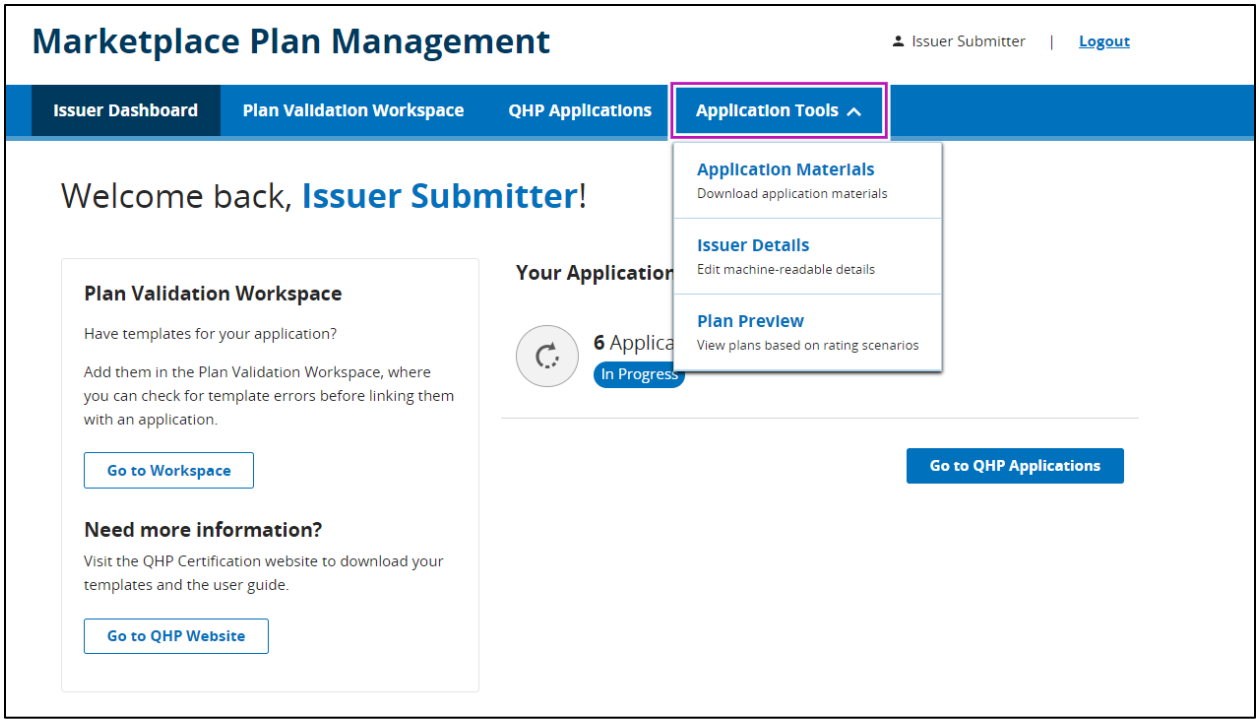


Figure 4-1. Home Page

4.1 Issuer Dashboard Communications Table

Within the in the Issuer Dashboard, Issuers will have access to download files CMS has shared via the Communications Table. Issuers will access the Appointment Wait Time (AWT) Provider Population File (PPF) zips on the Issuer Dashboard for PY25. Issuers will be able to view and individually download the PPF zips for each Issuer ID they have access to, or download in bulk if applicable. See Figure 4-2. Issuers should download their Provider Population Files by December 1st, 2024.

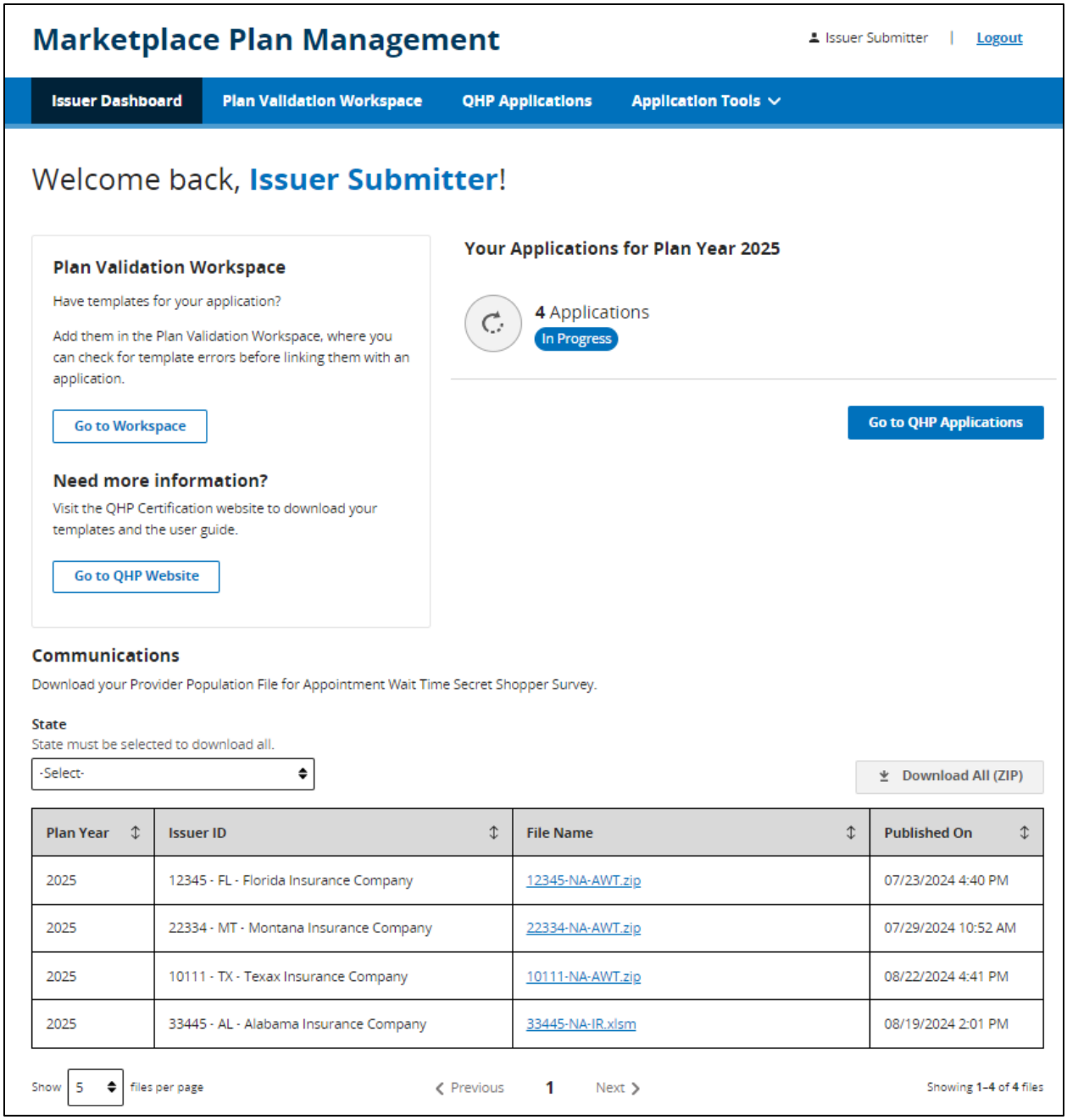


Figure 4-2. Issuer Dashboard View for AWT Communications Table

5 Plan Validation Workspace

The Plan Validation Workspace is used to upload, validate, and cross-validate QHP templates. Prior to using the Workspace, users must complete their QHP template and use the Finalize macro to generate an XML or ZIP file to upload. Instructions for using the Workspace are detailed in the sections below.

5.1 Uploading Templates for Validation

When first arriving at the Plan Validation Workspace, the user is required to select the Plan Year and Issuer they wish to validate templates for, then select the 'Show Workspace' button to begin uploading files for validation. *See Figure* 5-1.

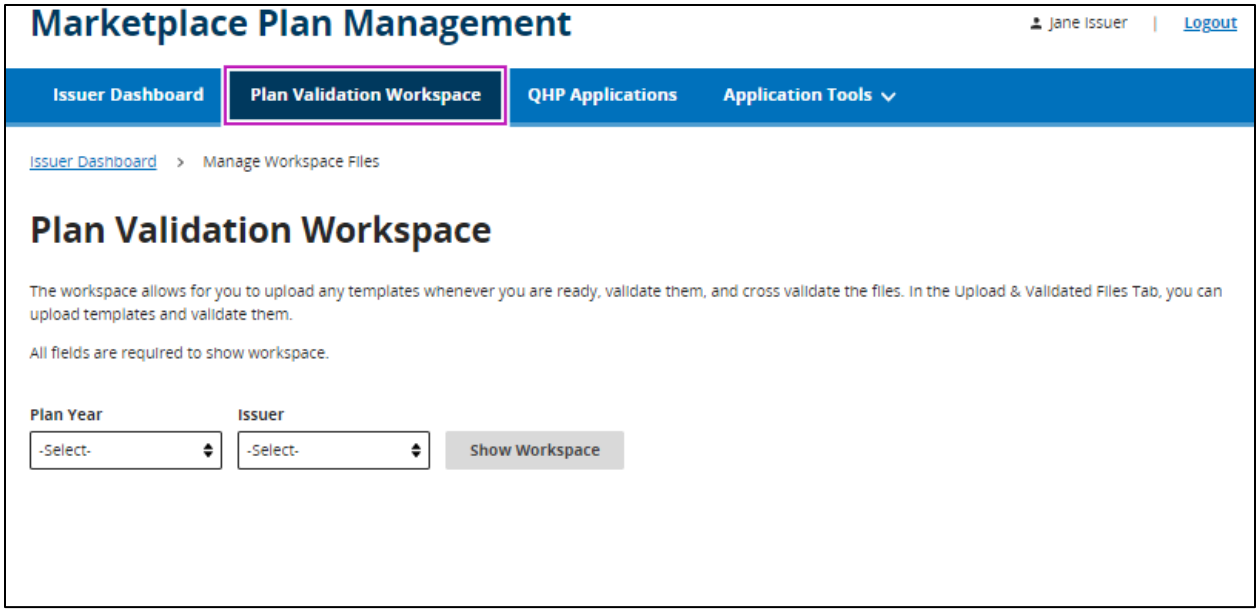


Figure 5-1. Show Workspace

Upon selecting 'Show Workspace,' an Upload Files section will appear where the user can upload files for validation. The user may select 'choose from folder' or drag and drop files into the Upload Files section for validation. *See Figure 5-2.*

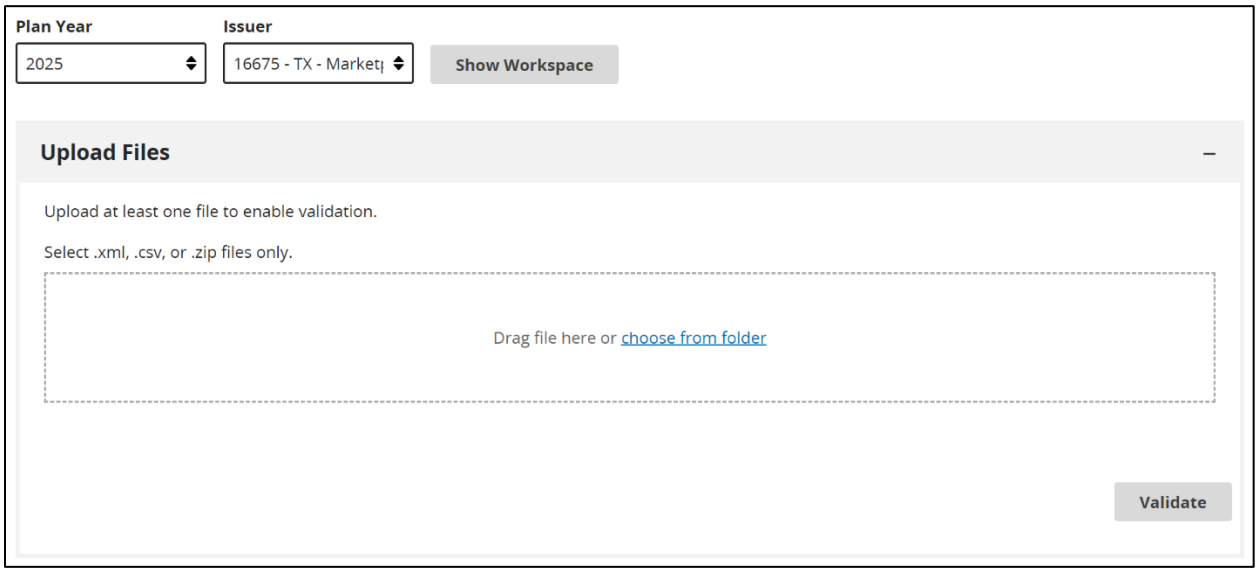


Figure 5-2. QHP Templates Uploaded

The system automatically identifies the type of template uploaded and displays that to the user. The user may select the 'Validate' button to submit the files for validation or choose to remove a file by selecting the trash can icon.

5.2 Viewing Template Validation Results

Once templates have been submitted for validation, the Validation Results section will display to the user. *See Figure 5-3.*

Note: When a user submits a template for validation through the System for Electronic Rate and Form Filing (SERFF), those validations results will also display in the Validation Results section and can be identified by the Uploaded By value of "SERFF"

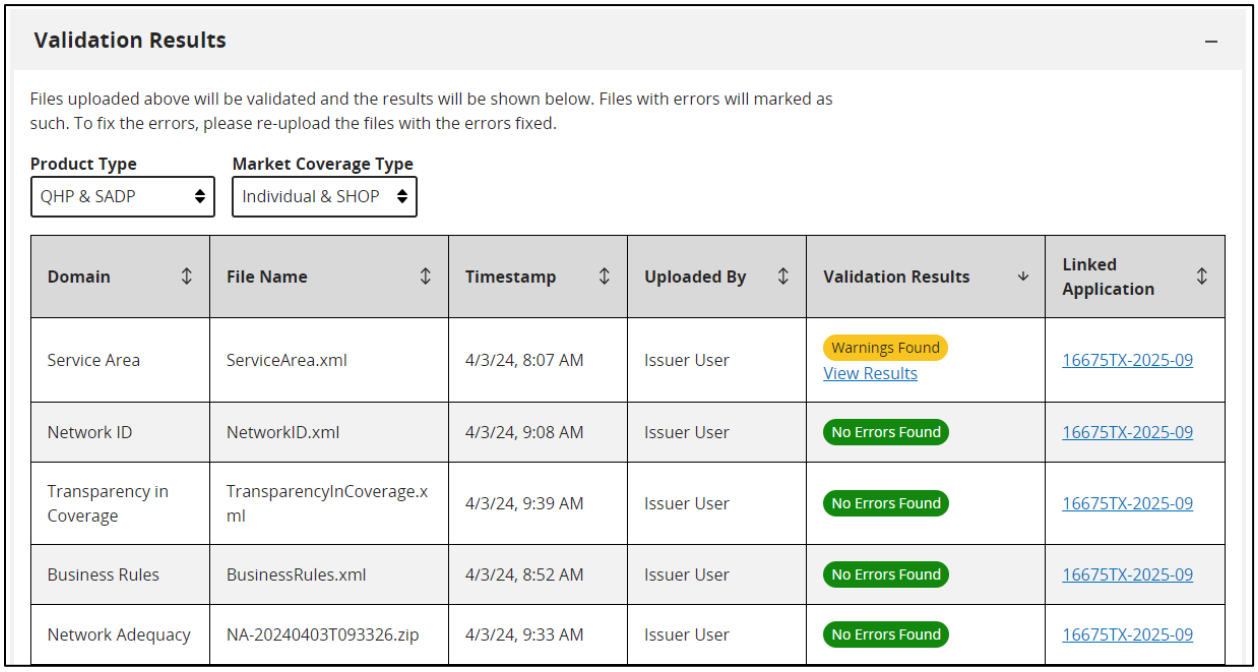


Figure 5-3. Validation Results

The user may filter the validation results in the table using the 'Product Type' and 'Market Coverage Type' filters at the beginning of the section. The possible Validation Results are described in the table below.

Table 5-1. Validation Results

Validation Result Badge	Description
No Errors Found	The template XML passed all validations.
Warnings Found	The template XML is acceptable, but the user may need to provide a justification if the template is linked to a QHP Application, or there is an unexpected data condition CMS would like to flag to the user.

Validation Result Badge	Description
Errors Found	The template XML contains Errors and requires corrections before the template can be linked to the QHP Application. This status will also display if there are errors and warnings present in the template.
Processing Error	The template XML cannot be processed by the system due to a file format issue. Try generating a new XML file using the Finalize macro in the template and re-uploading. If the issue continues, contact the help desk.

If the template has a status of "Warnings Found" or "Errors Found," the user may select the 'View Results' link to view the detailed validation messages. *See Figure 5-4.*

Note: Users will only receive up to 500 validation errors/warnings when uploading a file. If the user receives 500 validation errors, it is possible there are more errors not being returned and the user will receive them after correcting the existing errors.

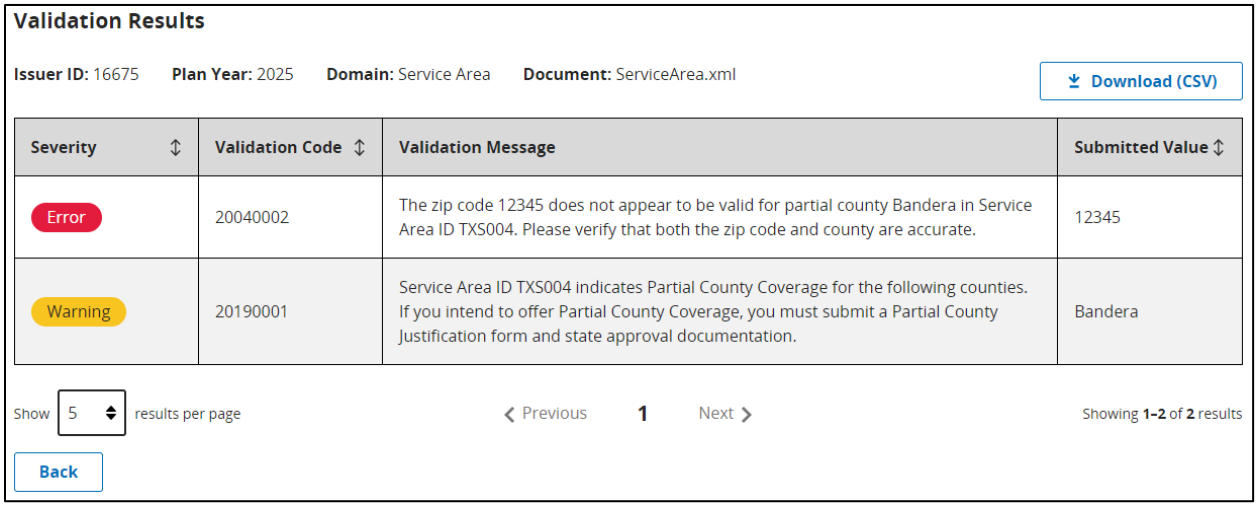


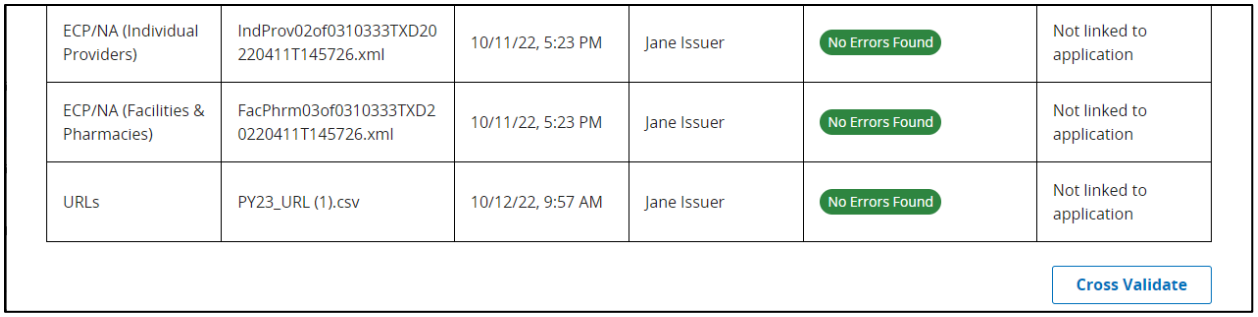
Figure 5-4. Viewing Validation Results Details

From this screen, the user may view the validation messages directly in the User Interface (UI) or choose to download the validation messages as a file.

5.3 Cross Validating Templates

After reviewing and addressing all validation results, the user may proceed with performing cross validation between templates by selecting the 'Cross Validate' button. *See Figure 5-5.*

Note: Only templates in a validation status of "No Errors Found" and/or "Warnings Found" can be cross validated.



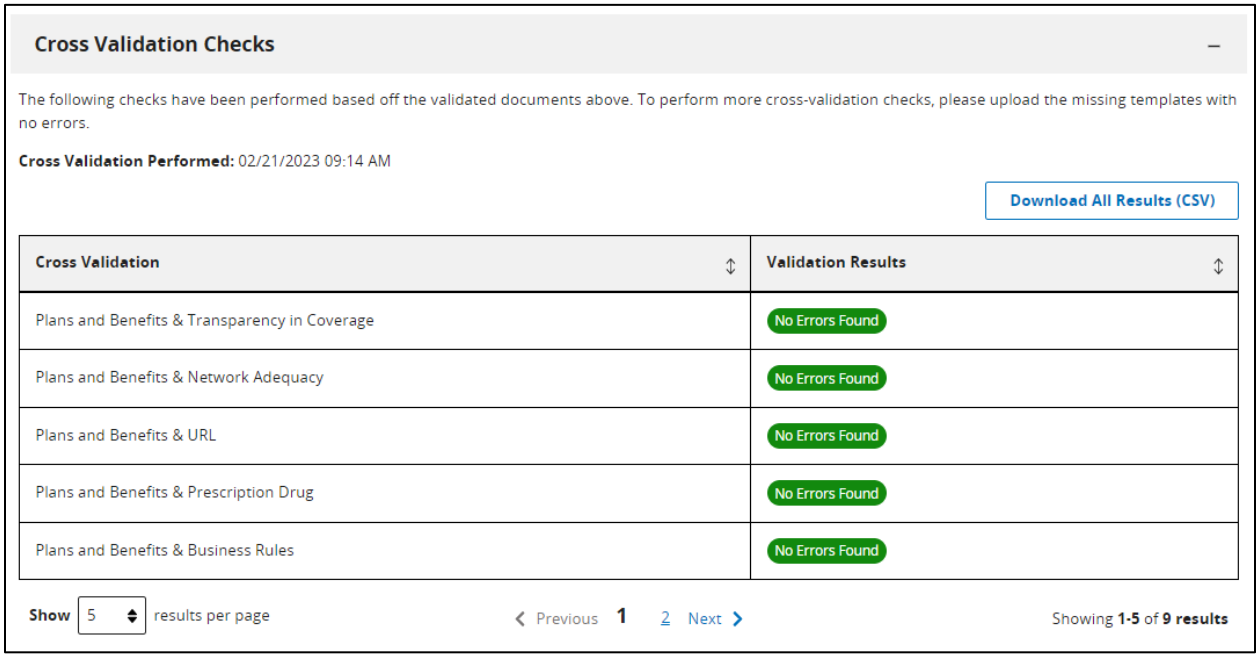
ECP/NA (Individual Providers)	IndProv02of0310333TXD20220411T145726.xml	10/11/22, 5:23 PM	Jane Issuer	No Errors Found	Not linked to application
ECP/NA (Facilities & Pharmacies)	FacPhrm03of0310333TXD20220411T145726.xml	10/11/22, 5:23 PM	Jane Issuer	No Errors Found	Not linked to application
URLs	PY23_URL (1).csv	10/12/22, 9:57 AM	Jane Issuer	No Errors Found	Not linked to application

Cross Validate

Figure 5-5. Cross Validate Templates

5.4 Viewing Cross Validation Results

Similar to the Validation Results section, cross validation results are displayed in a new section called Cross Validation Checks. *See Figure 5-6.*



Cross Validation Checks

The following checks have been performed based off the validated documents above. To perform more cross-validation checks, please upload the missing templates with no errors.

Cross Validation Performed: 02/21/2023 09:14 AM

Download All Results (CSV)

Cross Validation	Validation Results
Plans and Benefits & Transparency in Coverage	No Errors Found
Plans and Benefits & Network Adequacy	No Errors Found
Plans and Benefits & URL	No Errors Found
Plans and Benefits & Prescription Drug	No Errors Found
Plans and Benefits & Business Rules	No Errors Found

Show 5 results per page Previous 1 2 Next Showing **1-5** of **9 results**

Figure 5-6. Cross Validation Results

Users may view validation warnings and errors similar to the Validation Results section.

6 Creating a New QHP Application

Instructions for creating a new QHP Application are detailed in the sections below.

6.1 Create a New QHP Application

After navigating to the QHP Applications section after validating all templates, the user can select a Plan Year, Issuer, Product Offering, and Market Coverage Type to create a new QHP

Application. *See Figure 6-1.* A user may only create one application per plan year per Issuer, and an application may not be created for a State-based Exchange (SBE) state.

Note: For the Product Offering and Market Coverage Type fields, the user must select the option that reflects all product offerings (QHPs, SADPs, or Both) and markets (Individual, Small Group, or Both) they intend to submit data for as part of their QHP Application.

Figure 6-1. Start Application

When ready, the user selects the 'Create Application' button to create the new application.

6.2 Link Templates to Application

When a new application is created, a prompt appears allowing the user to select any valid templates XML (i.e. Template XML containing "No Errors Found") available in the Workspace they would like to link to the new QHP Application. *See Figure 6-2.* Only templates with a status of "No Errors Found" and/or "Warnings Found" can be linked to a QHP Application.

Note: For applications created for State Partnership Exchange (SPE) or State-based Exchange on the Federal Platform (SBE-FP) states, this prompt will not display QHP templates that should be transferred from the System for Electronic Rate and Form Filing (SERFF).

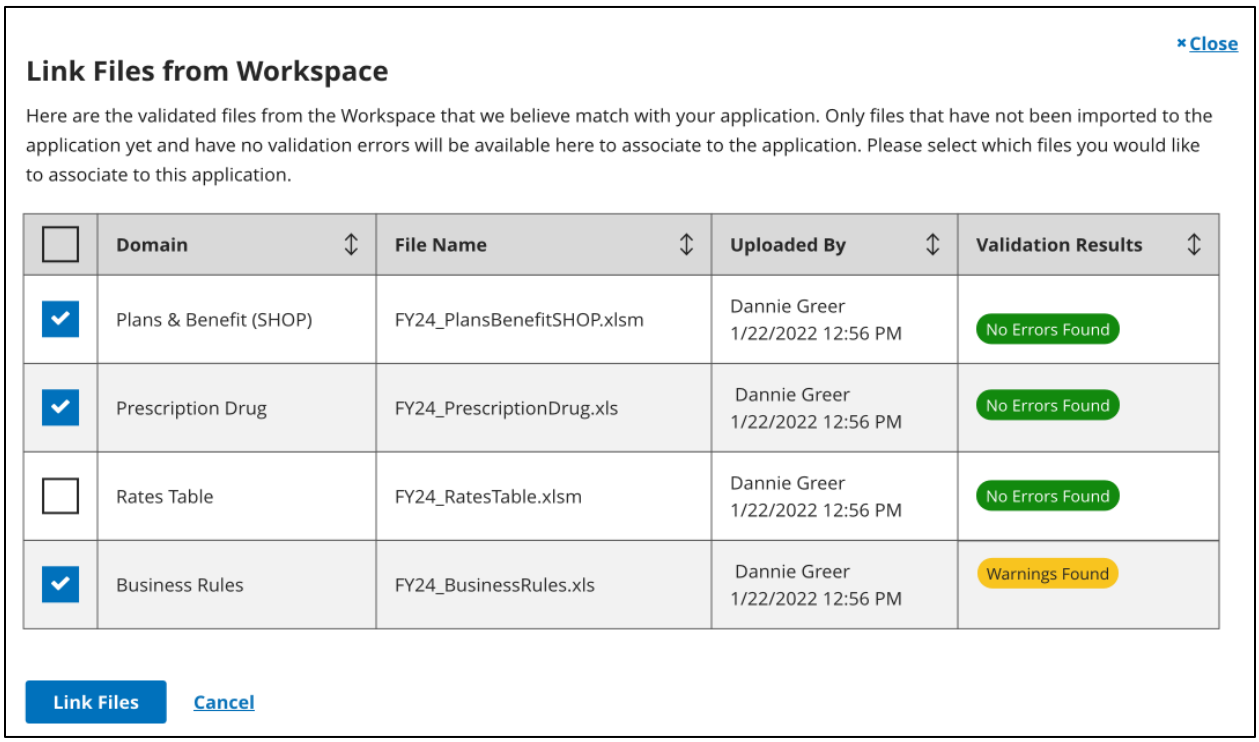


Figure 6-2. Link Chosen Files to Workspace

Once templates are selected, the user may select the 'Link Files' button to add the templates to the QHP Application.

Note: Users offering coverage in the Federally-Facilitated Exchange (FFE) or FFE-Direct Enrollment exchange models may also choose to link templates from the Workspace to their application on the Application Summary page using the 'Link Files' button.

6.3 Application Overview

Once the user links files to the application or chooses to close the prompt, they are directed to the Application Overview. Here the user is presented with a list of sections that they are required to complete as part of the QHP Application. The sections that are displayed are based on the Market Coverage Type, Product Offering, and Exchange Model for the applicable plan.

While users in FFE states will be able to access and complete each section of the application through MPMS, users of the SERFF system will not be able to edit certain sections/groups of the application. Those sections are Business Rules, Prescription Drugs, Service Area, Network ID, and Rates Table. In these cases, MPMS is expecting to receive the template data and/or supporting documents through the SERFF Plan Transfer service, rather than making edits directly in MPMS. *See Figure 6-3.*

Note: The Plans and Benefits section will be editable for SERFF issuers submitting an application containing Individual Market QHPs, otherwise the section will not be editable.

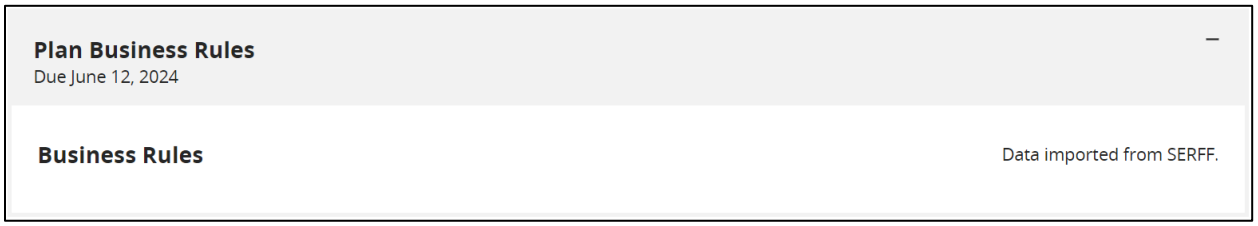


Figure 6-3. Data imported from SERFF

7 Common Actions within an Application

The QHP Application is divided into individual sections and grouped together so that they can be submitted to CMS for review and feedback. Instructions for completing each section of the QHP Application are detailed below.

7.1 Linking Templates From the Workspace

Users are not able to upload a template XML directly into the QHP Application, and instead must link valid templates XML from the Workspace to the application. Once a QHP Application is created, there are two ways the user may link a template XML from the Workspace to the application.

The first option is using the 'Link Files' button at the top of Application Overview. *See Figure 7-1.*

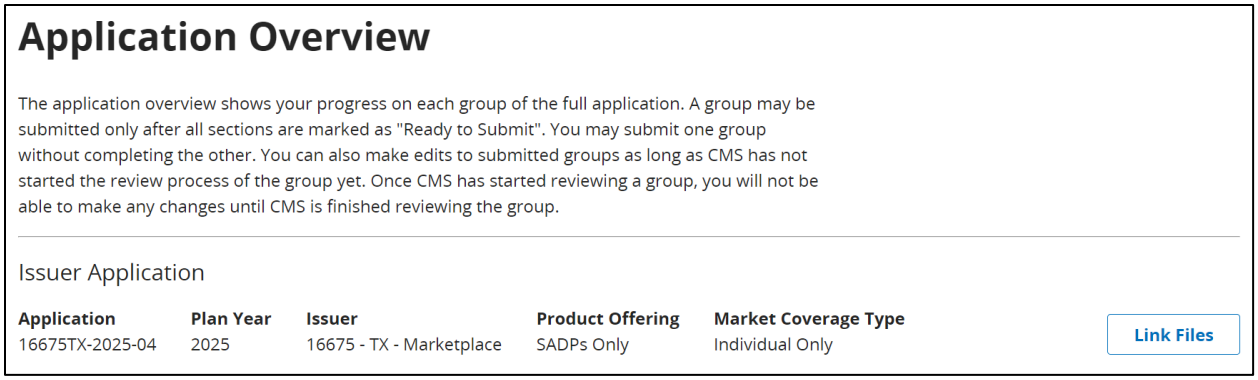


Figure 7-1. Link Files to Application

The second, and recommended option if a new template XML needs to be uploaded, allows the user to navigate directly to the Workspace from a section of the QHP Application, then link the new file. To do this, the user may select the 'Open Workspace' link found in an application section. *See Figure 7-2.*

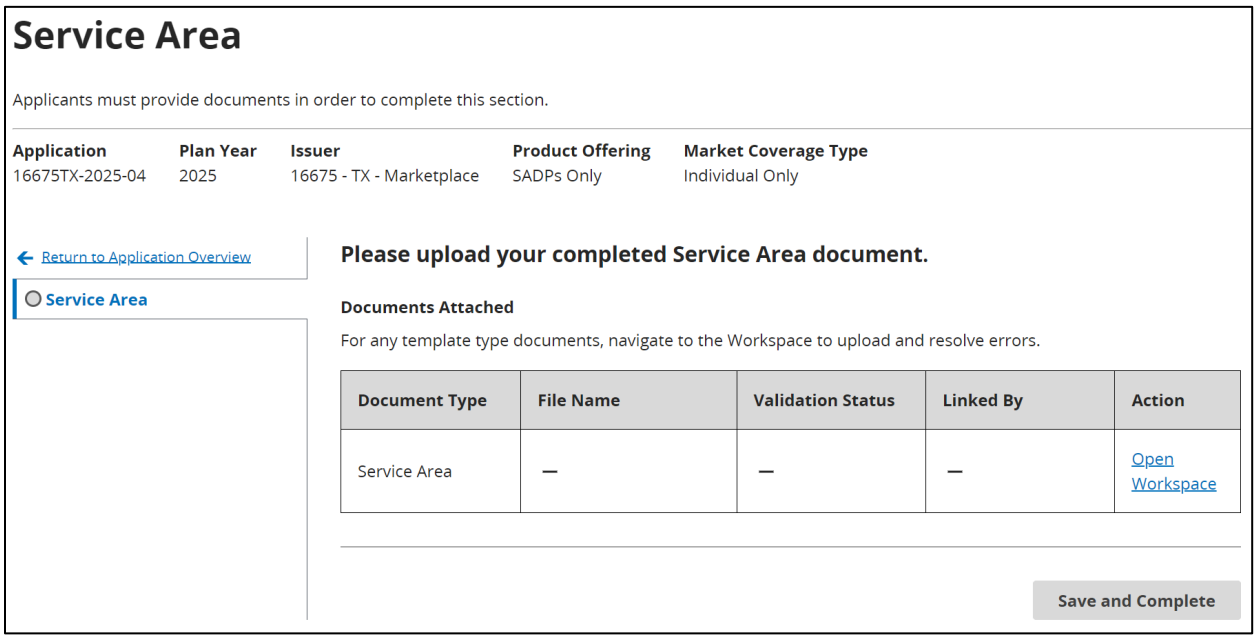


Figure 7-2. Open Workspace

Once in the Workspace, the user may upload the new template XML and view validation results as described in section 5. After a valid template XML is uploaded, the user may scroll to the bottom of the Workspace screen and select the 'Link to Application' button. *See Figure 7-3.*

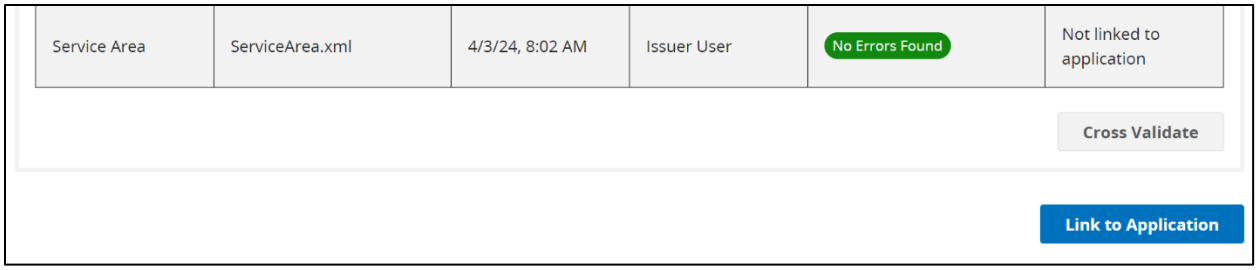


Figure 7-3. Link to Application

Selecting the 'Link to Application' button will prompt the user to select a valid template XML to link to the application. *See Figure 7-4.* The templates XML listed in the prompt are limited to the templates XML that apply to the section of the application the user navigated from.

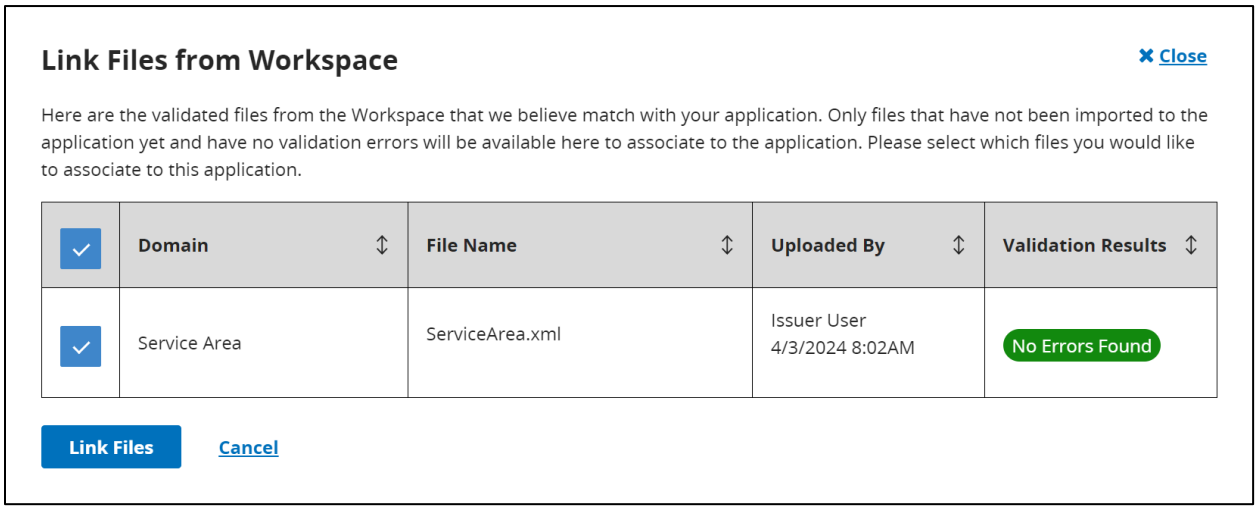


Figure 7-4. Link Files from Workspace

After selecting the 'Link Files' button, the user is redirected back to the section of the application, and the template XML is now successfully linked to the Application. *See Figure 7-5.*

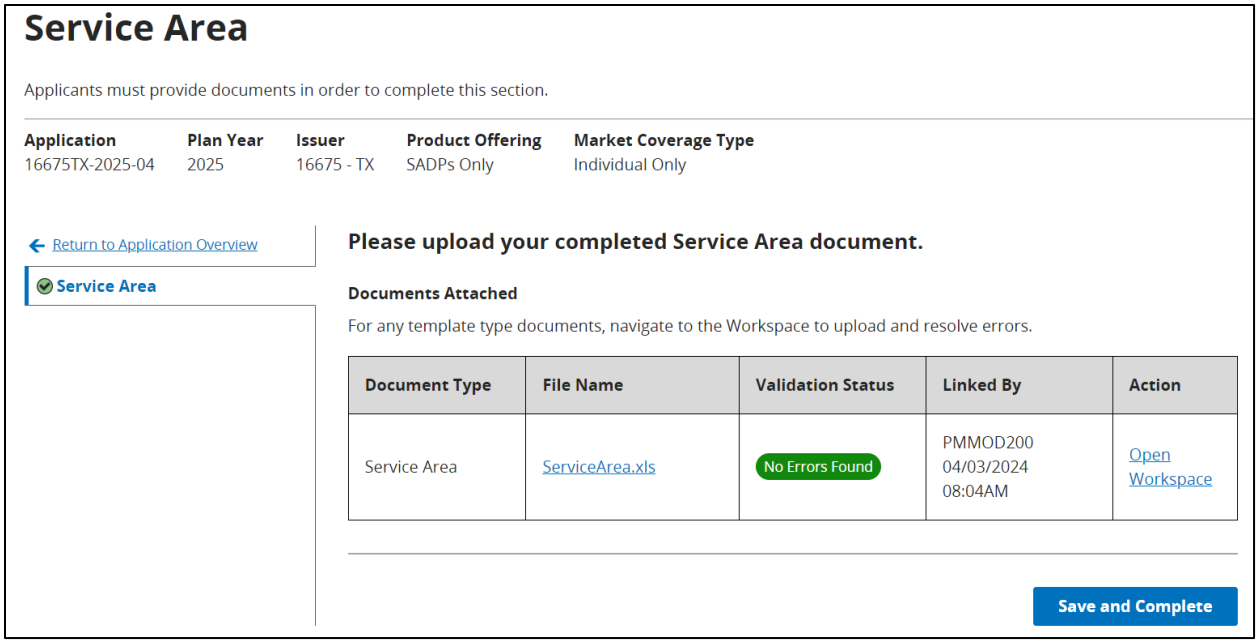


Figure 7-5. Templates Successfully Linked

7.2 Uploading Supporting Documentation

Supporting and Justification Documentation is sometimes needed when a warning is found in a template XML. The following details how to upload Supporting and Justification Documents.

To upload a Supporting and Justification Document, a user needs to select the 'Add document' button. In some cases, uploading multiple documents is required. To upload more than one document, select the 'Add document' button and individually add each document *See Figure 7-6.*

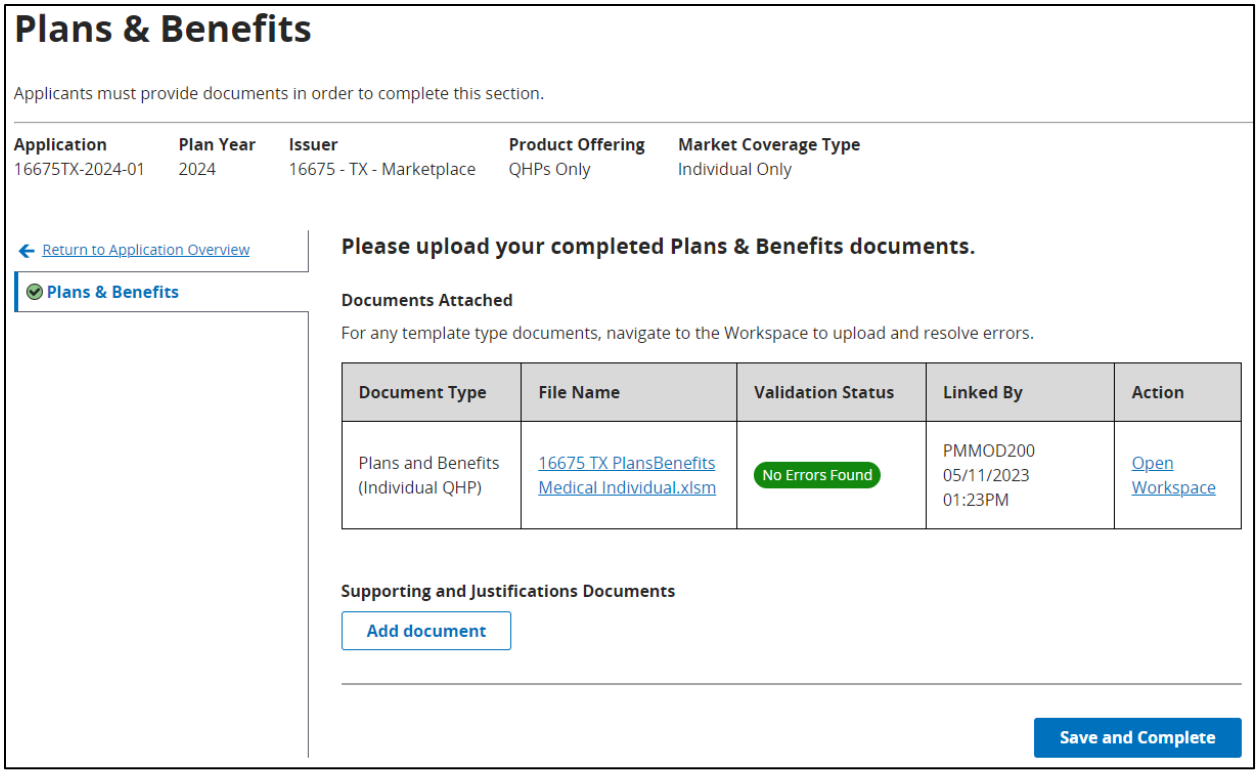


Figure 7-6. Supporting and Justifications Documents

Upload supporting documents by selecting a document type in the dropdown menu and then dragging or selecting the supporting and justification document from a local folder. *See Figure 7-7*. After the file appears, selecting the 'Upload' button will upload the document to the section.

Note: Each document type has a list of supported file types when uploading. There are also characters that are restricted from file names. Restricted characters include: ' (Apostrophe), / (Forward Slash), ; (Semicolon), # (Pound), ((Open Parenthesis),) (Closed Parenthesis), : (Colon), % (Percent), = (Equal Sign), < (Less Than), > (Greater Than), & (Ampersand), \ (Backslash), and " (Quotation Mark).

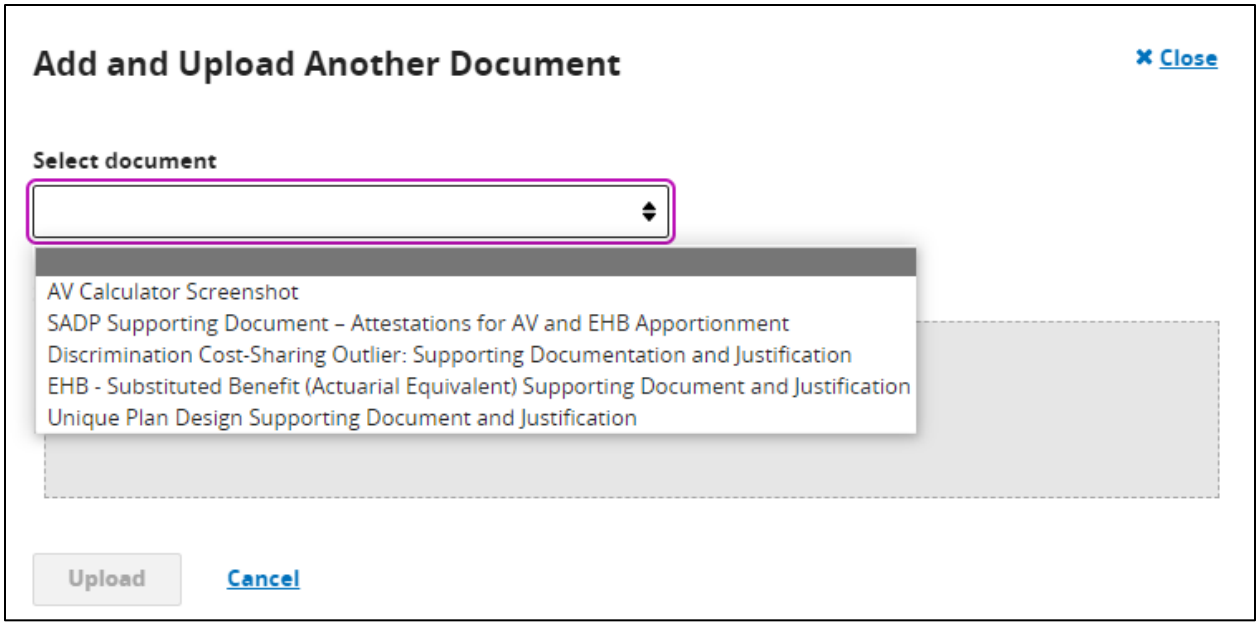


Figure 7-7. Add and Upload Supporting Documents

After the files are uploaded, they will appear in the domain. *See Figure 7-8.* A user may select the File Name link to download the supporting document or the 'Upload' action button to re-upload a file. Selecting the 'Save and Complete' button returns the user to Application Overview.

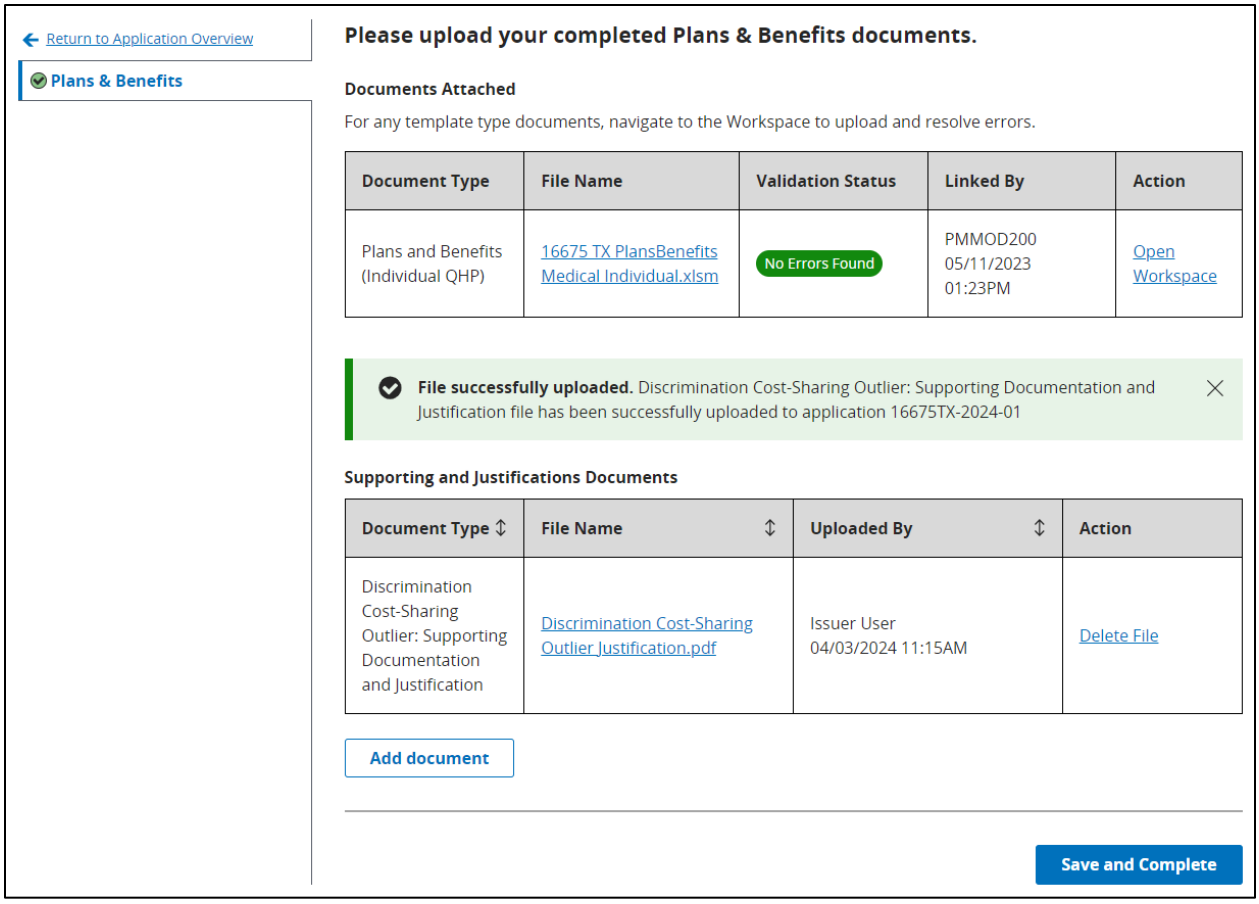


Figure 7-8. Uploaded Supporting Documents

7.3 Removing Supporting Documents

A user may remove a supporting document within a domain section of the QHP Application. Under Supporting and Justification Documents, a user may select the 'Delete Files' action to remove a previously uploaded file. *See Figure 7-9.*

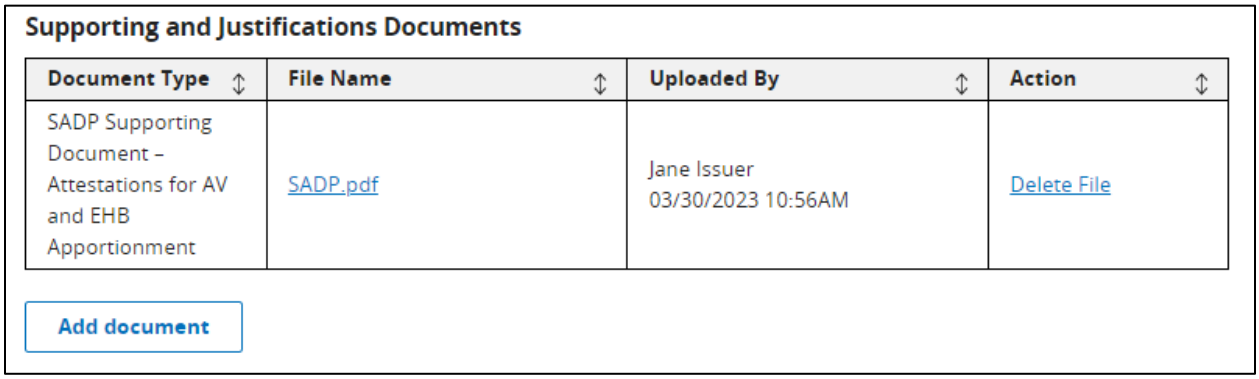


Figure 7-9. Delete Supporting File

Selecting this action displays a pop-up to the user asking if they wish to continue and delete the file. The user may select 'Yes, Delete File' to remove the previously uploaded file, or select 'No, Keep File' to keep the selected file or the 'Close' button to continue editing. *See Figure 7-10*. If a file is deleted, the action cannot be undone.

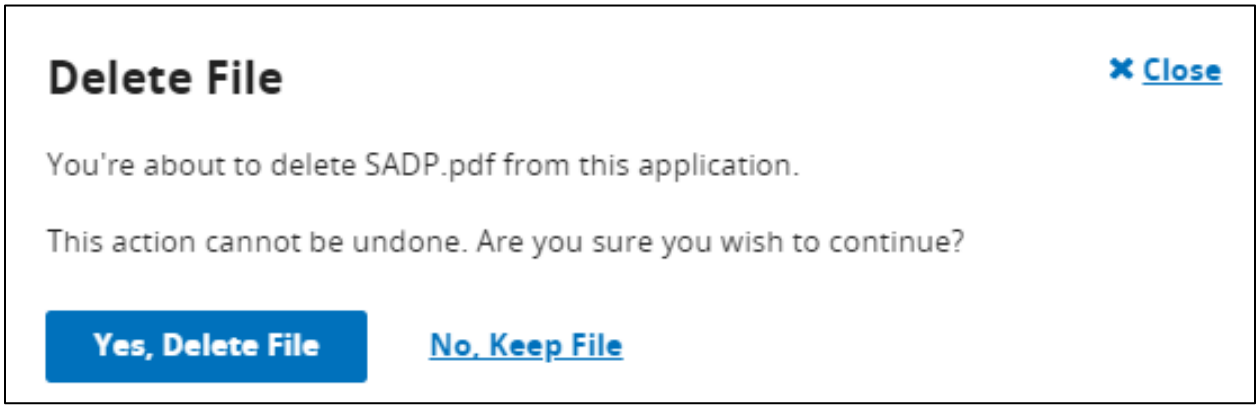


Figure 7-10. Delete File Pop-up

A user may also replace any supporting documents within a domain section. Under Supporting and Justification Documents a user may select the Replace a File action to replace a previously uploaded file. *See Figure 7-11.* This action displays a pop-up for the user to upload the file they wish to replace the previous file with.

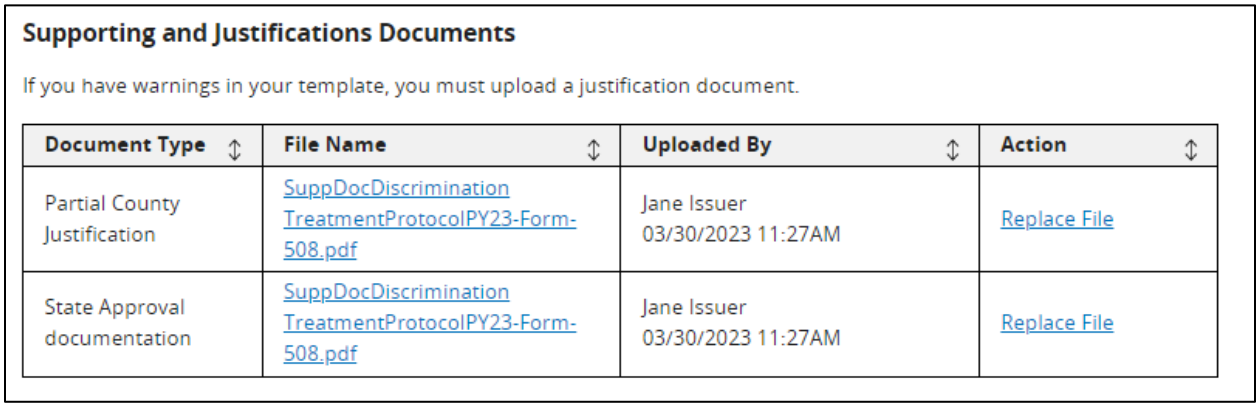


Figure 7-11. Replace Supporting File

8 Completing Sections of an Application

Each section of the QHP Application may have dynamic requirements based on the type of QHP Application the user is completing. Details and instructions on these dynamic requirements are detailed in the sections below.

8.1 Administrative Section

The Administrative section is required for all QHP Applications and must be error free in order for the user to complete the section. The information displayed in the Administrative Section is retrieved from the HIOS Plan Finder, and any errors identified in a section must be resolved by making updates to the HIOS Plan Finder module.

Note: Updates made in the HIOS Plan Finder module may take up to an hour to be reflected in the Administrative section.

8.1.1 Completing the Administrative Section

The Administrative Section is divided into 3 sub-sections: Corporate & Billing Information, Customer Service Contact – Individual, and Customer Service Contact – SHOP. *See Figure 8-1.*

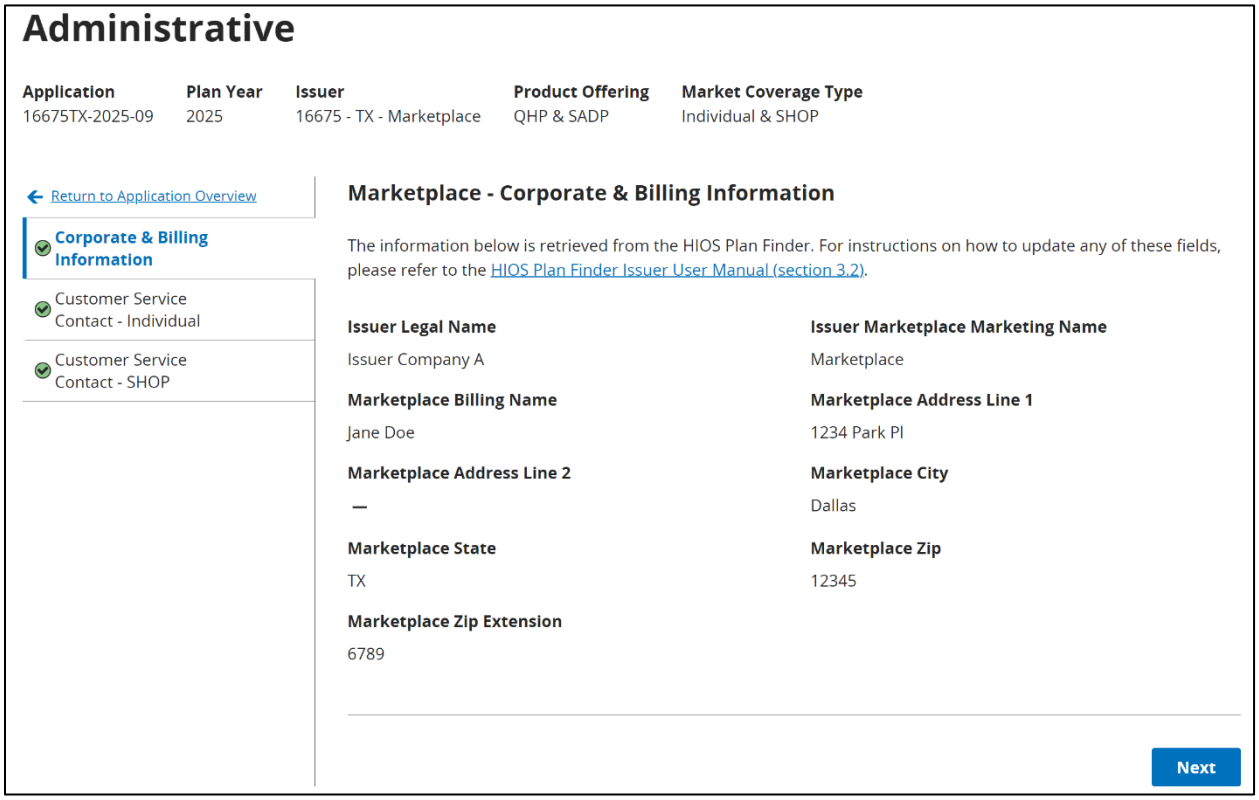


Figure 8-1. Administrative Section

Table 8-1 below provides the logic used to determine what Administrative Data displays to the user.

Table 8-1. Administrative Section Display Logic

Market Coverage Type	Administrative Data Displayed
Individual & SHOP	Corporate & Billing Information Customer Service Contact – Individual Customer Service Contact – SHOP
Individual	Corporate & Billing Information Customer Service Contact – Individual
SHOP	Corporate & Billing Information Customer Service Contact – SHOP

Table 8-2 below provides the mapping of fields in the HIOS Plan Finder to the Administrative Section.

Table 8-2. HIOS Plan Finder Fields

Administrative Section	Administrative Section Field Name	HIOS Plan Finder Section	HIOS Plan Finder Field Name
Corporate & Billing Information	Issuer Legal Name	Corporate Information	Issuer Legal Name
Corporate & Billing Information	Issuer Marketplace Marketing Name	Corporate Information	Issuer Marketplace Marketing Name
Corporate & Billing Information	Marketplace Billing Name	Marketplace Billing Information	Marketplace Billing Name
Corporate & Billing Information	Marketplace Address Line 1	Marketplace Billing Information	Marketplace Address Line 1
Corporate & Billing Information	Marketplace Address Line 2	Marketplace Billing Information	Marketplace Address Line 2
Corporate & Billing Information	Marketplace City	Marketplace Billing Information	Marketplace City
Corporate & Billing Information	Marketplace State	Marketplace Billing Information	Marketplace State
Corporate & Billing Information	Marketplace Zip	Marketplace Billing Information	Marketplace Zip
Corporate & Billing Information	Marketplace Zip Extension	Marketplace Billing Information	Marketplace Zip Extension
Customer Service Contact - Individual	Individual Customer Service Phone	Issuer Marketplace Information	IFP Customer Service Phone
Customer Service Contact - Individual	Individual Customer Service Phone Extension	Issuer Marketplace Information	IFP Customer Service Phone Extension
Customer Service Contact - Individual	Individual Customer Service Toll Free	Issuer Marketplace Information	IFP Customer Service Toll Free
Customer Service Contact - Individual	Individual Customer Service TTY	Issuer Marketplace Information	IFP Customer Service TTY

Administrative Section	Administrative Section Field Name	HIOS Plan Finder Section	HIOS Plan Finder Field Name
Customer Service Contact - Individual	Individual Customer Service URL	Issuer Marketplace Information	IFP Customer Service URL
Customer Service Contact - SHOP	SHOP Customer Service Phone	Issuer Marketplace Information	SHOP Customer Service Phone
Customer Service Contact - SHOP	SHOP Customer Service Phone Extension	Issuer Marketplace Information	SHOP Customer Service Phone Extension
Customer Service Contact - SHOP	SHOP Customer Service Toll Free	Issuer Marketplace Information	SHOP Customer Service Toll Free
Customer Service Contact - SHOP	SHOP Customer Service TTY	Issuer Marketplace Information	SHOP Customer Service TTY
Customer Service Contact - SHOP	SHOP Customer Service URL	Issuer Marketplace Information	SHOP Customer Service URL

Once all errors resolve in the HIOS Plan Finder, and reflect in the Administrative Section, the user may select the ‘Save and Complete’ button to complete the section.

8.2 Interoperability Section

The Interoperability Section is required for QHP Applications in FFE and SPE states when the Product Offering includes "QHP", and the Market Coverage Type includes "Individual". This section requires the user to respond to a series of questions, as well as link relevant justification documents to the application based on their answers. An introduction is provided for the user, as well as instructions for completing the section *See Figure 8-2.*

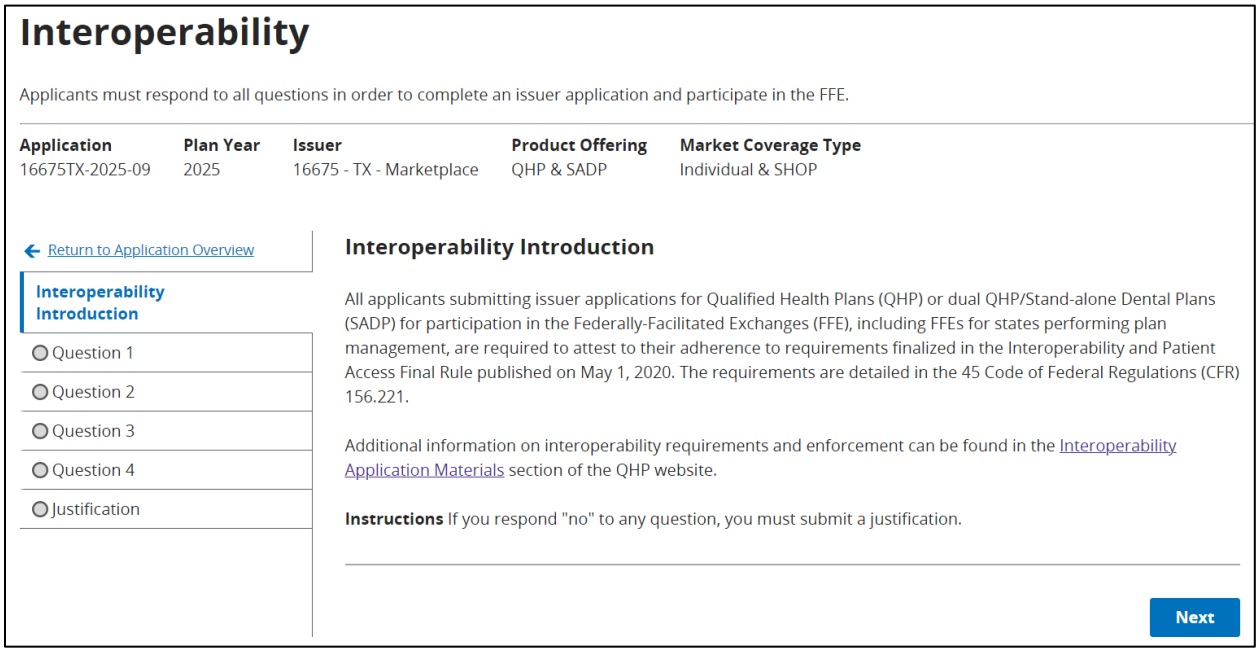


Figure 8-2. Interoperability Introduction

8.2.1 Responding to Interoperability Questions

Within each question, the user must respond 'Yes' or 'No, I will submit the Justification Form at the end of this section', then select the 'Save' button to save the response or select the 'Save and Next' button to save and proceed to the next question. *See Figure 8-3.*

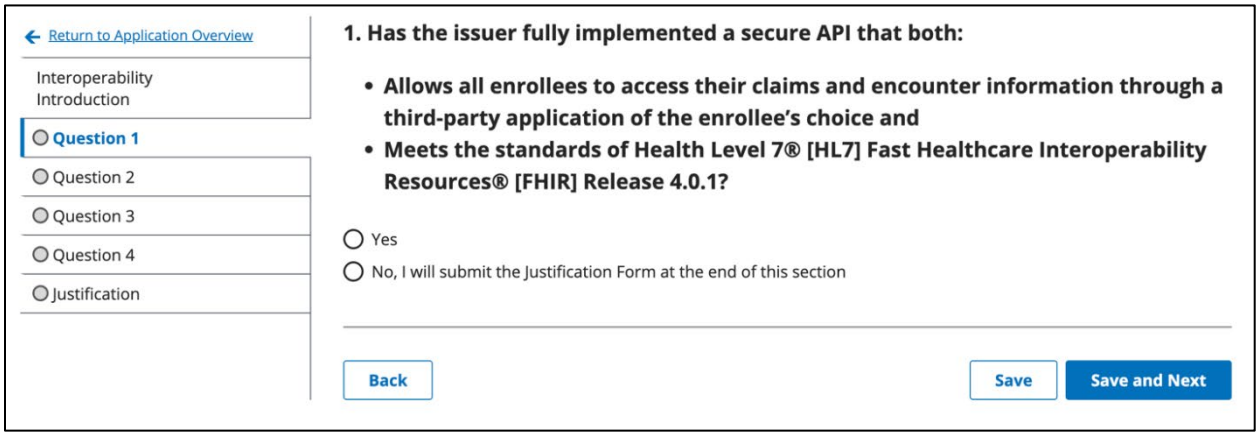


Figure 8-3. Interoperability Question 1

If a user answers "Yes" to questions 3 or 4, they are required to provide an active URL to demonstrate compliance with the question. A submitted URL must start with http:// or https://. Upon responding to the question or providing a URL, the user may select the 'Save' button to save their response or the 'Save and Next' button to proceed to the next question. *See Figure 8-4.*

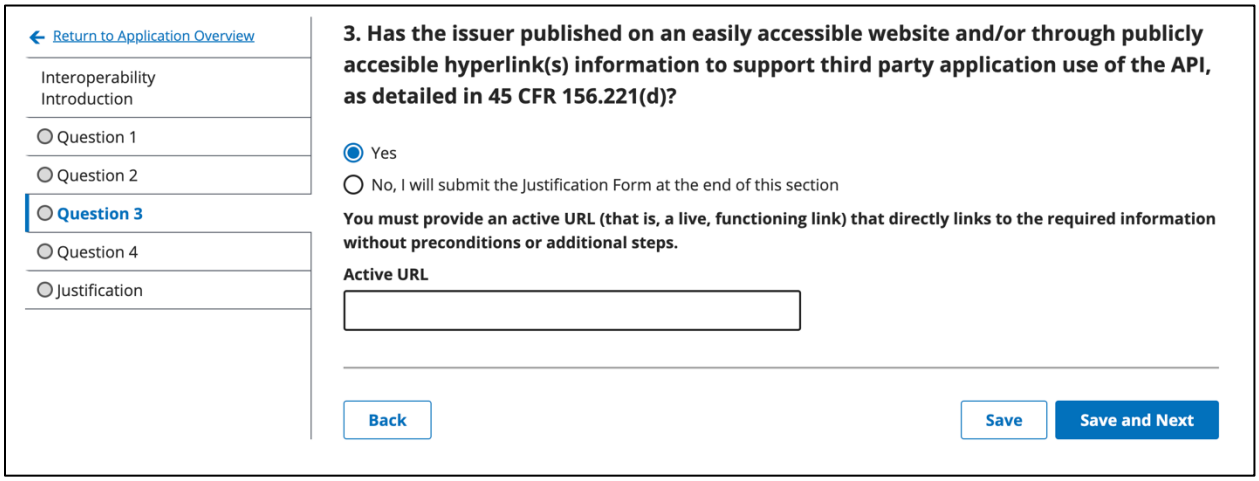


Figure 8-4. Interoperability Question 3

If the user provides a URL that has errors, an Interoperability Validation Results pop-up window will appear with detailed results. *See Figure 8-5.* Any invalid characters and missing URL format errors will appear inline in red with the text box.

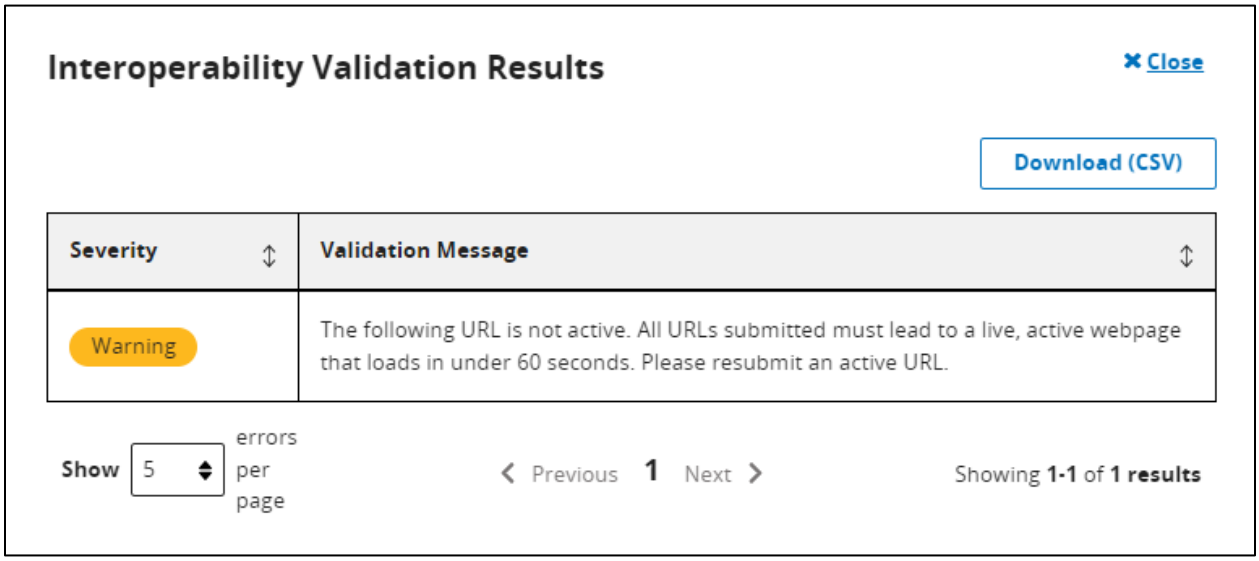


Figure 8-5. Interoperability Errors

8.2.2 Submitting an Interoperability Justification

If a user answers "No" to any of the interoperability questions, they are required to upload a Justification Form document that contains information detailed in the section. *See Figure 8-6.*

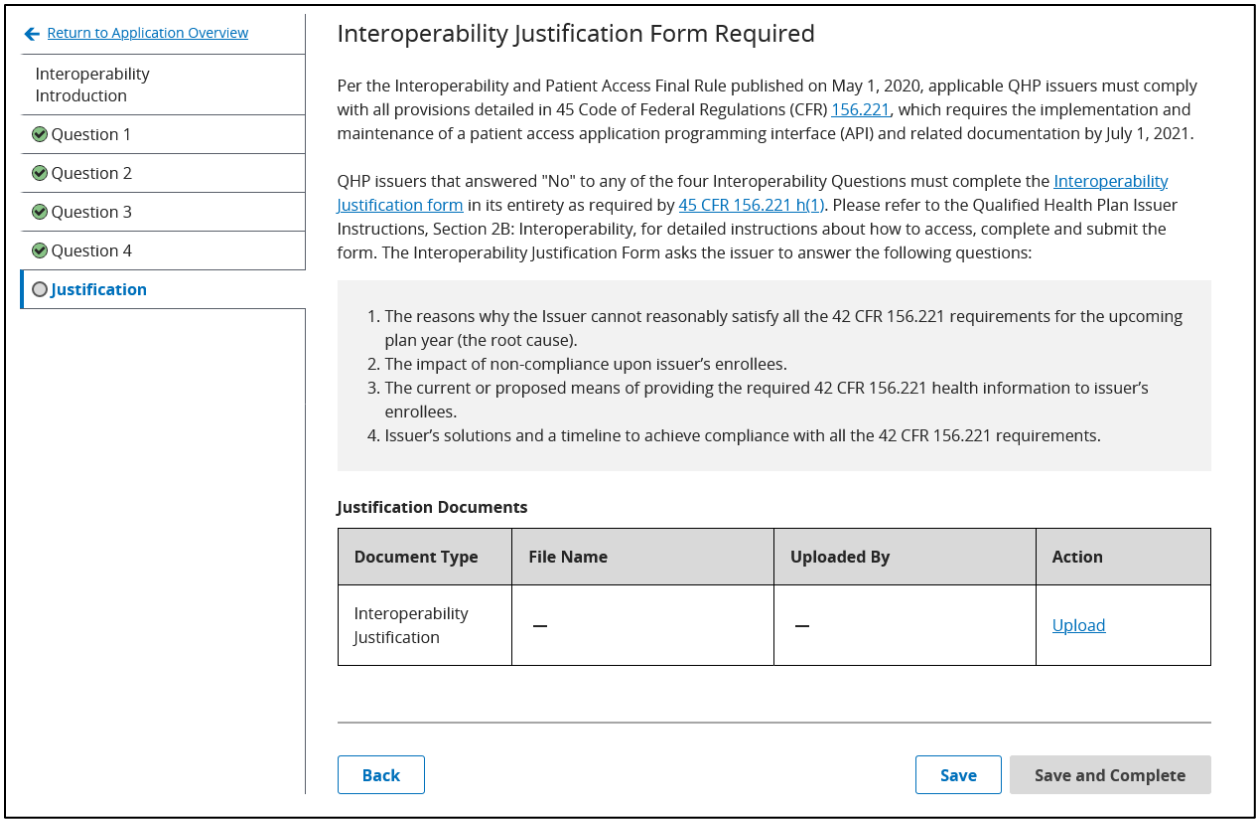


Figure 8-6. Interoperability Justification Documents

If a user answers "Yes" to all four questions, they are not required to upload a justification document. *See Figure 8-7.*

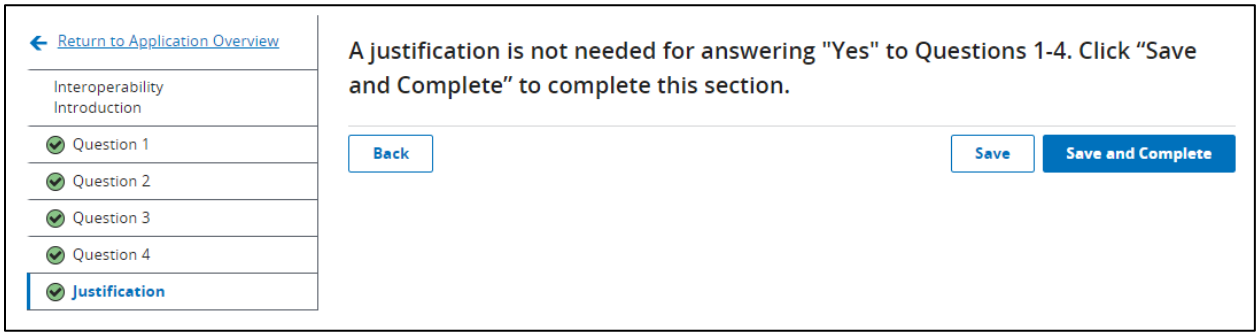


Figure 8-7. Interoperability Justification Documents Are Not Required

Once all questions have been responded to and any Justification Documents have been uploaded, the user may select the 'Save and Complete' button, redirecting the user to Application Overview, and the Interoperability Section displays as Completed.

8.3 Program Attestations Section

The Program Attestations section is required for all QHP Applications, and dynamically adjusts based on the Product Offerings of the application being submitted.

Note: This section will not display for SERFF Issuers.

8.3.1 Responding to Program Attestations

Table 8-3 below provides the logic used to determine what Program Attestations display to the user based on the Product Offering.

Table 8-3. Program Attestation Display Logic

Product Offering	Attestations Displayed
QHP & SADP	QHP & SADP Attestation QHP Attestation SADP Attestation
QHP	QHP & SADP Attestation QHP Attestation
SADP	QHP & SADP Attestation SADP Attestation

Within the Attestation section, the user must agree to the statement listed by selecting the check box. *See Figure 8-8.* Selecting the 'Save and Complete' button returns the user to Application Overview.

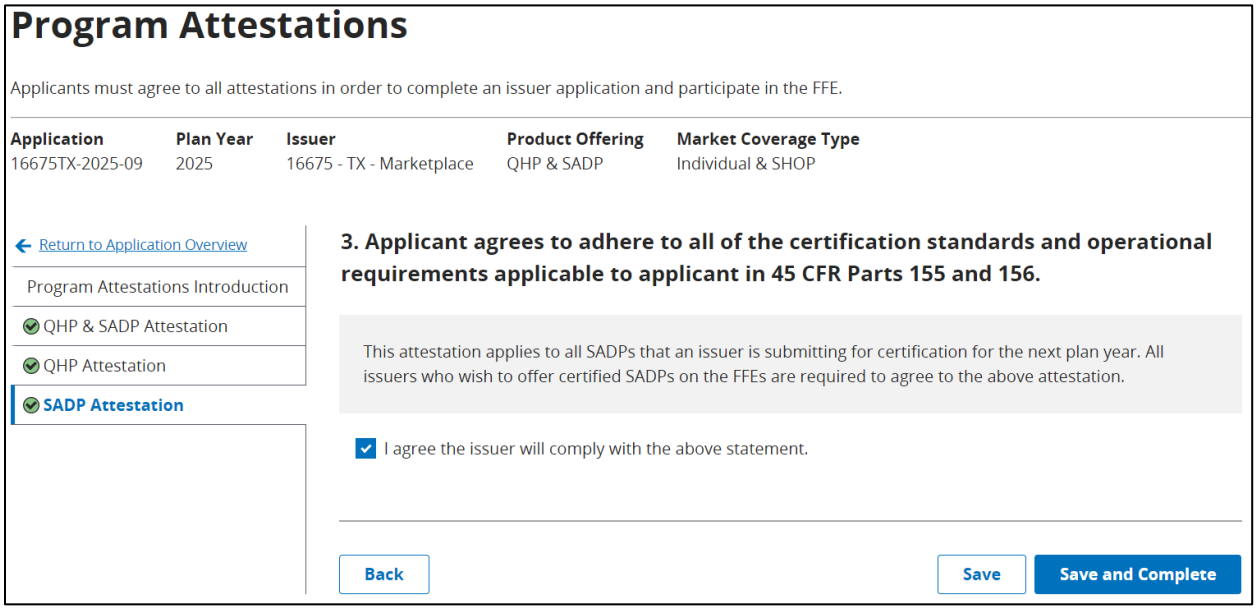


Figure 8-8. Program Attestations

8.4 Business Rules Section

The Business Rules Section is required as part of all QHP Applications, and only requires a Business Rules template XLS to be linked. *See Figure 8-9.*

Note: This section and group will not be editable for SERFF Issuers.

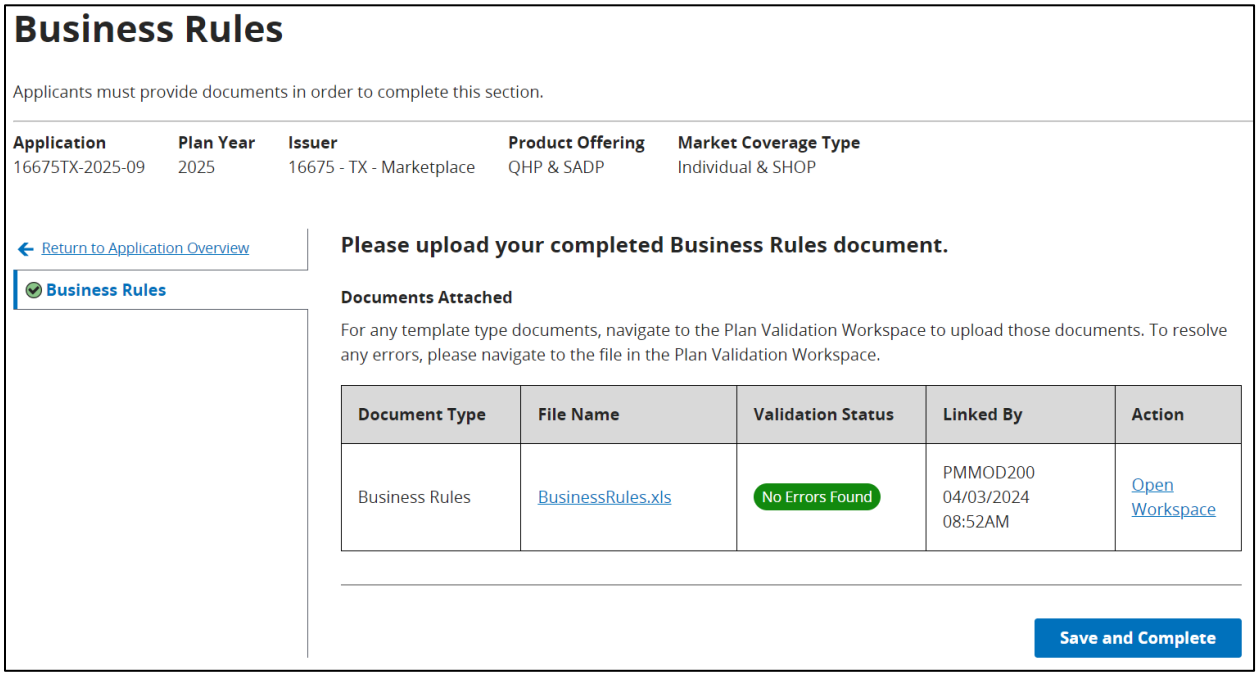


Figure 8-9. Business Rules Section

8.5 Plans and Benefits Section

The Plans and Benefits Section is required for all QHP Applications, and dynamically adjusts based on the type of application being submitted and whether the Plans and Benefits templates XML linked to the application require supporting documentation.

Note: This section will only be editable by SERFF issuers submitting Individual QHPs beginning in section 8.6.3. Sections 8.6.1 and 8.6.2 are not applicable for SERFF issuers.

8.5.1 Linking Plans and Benefits Templates

The list of Plans and Benefits templates listed in the Documents Attached section are dynamically adjusted based on the Product Offering and Market Coverage Type of the application. See Figure 8-10.

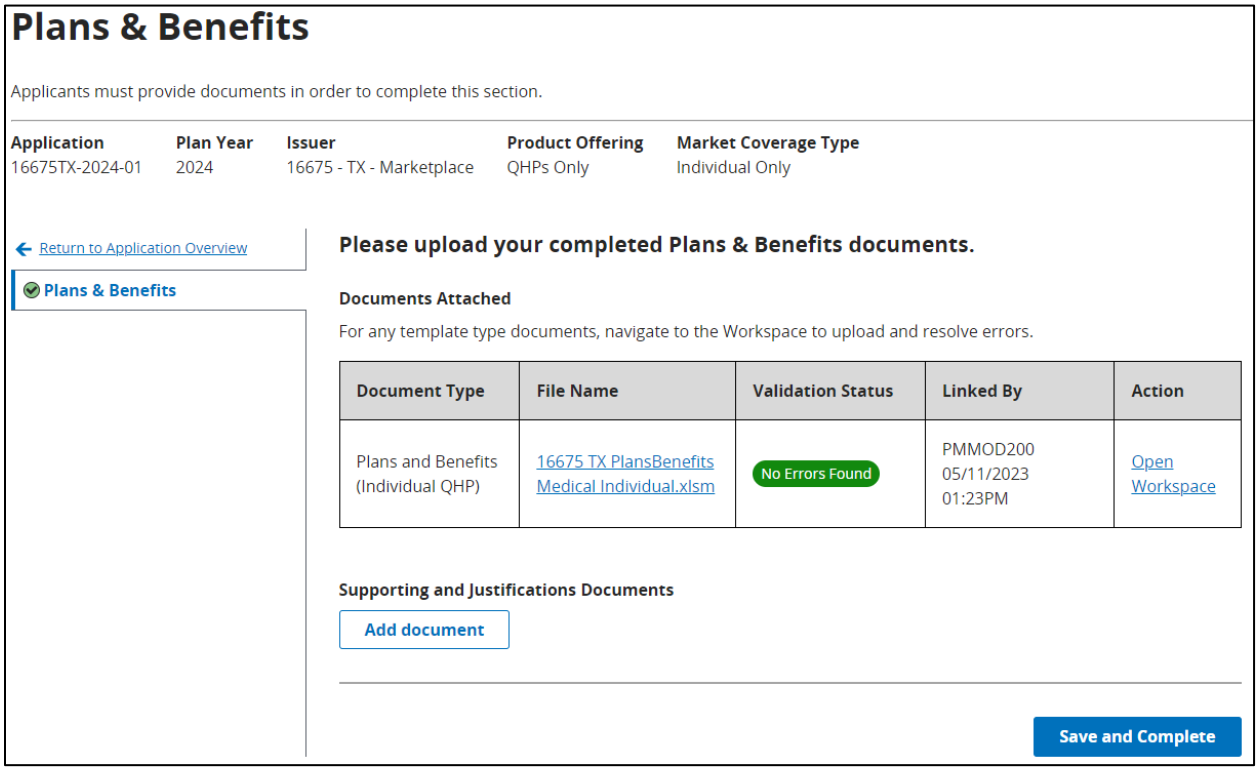


Figure 8-10. Plans and Benefits Templates

Table 8-4 below provides the logic used to determine what Plans and Benefits templates are displayed to the user.

Table 8-4. Plans and Benefit Template Display Logic

Product Offering	Market Coverage Type	Templates Displayed
QHP & SADP	Individual & SHOP	Plans & Benefits (Individual QHP) Plans & Benefits (Individual SADP) Plans & Benefits (SHOP QHP) Plans & Benefits (SHOP SADP)
QHP & SADP	Individual	Plans & Benefits (Individual QHP) Plans & Benefits (Individual SADP)
QHP & SADP	SHOP	Plans & Benefits (SHOP QHP) Plans & Benefits (SHOP SADP)
QHP	Individual & SHOP	Plans & Benefits (Individual QHP) Plans & Benefits (SHOP QHP)
QHP	Individual	Plans & Benefits (Individual QHP)
QHP	SHOP	Plans & Benefits (SHOP QHP)
SADP	Individual & SHOP	Plans & Benefits (Individual SADP) Plans & Benefits (SHOP SADP)
SADP	Individual	Plans & Benefits (Individual SADP)
SADP	SHOP	Plans & Benefits (SHOP SADP)

8.5.2 Adding Supporting Documentation

The list of supporting documents the user may select from are also dynamically adjusted based on the Product Offering and Market Coverage Type of the application. *See Figure 8-11*.

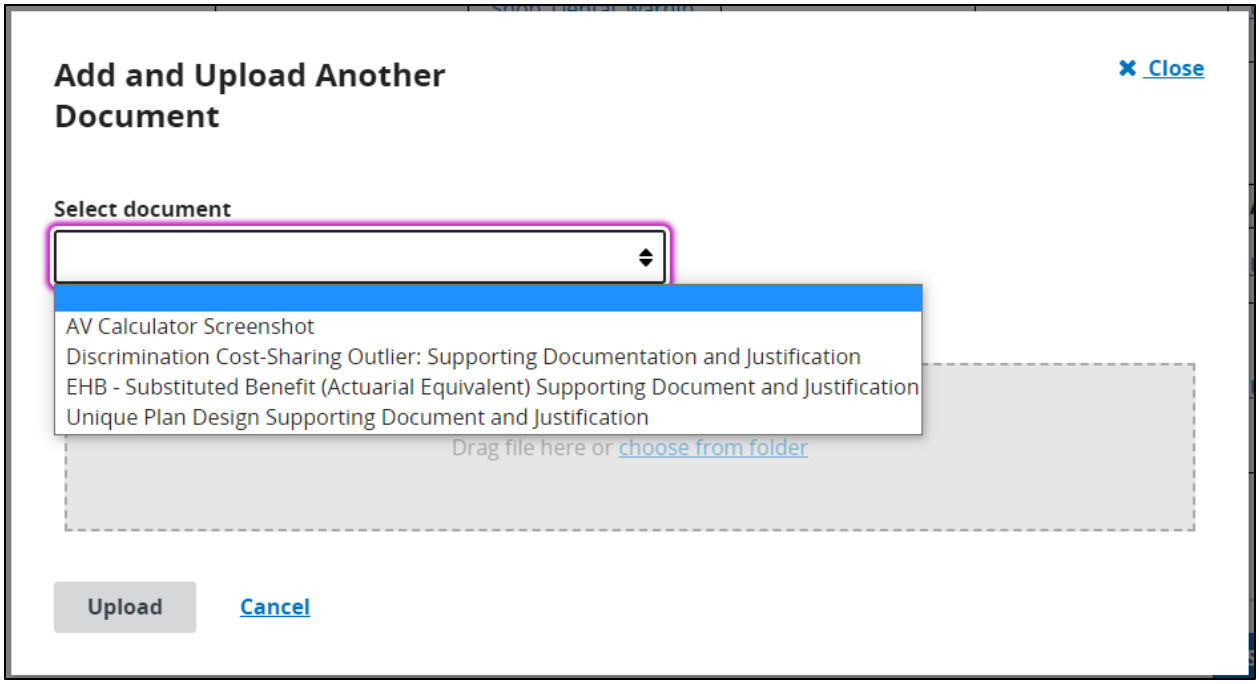


Figure 8-11. Plans and Benefits Supporting Documents

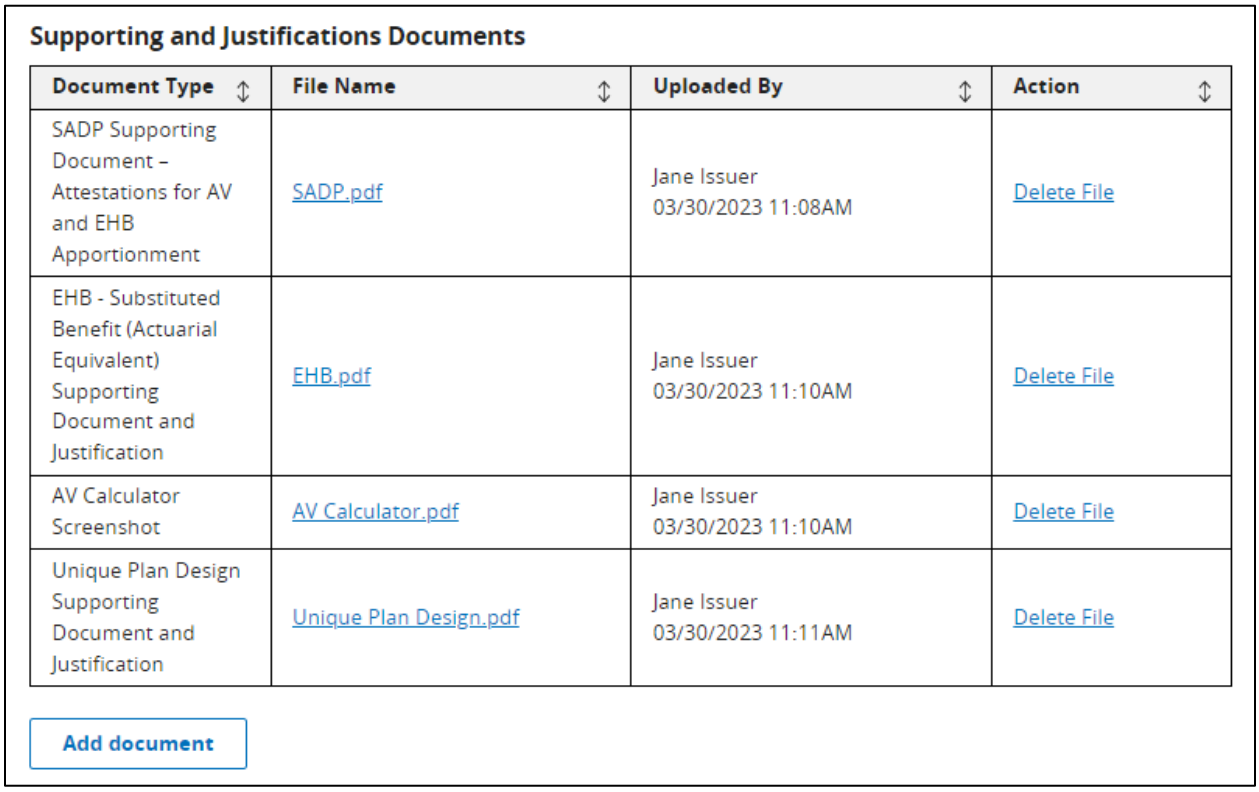
Table 8-5 below provides the logic used to determine what Supporting Document types are displayed to the user.

Table 8-5. Plans and Benefits Supporting Documentation Display Logic

Product Offering	Market Coverage Type	Supporting Documents Displayed
QHP & SADP	Individual & SHOP	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification • Unique Plan Design Supporting Document and Justification • SADP Supporting Document – Attestations for AV and EHB Apportionment
QHP & SADP	Individual	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification • Unique Plan Design Supporting Document and Justification • SADP Supporting Document – Attestations for AV and EHB Apportionment

Product Offering	Market Coverage Type	Supporting Documents Displayed
QHP & SADP	SHOP	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification • SADP Supporting Document – Attestations for AV and EHB Apportionment
QHP	Individual & SHOP	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification
QHP	Individual	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification
QHP	SHOP	• AV Calculator Screenshot • Discrimination Cost Sharing Outlier: Supporting Documentation and Justification • EHB – Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification
SADP	Individual & SHOP	• SADP Supporting Document – Attestations for AV and EHB Apportionment
SADP	Individual	• SADP Supporting Document – Attestations for AV and EHB Apportionment
SADP	SHOP	• SADP Supporting Document – Attestations for AV and EHB Apportionment

Any supporting documents required based on the Warnings found in the Plans and Benefits templates linked to the application are automatically displayed in the Supporting and Justifications Documents table. *See Figure 8-12.*



Supporting and Justifications Documents

Document Type	File Name	Uploaded By	Action
SADP Supporting Document – Attestations for AV and EHB Apportionment	SADP.pdf	Jane Issuer 03/30/2023 11:08AM	Delete File
EHB - Substituted Benefit (Actuarial Equivalent) Supporting Document and Justification	EHB.pdf	Jane Issuer 03/30/2023 11:10AM	Delete File
AV Calculator Screenshot	AV Calculator.pdf	Jane Issuer 03/30/2023 11:10AM	Delete File
Unique Plan Design Supporting Document and Justification	Unique Plan Design.pdf	Jane Issuer 03/30/2023 11:11AM	Delete File

Add document

Figure 8-12. Select Supporting Documents

8.5.3 Non-standardized Plan Option Limit Exception Justifications

For Plan Year 2025, users submitting a QHP application that includes Individual QHPs will be required to select the 'Cross Validate Templates' button. If the user receives validation warning code 12210015, the system requires a justification to be submitted for each unique warning message.

Note: This new action is also required for SERFF submitting issuers. The 'Cross Validate Templates' button will be enabled once a Plans and Benefits and Service Area template is linked to the user's application (for FFE issuers), or once Plan Transfers have been received (for SERFF submitting issuers). *See Figure 8-13*

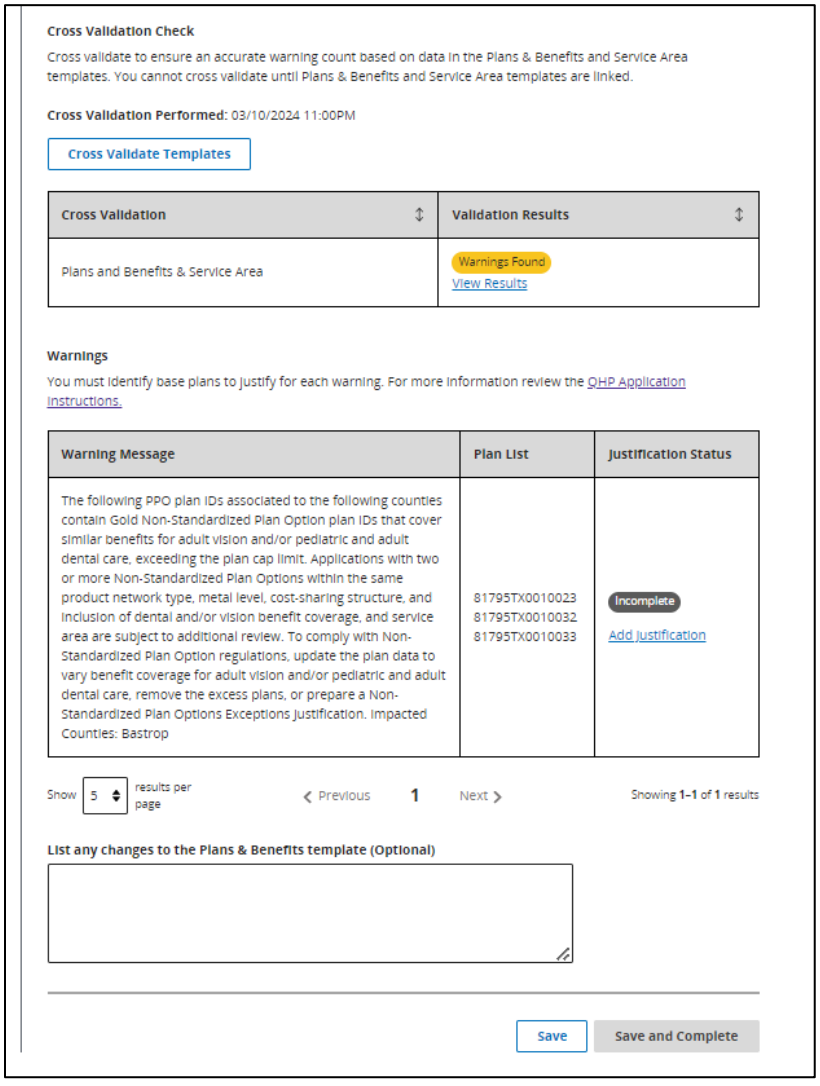


Figure 8-13. NSPOLE Justifications

The user must select which plans are being justified, respond to the questions on the screen for each plan, and upload the supporting actuarial memorandum before successfully saving the justification. When linking a new Plans and Benefits template, users are encouraged (but not required) to answer the optional question listing any changes to the Plans and Benefits template that they deem relevant to the NSPOLE justifications. *See Figure 8-14.*

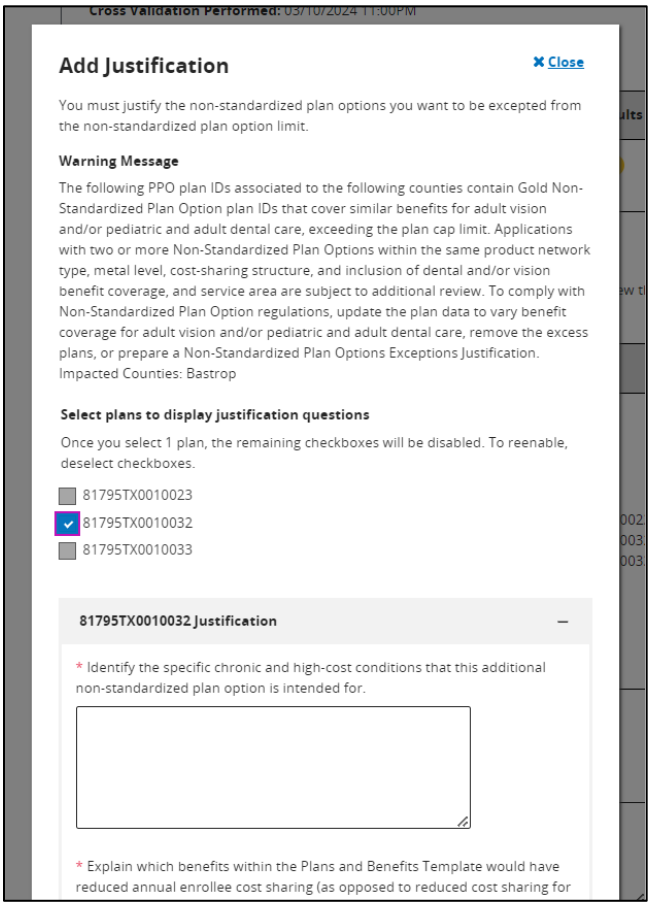


Figure 8-14. Add NSPOLE Justification Modal

Once the justification is saved, the user will receive a confirmation message indicating the justification was saved successfully, and the Justification Status is updated to Complete. *See Figure 8-15.*

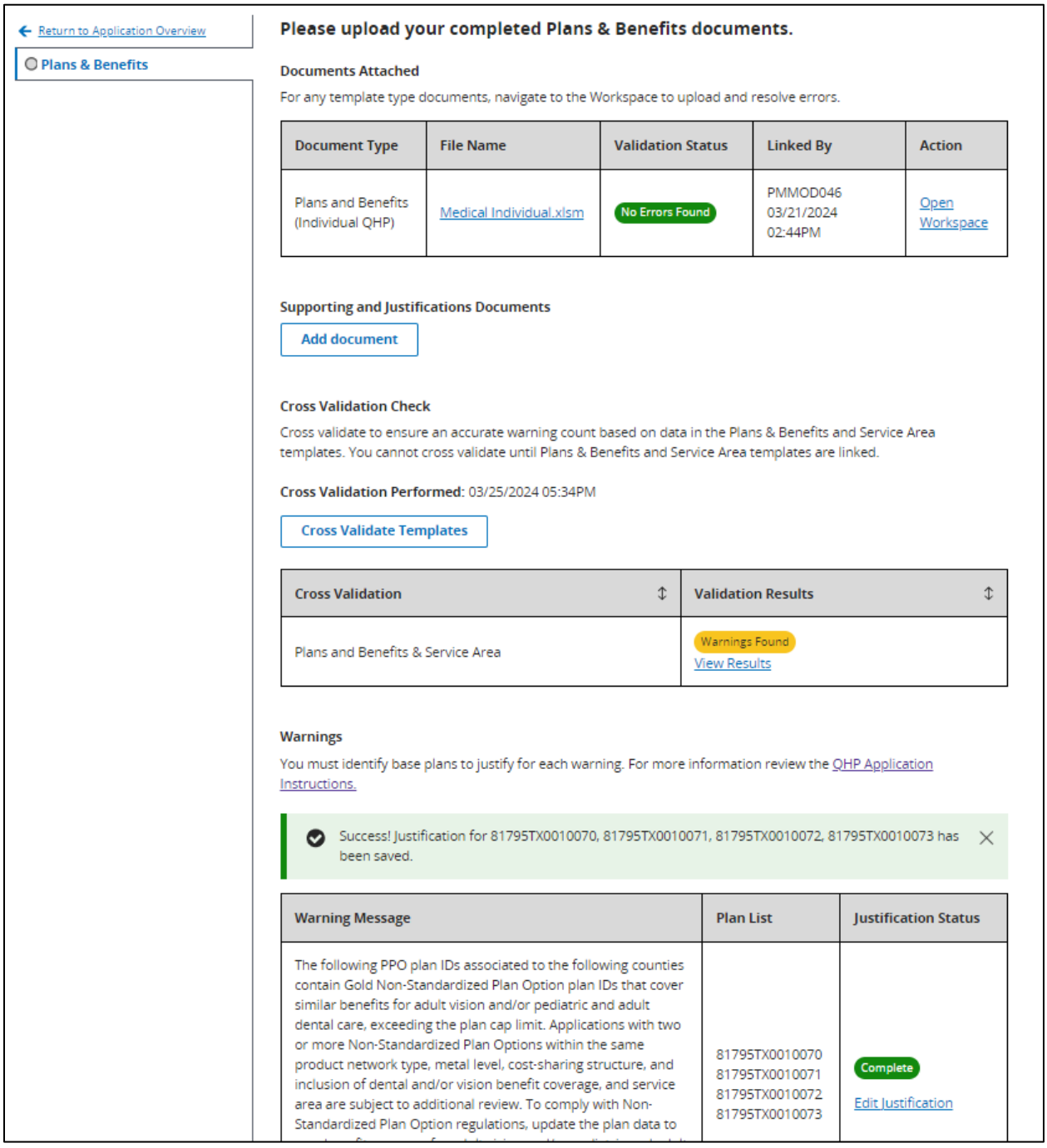


Figure 8-15. Save and Complete Plans and Benefits Section

8.6 Prescription Drug Section

The Prescription Drugs Section is required for QHP Applications with a Product Offering that includes "QHP", and dynamically displays the Supporting and Justification Documents section as required based on the status of the Prescription Drug template XML. Once the required supporting documents are uploaded, the user may select the 'Save and Complete' button. *See Figure 8-16.*

Note: This section will not be editable by SERFF Issuers.

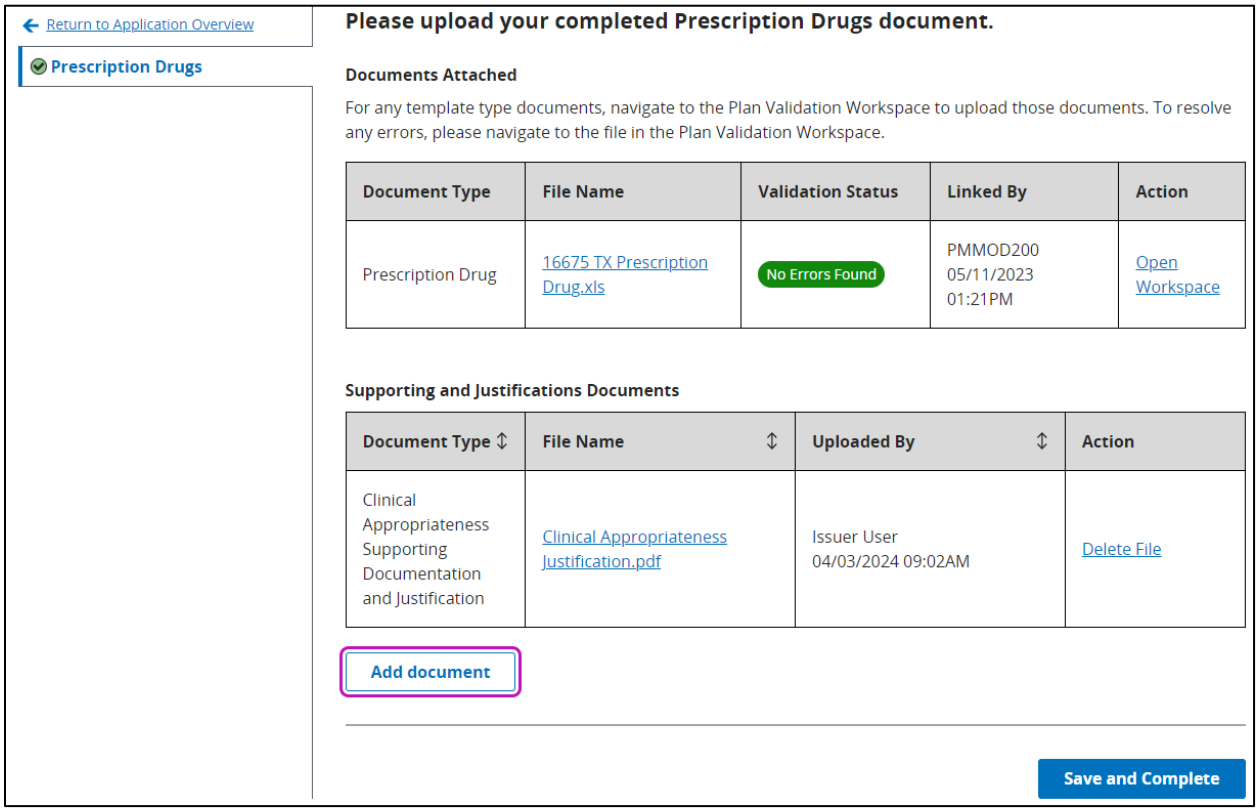


Figure 8-16. Save and Complete Prescription Drugs Section

8.7 Service Area Section

The Service Area Section is required for all QHP Applications and dynamically displays the Supporting and Justification Documents section as required based on the status of the Service Area template XML. Supporting and Justification Documents may not be required. *See Figure 8-17.*

Note: This section will not be editable by SERFF Issuers.

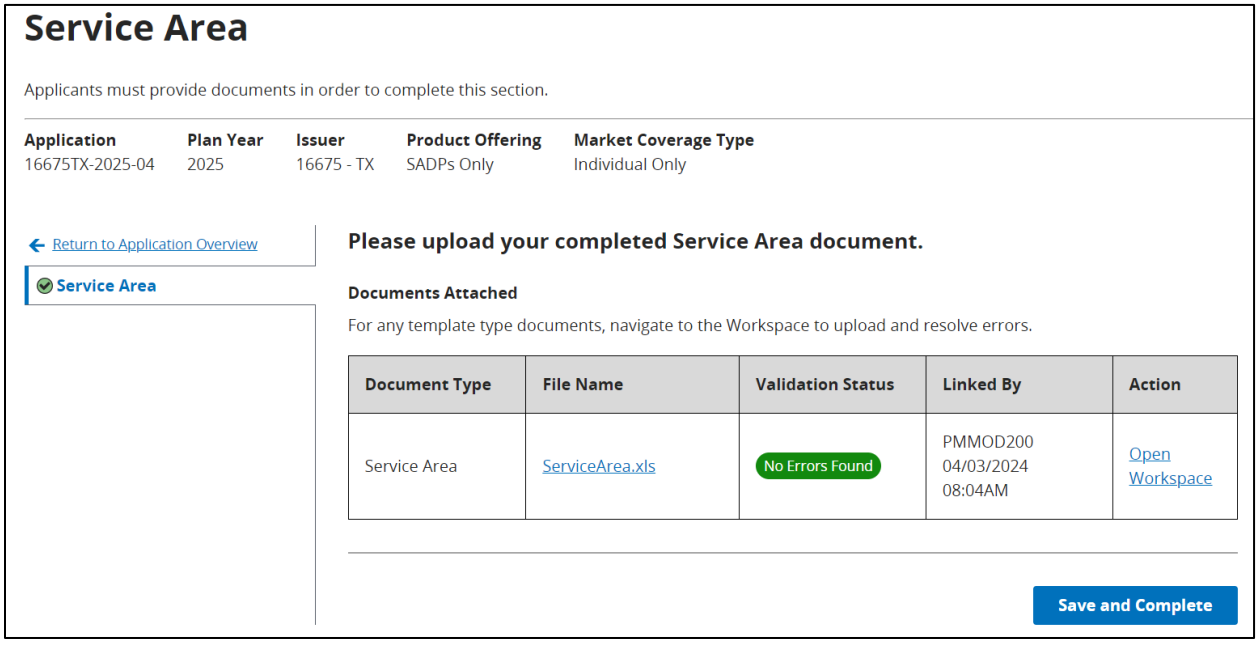


Figure 8-17. Service Area Section Page

Once any required supporting documents are uploaded, the user may select the 'Save and Complete' button. *See Figure 8-18.*

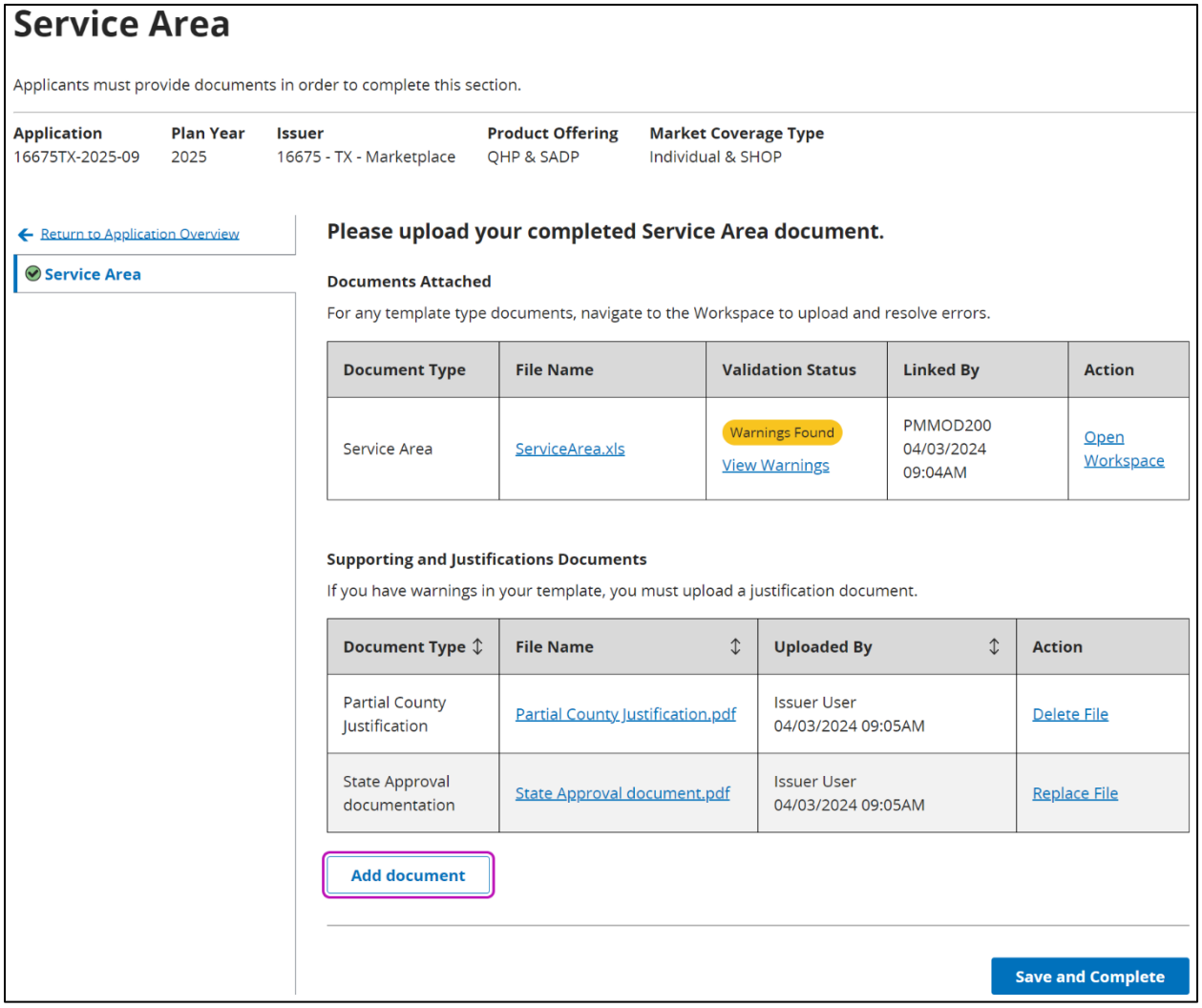


Figure 8-18. Save and Complete Service Area Section

8.8 Network ID Section

The Network ID Section is required as part of all QHP Applications, and only requires a Network ID template XLS to be linked. *See Figure 8-19.*

Note: This section will not be editable by SERFF Issuers.

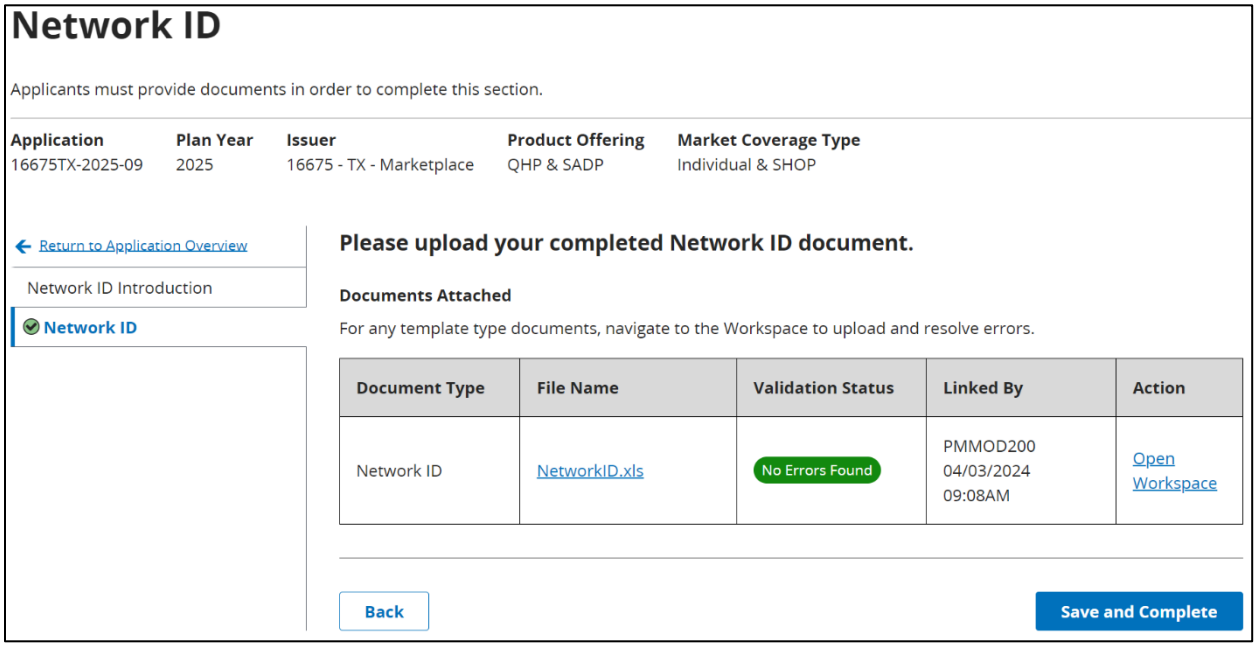


Figure 8-19. Network ID Section

8.9 Essential Community Providers

The Essential Community Providers Section is required for all QHP Applications. The user is required to indicate if they are an Alternate or General Standard Issuer. Additionally, if the user submitted a QHP application in the previous plan year, they have the option to import ECPs for specific networks from the prior year ECP/NA template. *See Figure 8-20.*

Note: The ECP Introduction & Setup page will be locked once the user selects 'Save and Next', and users will no longer be able to edit responses on this page.

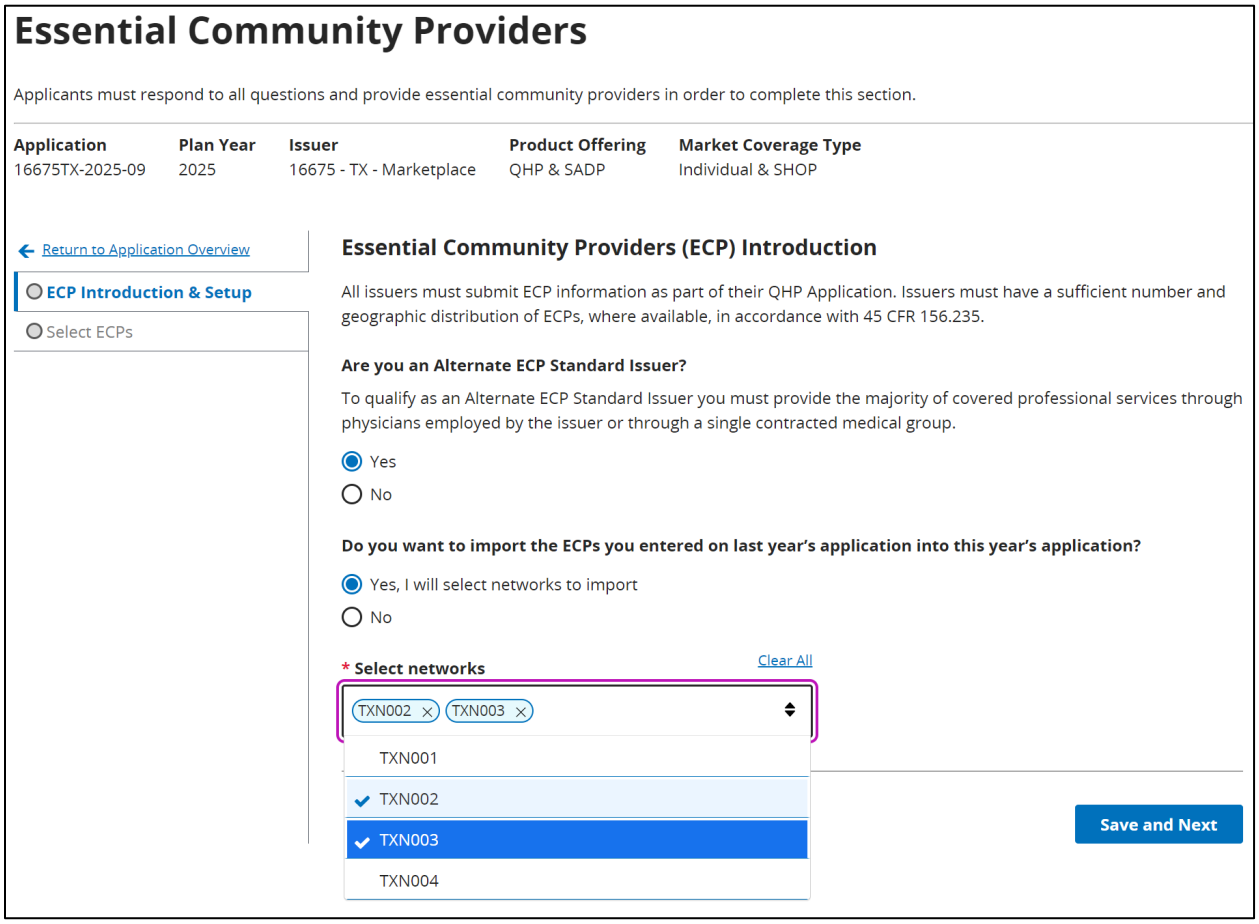


Figure 8-20. ECP Introduction and Setup

After selecting the 'Save and Next' button, the user is directed to the Select ECPs tab, where they can view, add, and edit ECPs in their list. *See Figure 8-21.*

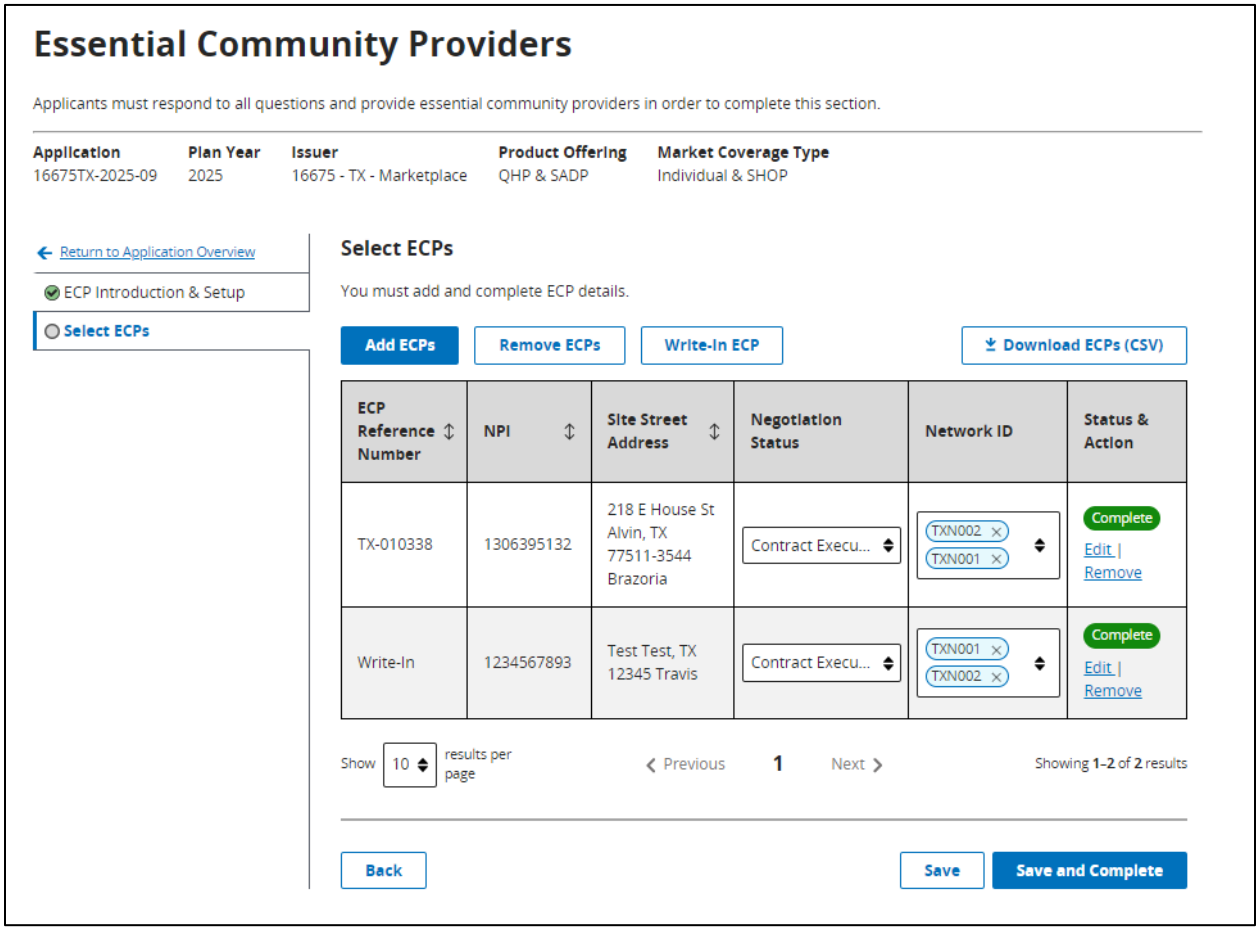


Figure 8-21. Select ECPs Tab

The user is able to search for and select available ECPs to add to their ECP list using the 'Add ECP' button. *See Figure 8-22.*

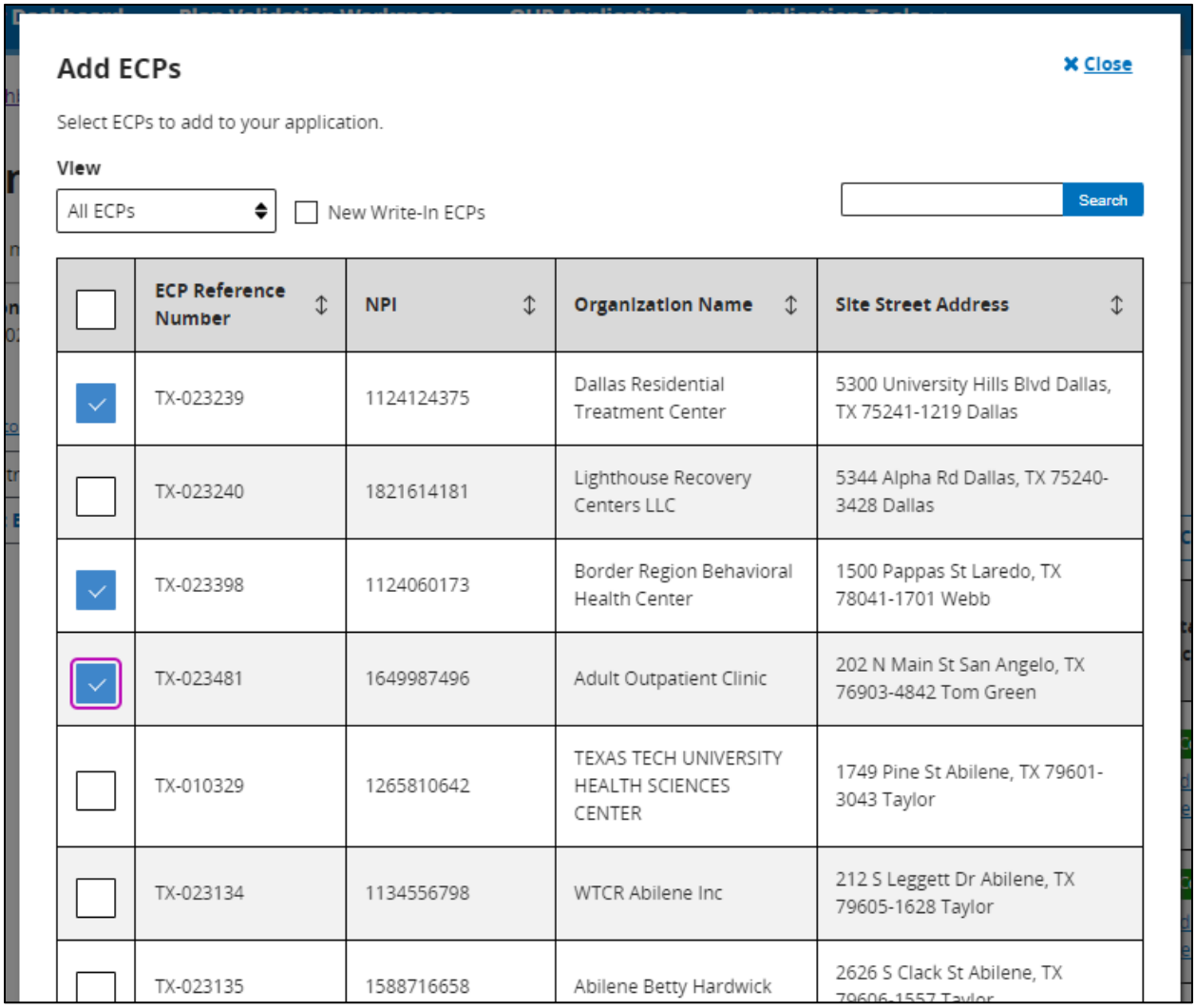


Figure 8-22. Add ECPs Modal

Alternate Standard issuers will be able to add custom write-in providers by selecting the 'Write-in ECP' button. *See Figure 8-23.*

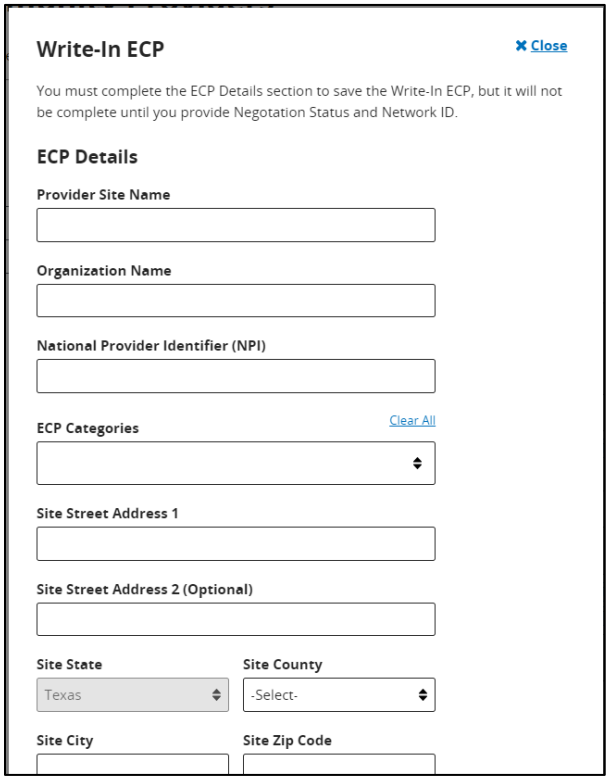


Figure 8-23. Add Write-In ECP Modal

Once an ECP is added to the table, users can edit or remove the provider. After selecting 'Edit' or 'View', a new modal displays additional details related to the provider. *See Figure 8-24.*

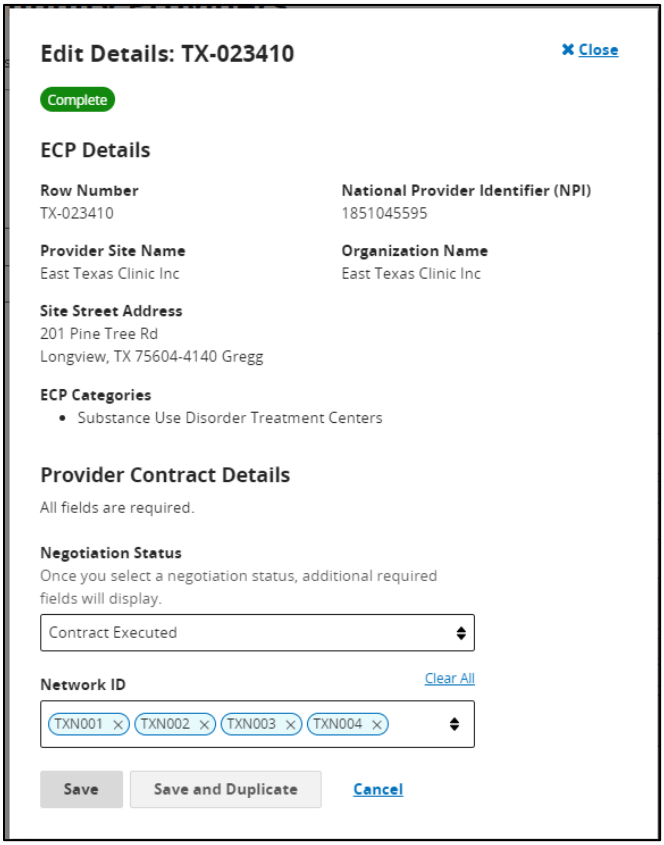
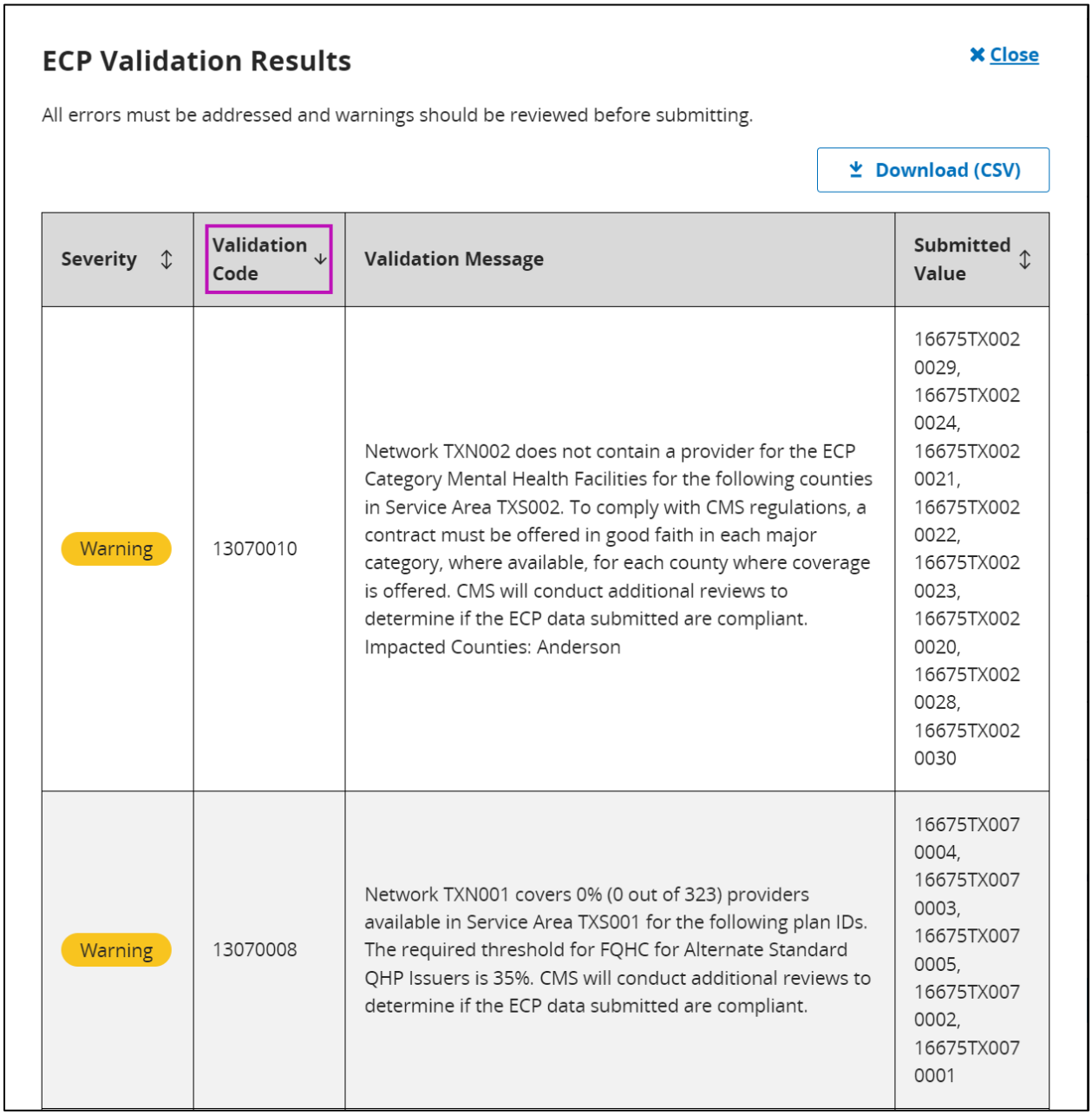


Figure 8-24. Edit ECP Details Modal

After selecting the 'Save and Complete' button, FFE users will see validation warnings if they are not meeting threshold or category per county requirements. If they choose to proceed, the user is redirected to Application Overview page, and the ECP section displays as 'Ready to Submit'. *See Figure 8-25.*



ECP Validation Results

Close

All errors must be addressed and warnings should be reviewed before submitting.

Download (CSV)

Severity	Validation Code	Validation Message	Submitted Value
Warning	13070010	Network TXN002 does not contain a provider for the ECP Category Mental Health Facilities for the following counties in Service Area TXS002. To comply with CMS regulations, a contract must be offered in good faith in each major category, where available, for each county where coverage is offered. CMS will conduct additional reviews to determine if the ECP data submitted are compliant. Impacted Counties: Anderson	16675TX0020029, 16675TX0020024, 16675TX0020021, 16675TX0020022, 16675TX0020023, 16675TX0020020, 16675TX0020028, 16675TX0020030
Warning	13070008	Network TXN001 covers 0% (0 out of 323) providers available in Service Area TXS001 for the following plan IDs. The required threshold for FQHC for Alternate Standard QHP Issuers is 35%. CMS will conduct additional reviews to determine if the ECP data submitted are compliant.	16675TX0070004, 16675TX0070003, 16675TX0070005, 16675TX0070002, 16675TX0070001

Figure 8-25. ECP Validation Results Modal

8.10 Network Adequacy

The Network Adequacy Section is required for all QHP Applications, and only requires a Network Adequacy template ZIP to be linked. *See Figure 8-26.*

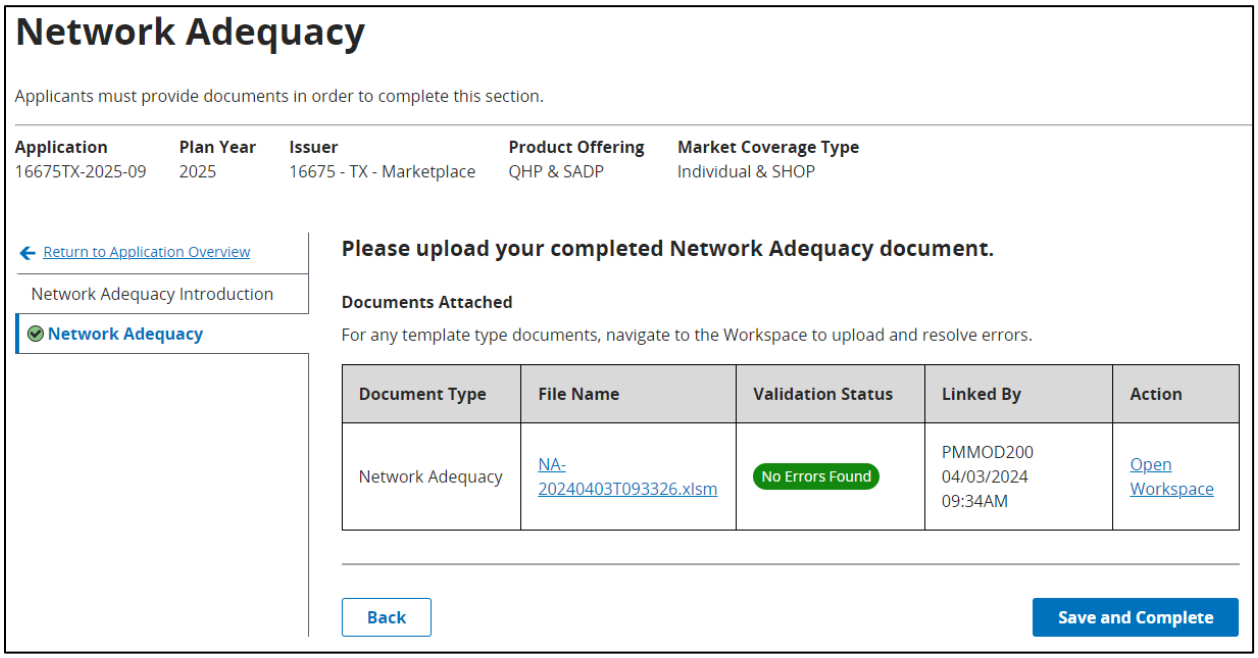


Figure 8-26. Network Adequacy section

8.11 Plan ID Crosswalk

The Plan ID Crosswalk Section is required for QHP Applications with a Market Coverage Type that includes "Individual", and dynamically adjusts based on the type of application being submitted and what Plan ID Crosswalk templates and justifications are required.

8.11.1 Responding to Introduction & Setup Questions

The user is required to respond to all questions on the Plan ID Crosswalk Introduction & Setup page. *See Figure 8-27.*

Note: The "What type of stand alone dental plans (SADPs) are you offering for PY2025?" question will not be displayed for QHP Applications that do not include a Product Offering of "SADP".

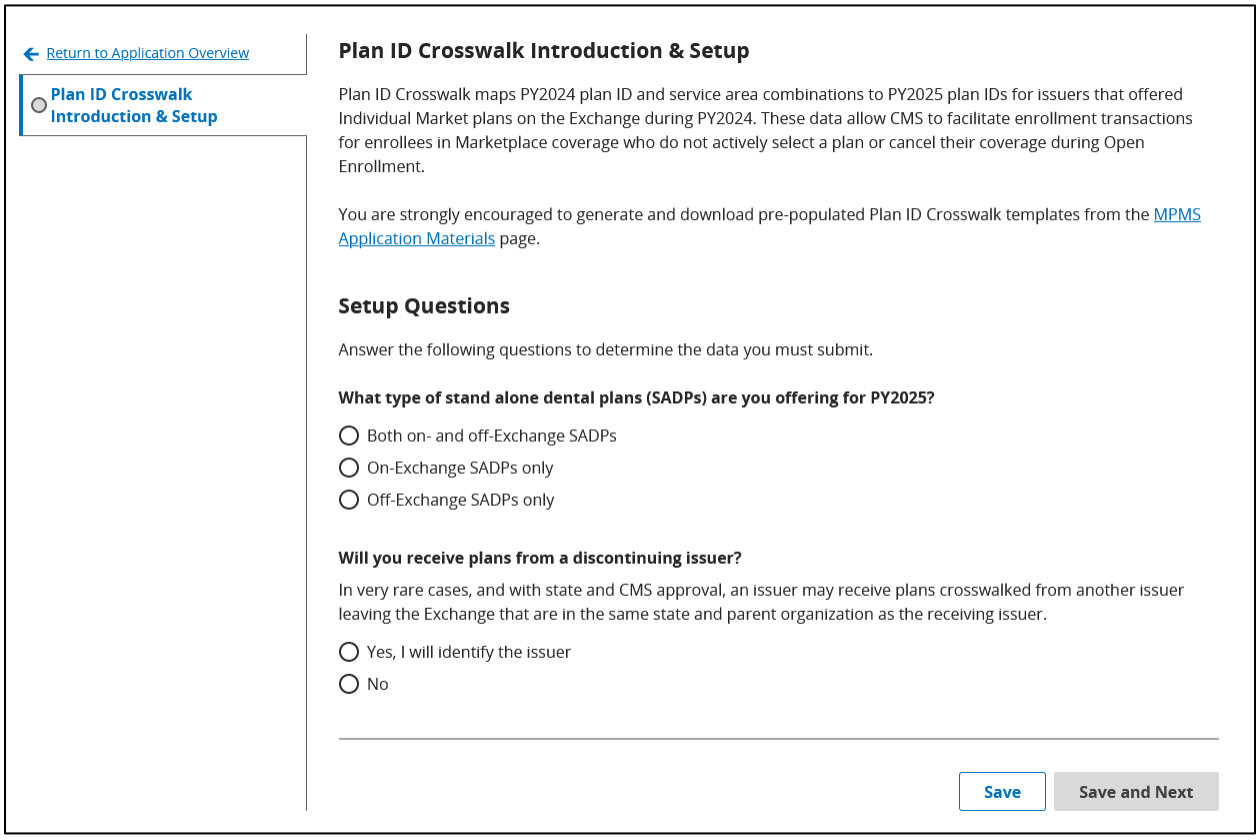


Figure 8-27. Plan ID Crosswalk Introduction & Setup

If the user responds ‘Yes, I will identify the issuer’, a dropdown displays requiring the user to select a Discontinuing Issuer ID. *See Figure 8-28.* If the user responds ‘No’, they can save their responses and continue to the next page by selecting the ‘Save and Next’ button.

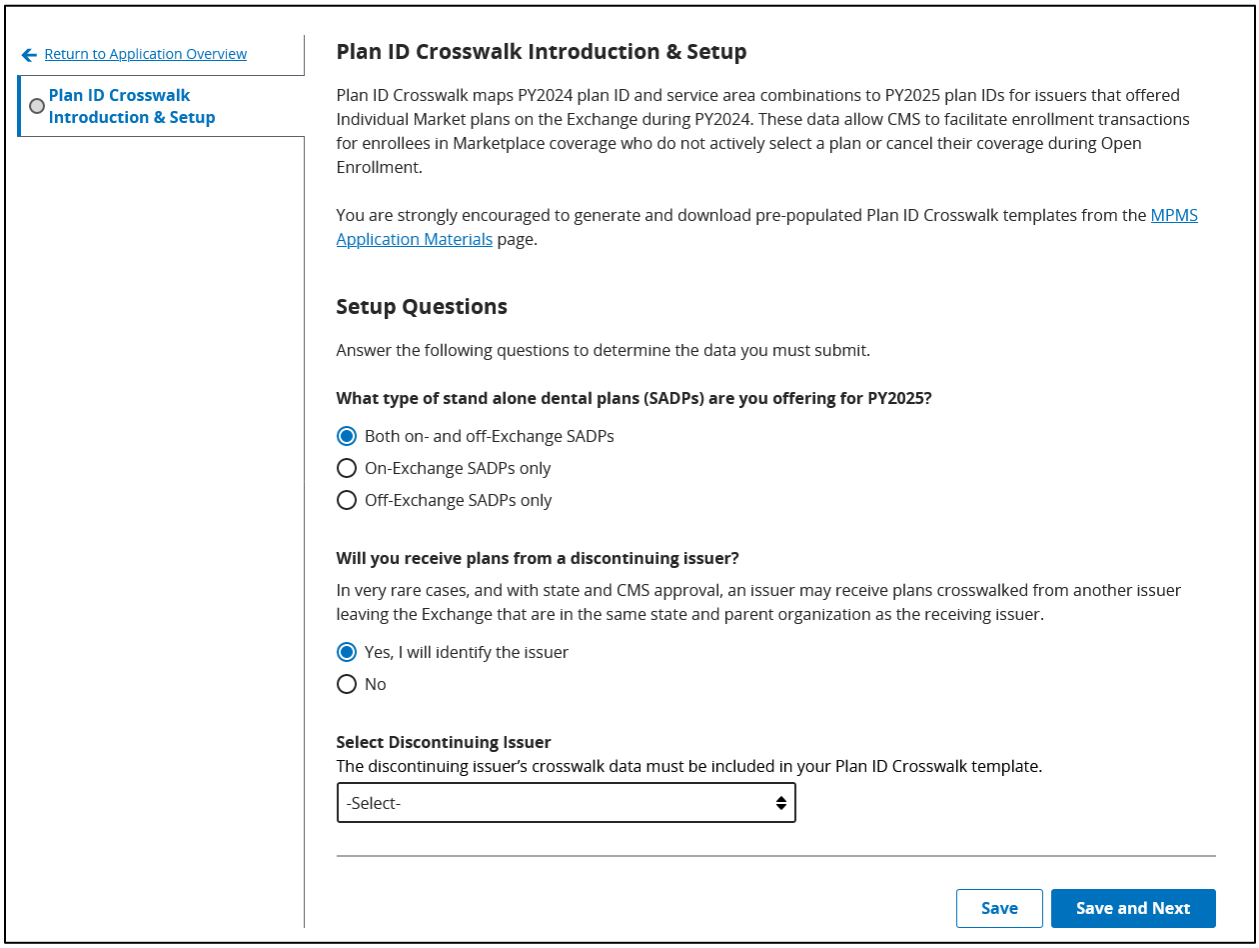


Figure 8-28. Select Discontinuing Issuer

Based on the responses, the user may be allowed to complete the Plan ID Crosswalk section without submitting any templates. In this scenario, the user will receive a pop-up allowing them to complete the section. See *Figure 8-29*. The user will be navigated to the Application Overview page after selecting 'Yes, Complete Section' and a success banner will display notifying the user the section is complete.

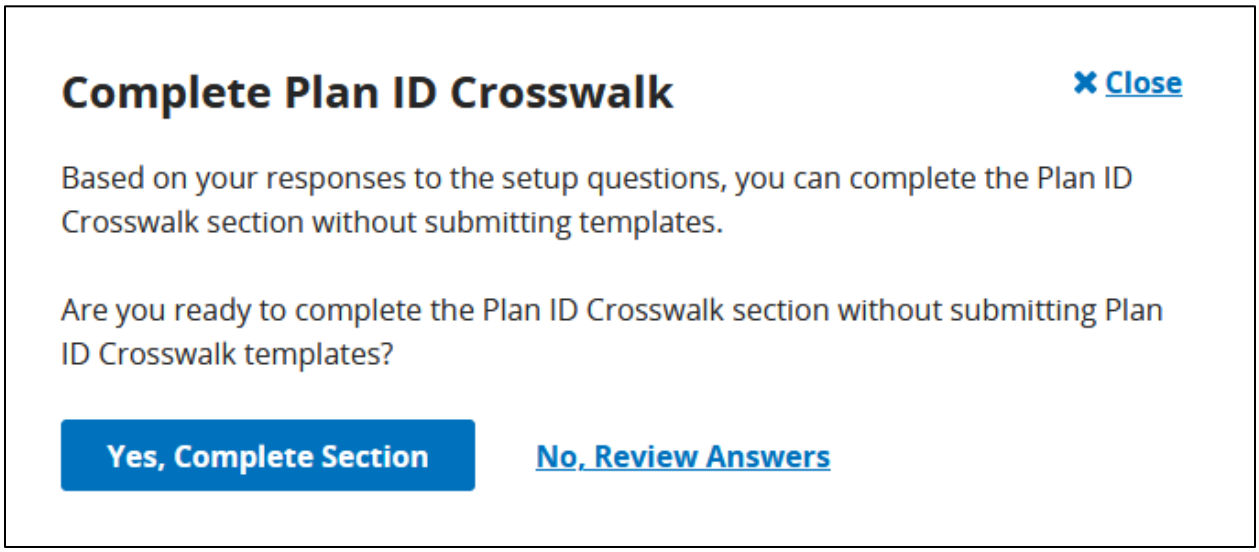


Figure 8-29. Complete Plan ID Crosswalk Section Pop-Up

8.11.2 Plan ID Crosswalk QHP/SADP

The Plan ID Crosswalk QHP and Plan ID Crosswalk SADP tabs will dynamically display based on the Product Offering details of the application and what plans were available in the previous plan year. See *Figure 8-30*.

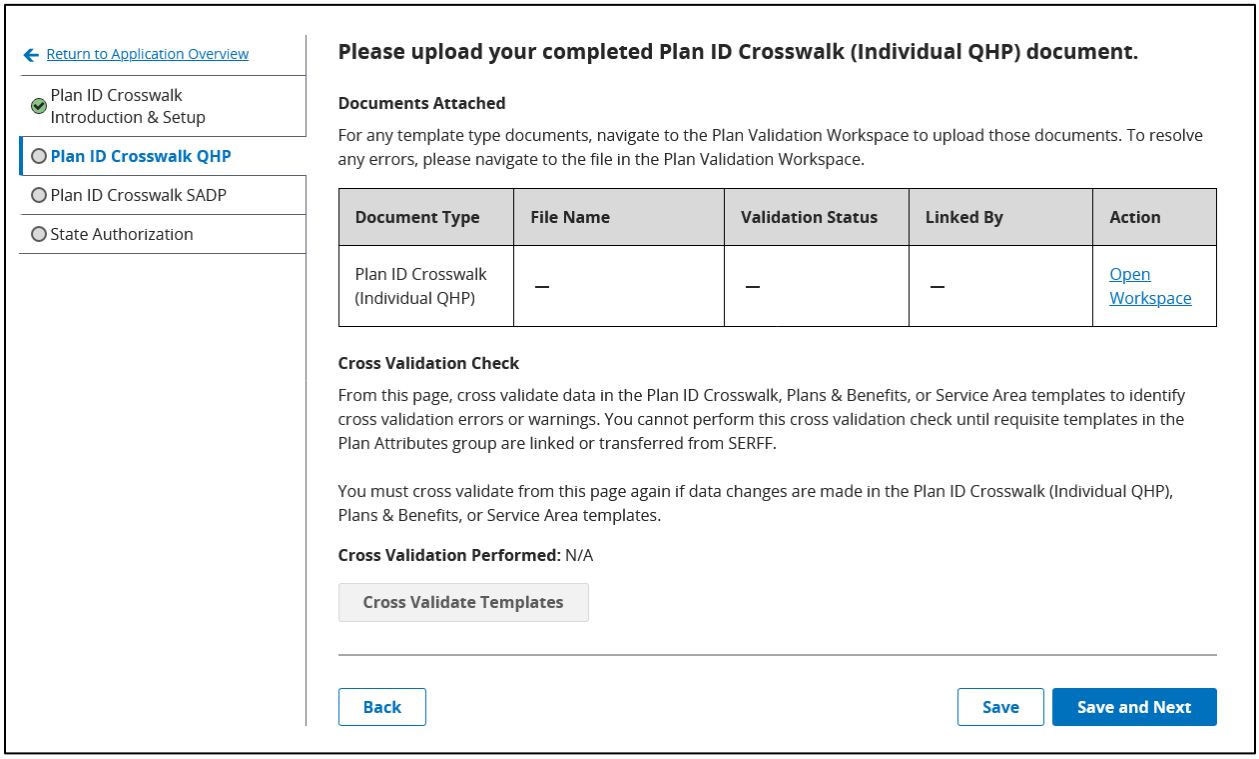


Figure 8-30. Plan ID Crosswalk QHP/SADP

After the user has linked the applicable Plans and Benefits and Service Area templates to their QHP application, and has linked the Plan ID Crosswalk template, they will be required to 'Cross Validate Templates' to identify any warnings that require a justification. See *Figure 8-31*.

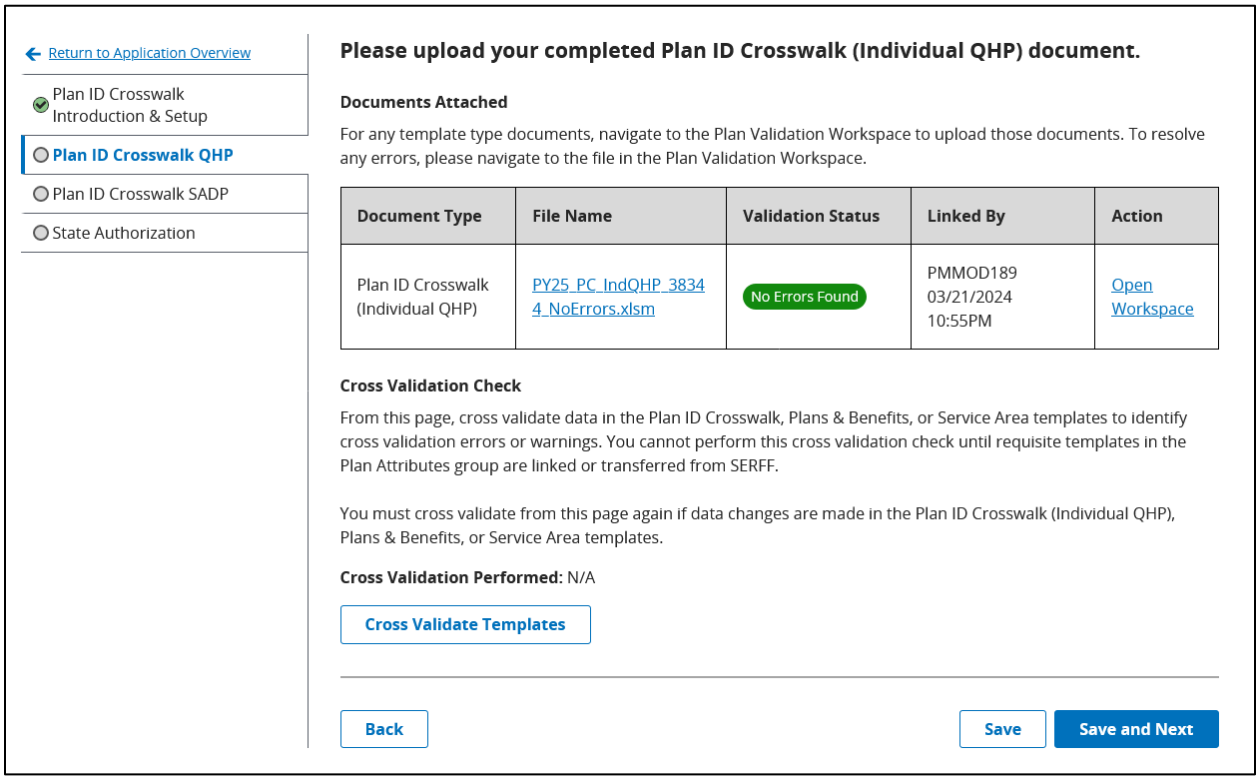


Figure 8-31. Cross Validate Templates Button Enabled

After the user cross validates, a new Justifications section may display indicating the number of warnings that require resolution. If a warning cannot be resolved with template data updates, the user can select the 'Add Justification' button to begin creating justifications to provide additional context. *See Figure 8-32.*

Note: If any errors were identified, MPMS will not display the Justification section. All errors must be resolved prior to creation of justifications.

Note: If the status of all the validation results is 'No Errors Found', MPMS will not display the Justification section.

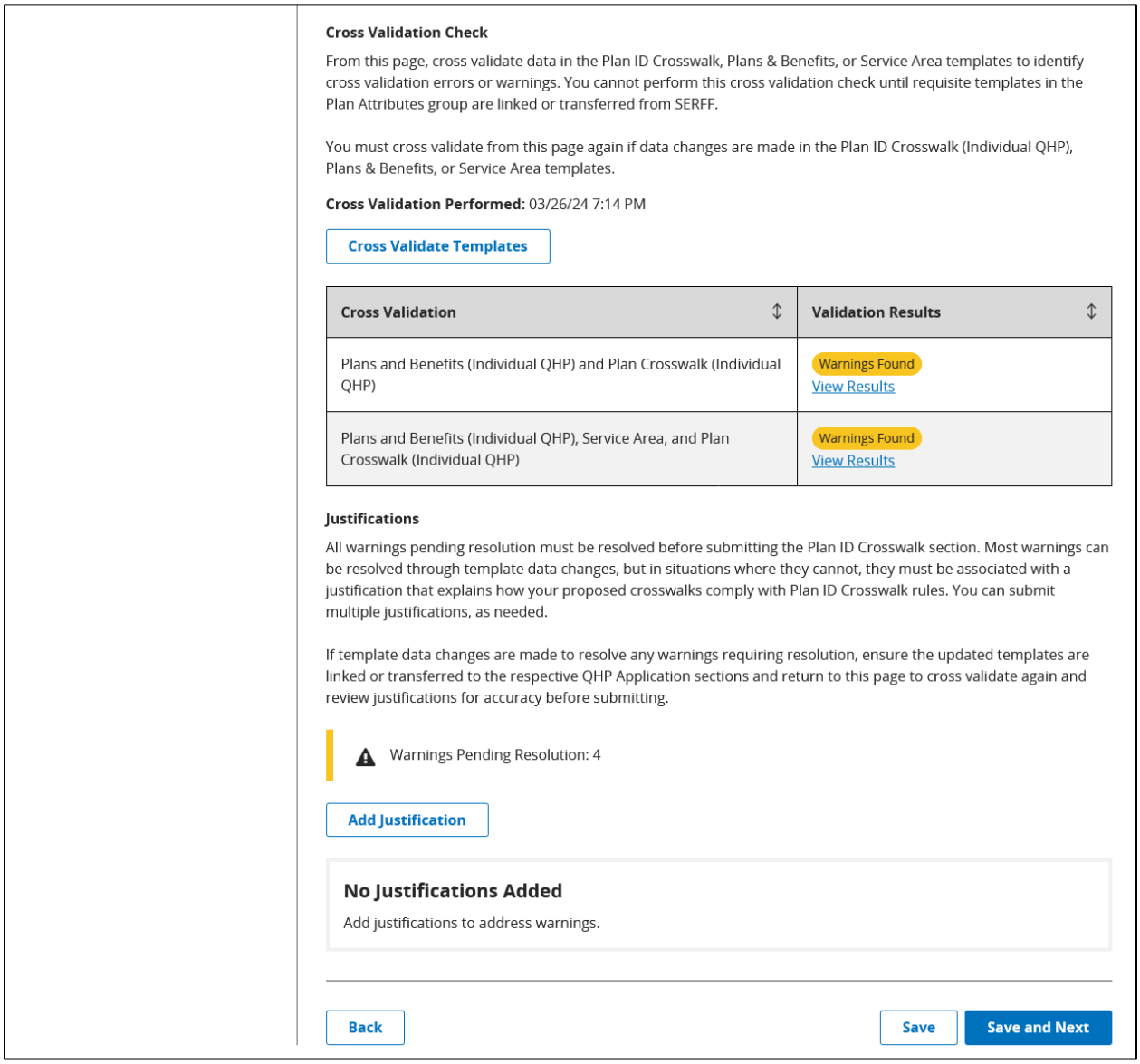


Figure 8-32. Justification Sub-Section

The user can enter their justification and select one or more warnings the justification applies to, as well as upload a supporting document if required. See *Figure 8-33*.

Note: A single warning may only be associated to one justification.

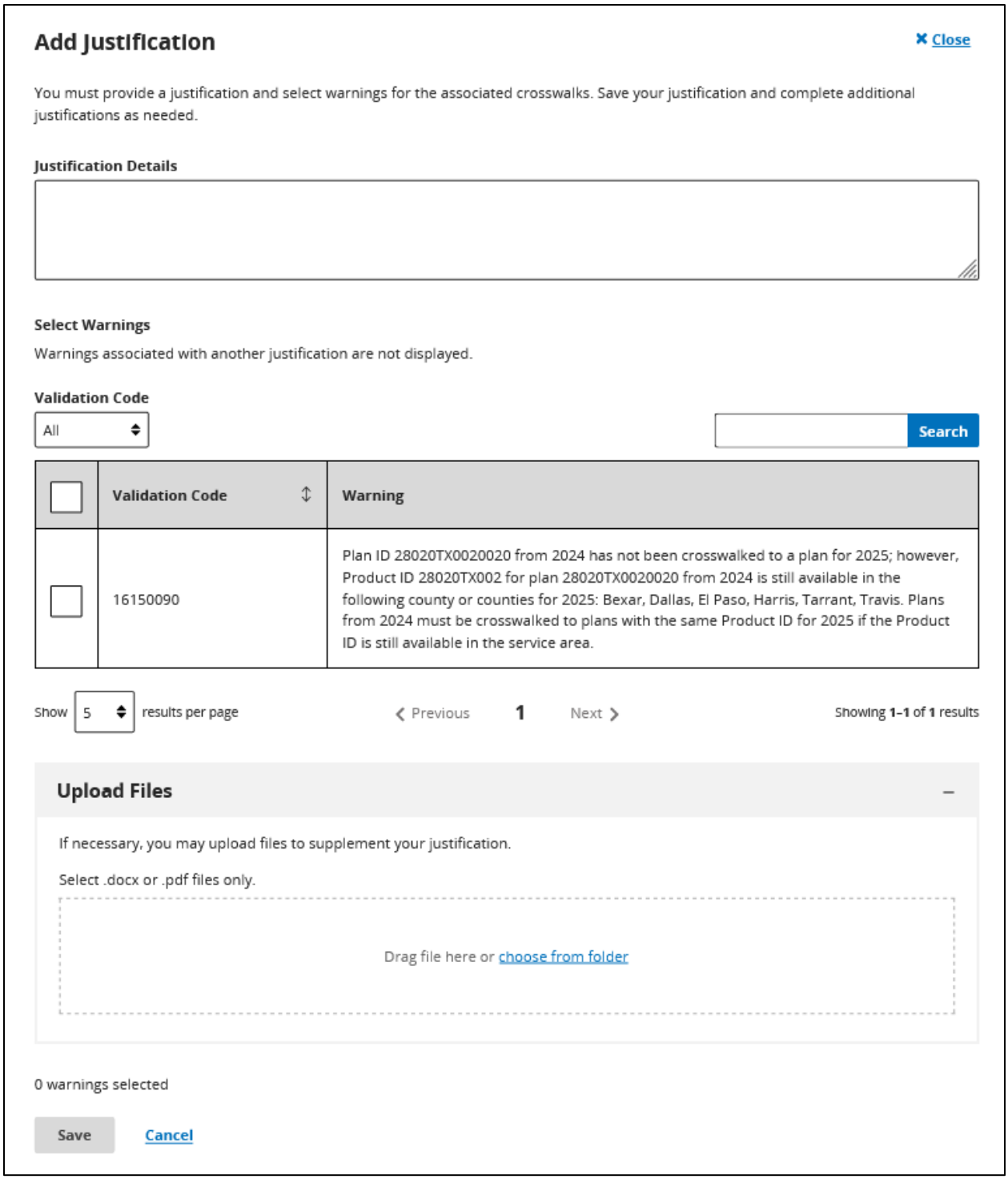


Figure 8-33. Add Justification Pop-Up

After a justification has been saved, the user will see the new justification display on the Plan ID Crosswalk tab, and can choose to edit or delete it as needed. The user must create as many justification groups as needed to ensure there are 0 warnings pending resolution. See *Figure 8-34*.

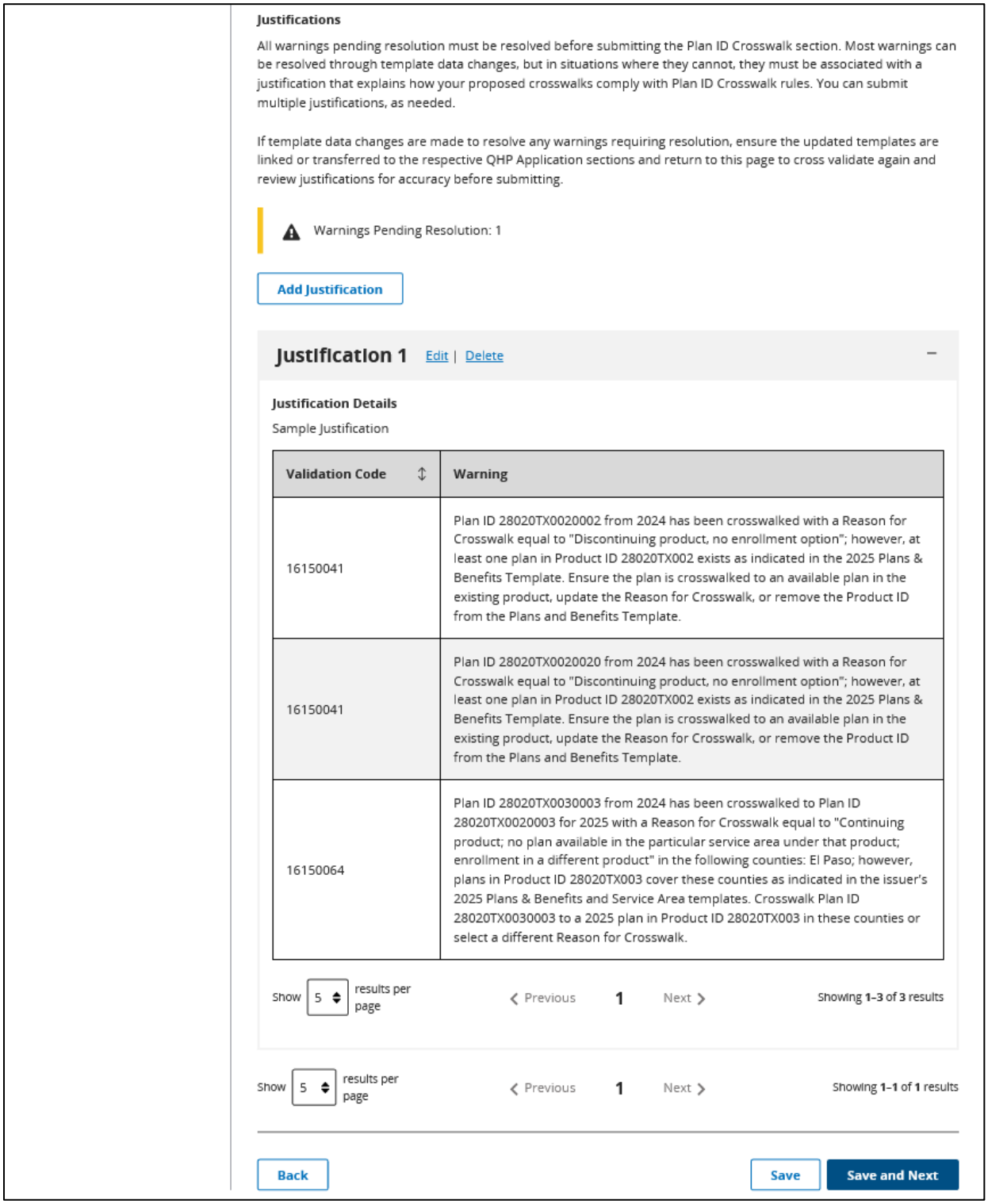


Figure 8-34. Justification Section with Justification Added

If the user links a new Plans & Benefits, Service Area, or Plan ID Crosswalk template to their application, a banner message will display indicating they need to re-execute cross validations. Until this action is performed, the Justification section will be hidden, and the user will not be able to make edits. If the user receives cross validation errors, they will be required to correct those before editing justifications. If the user still has cross validation warnings, the user's justifications will be refreshed to remove any warnings that no longer apply to their application, and they will be able to edit justifications again. See *Figure 8-35*.

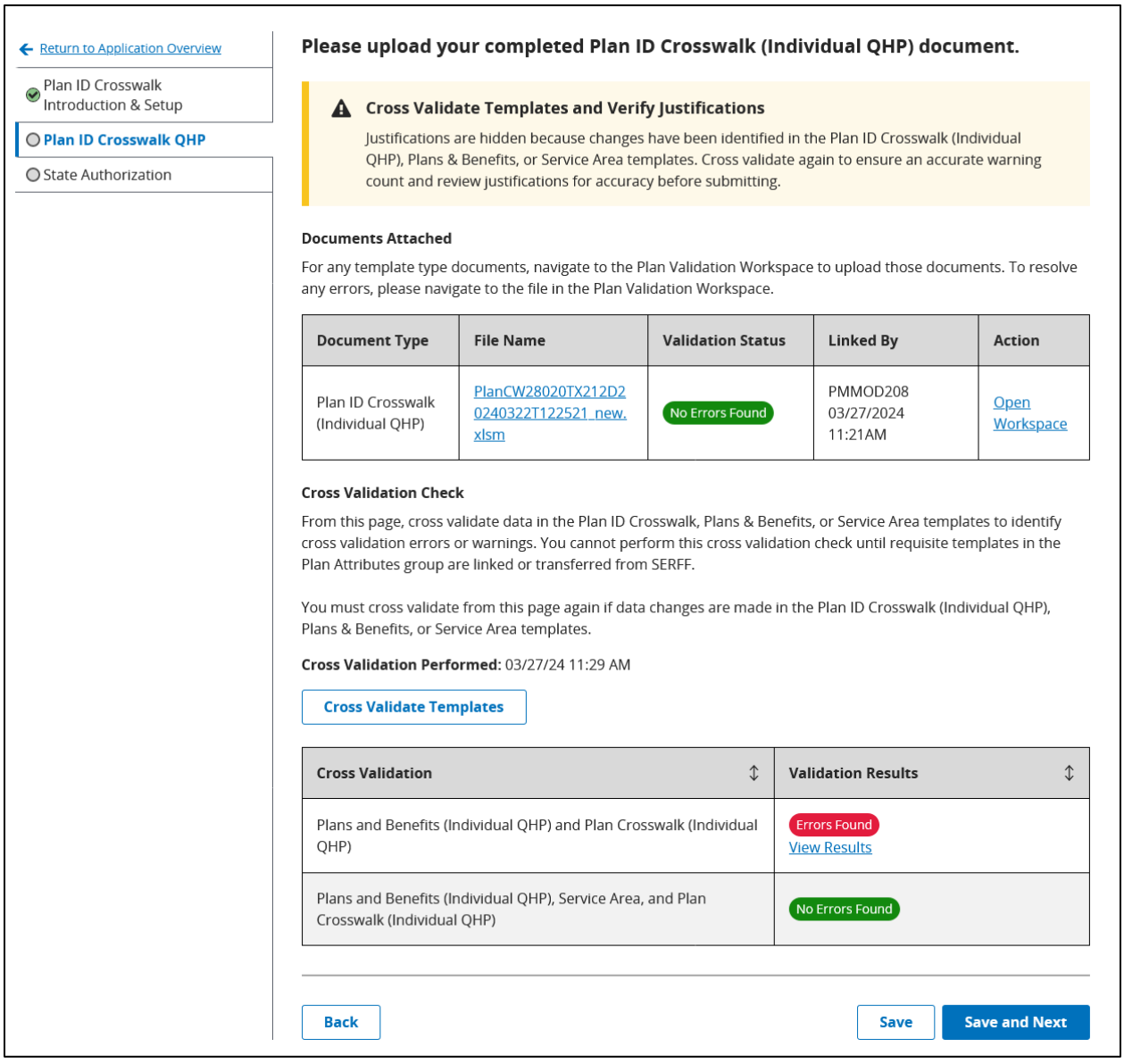


Figure 8-35. Cross Validate Templates Banner

8.11.3 State Authorization

The user may submit evidence of State Authorization of the crosswalks if it is available. The user is able to 'Save and Complete' the Plan ID Crosswalk section without the State Authorization submitted, however they will be required to provide one prior to plan certification. See *Figure 8-36*.

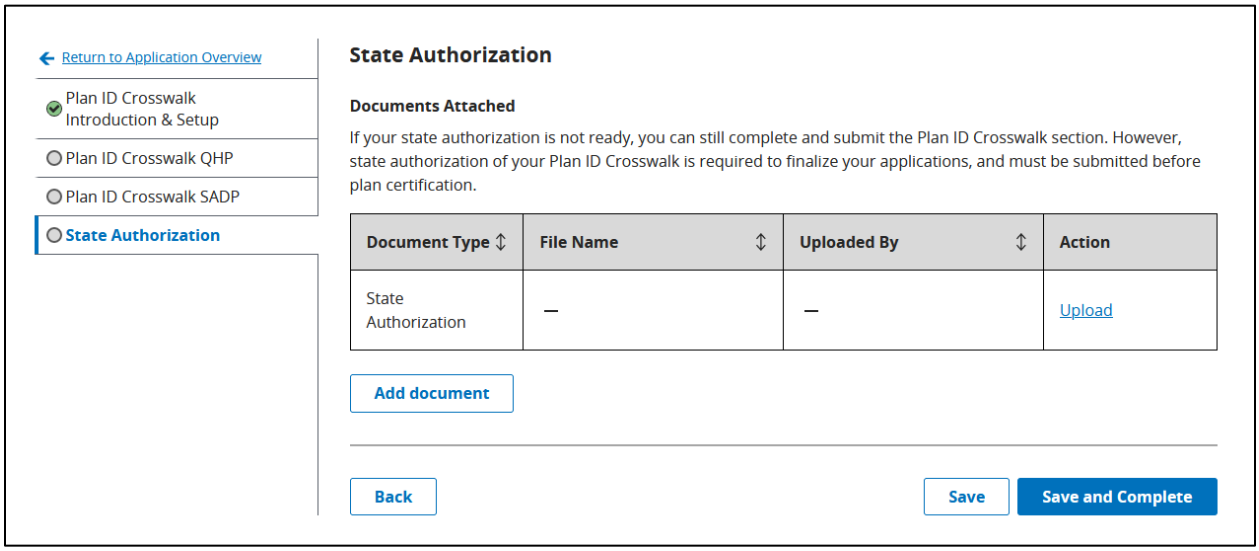


Figure 8-36. State Authorization

8.12 Accreditation Section

The Accreditation section is required for QHP Applications with a Product Offering that includes "QHP" and behaves the same across all application types.

Note: This section will not display for SERFF Issuers.

8.12.1 Responding to Question 1

The user is required to indicate whether they are accredited by an HHS recognized accrediting entity. *See Figure 8-37.*

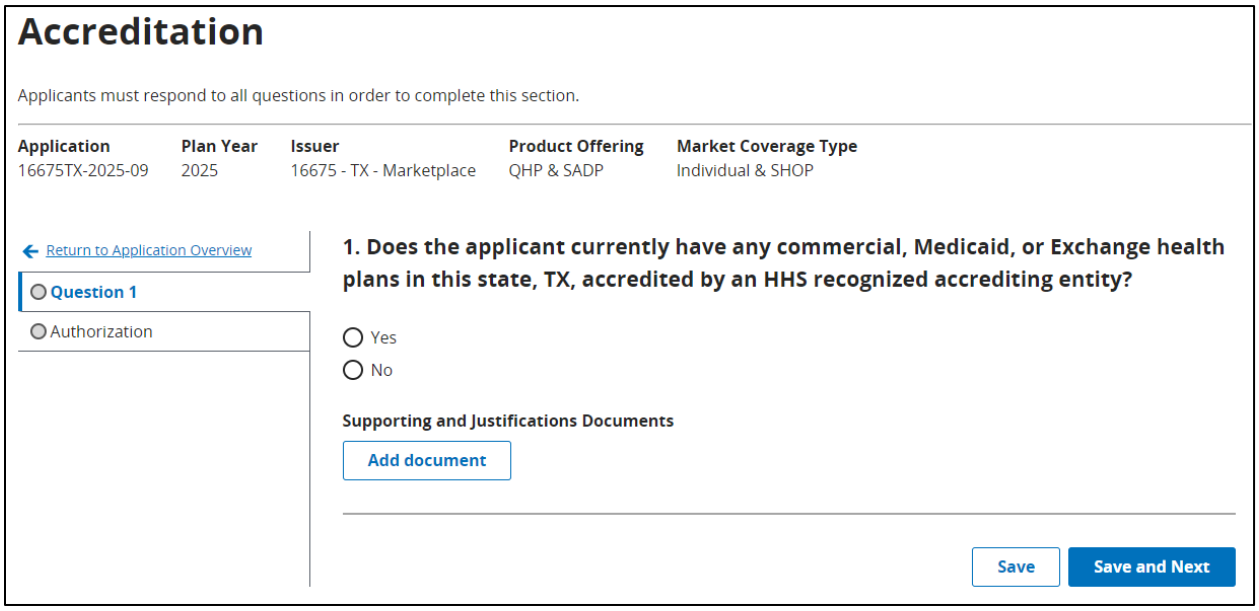


Figure 8-37. Accreditation Question 1

If the user selects 'Yes,' a second question displays requiring the user to indicate which entities they are accredited with. *See Figure 8-38.* The user may select one or more accrediting entities. If the user selects 'No,' they can either upload supporting documentation or proceed to the next step by selecting the 'Save and Next' button.

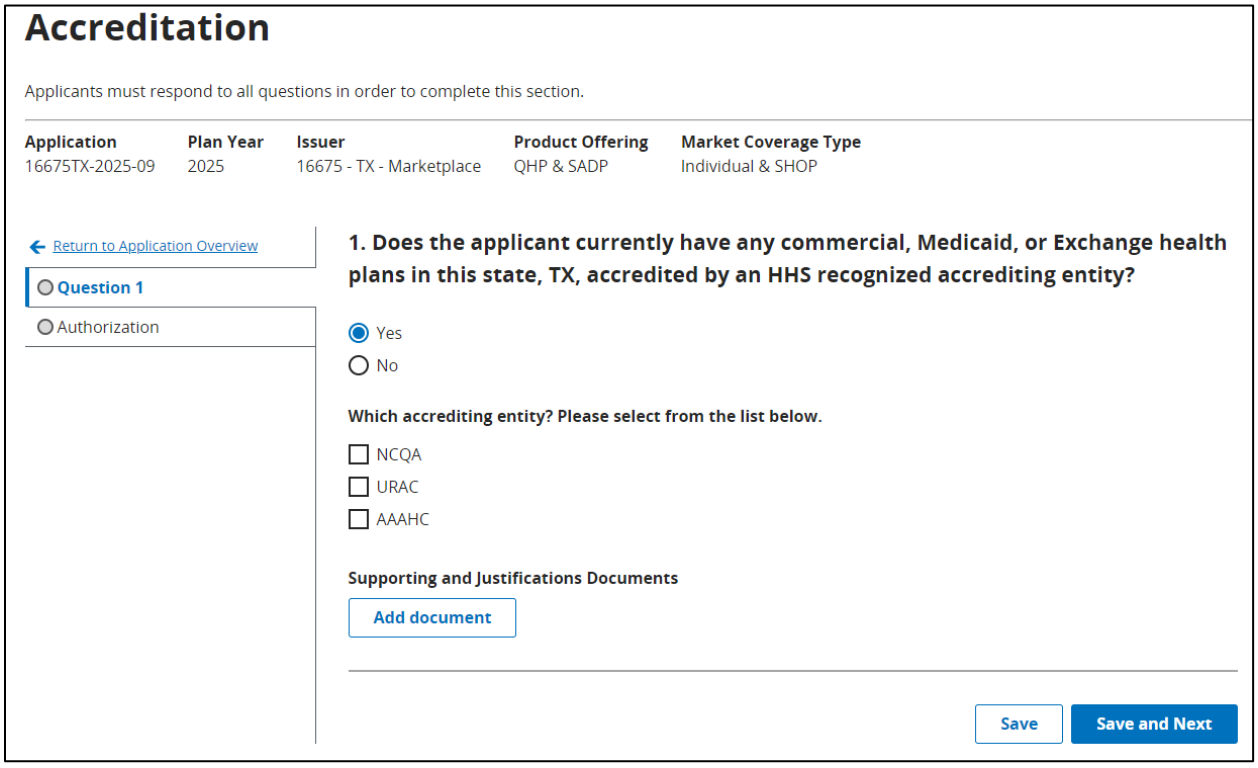


Figure 8-38. Select Accrediting Entity

The user may also choose to upload supporting documentation. *See Figure 8-39.*

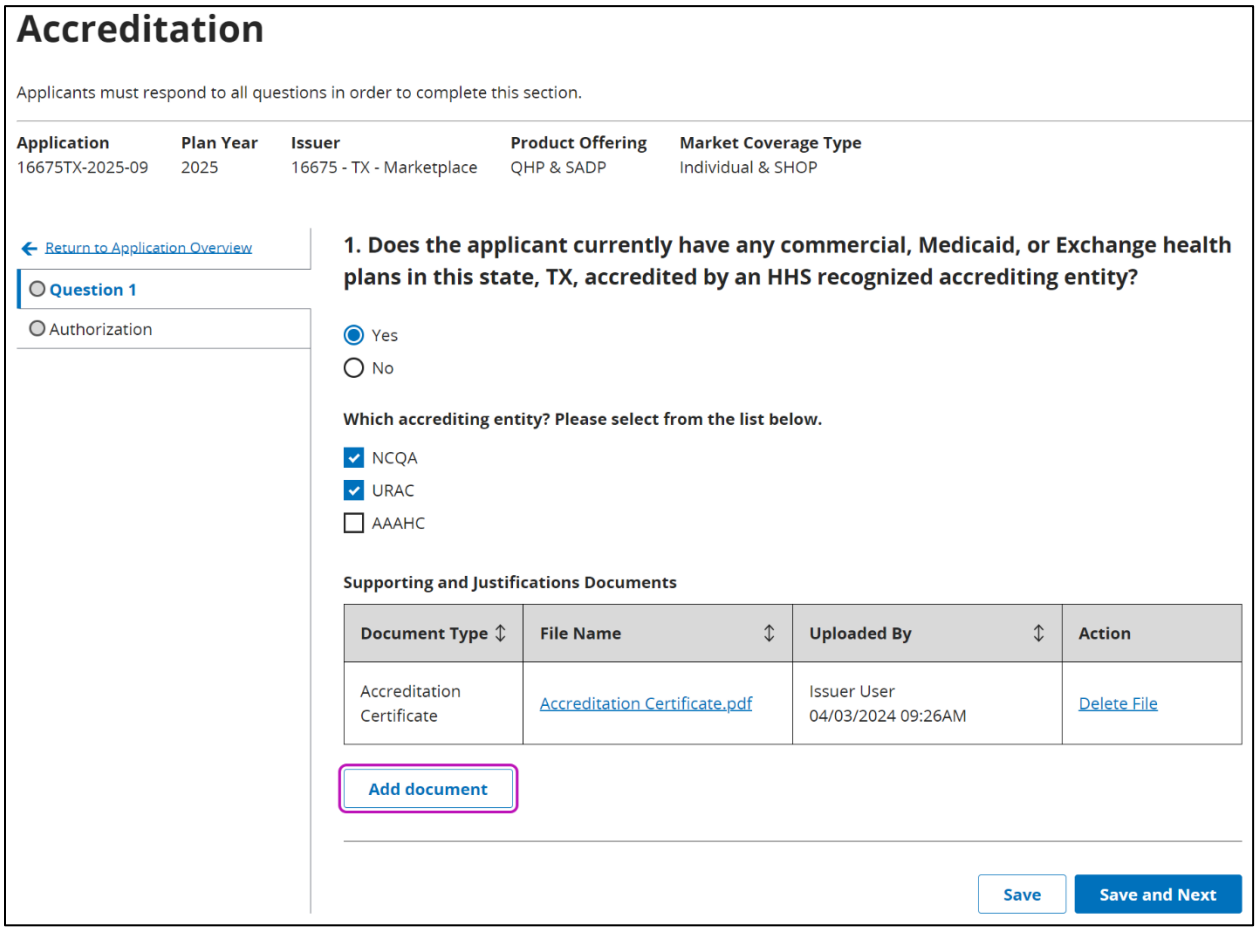


Figure 8-39. Accreditation Supporting Documentation

After selecting the 'Save and Next' button, the user is directed to the Authorization tab.

8.12.2 Authorization Acknowledgement

The Authorization tab requires the user to acknowledge the statement displayed on the screen. *See Figure 8-40.*

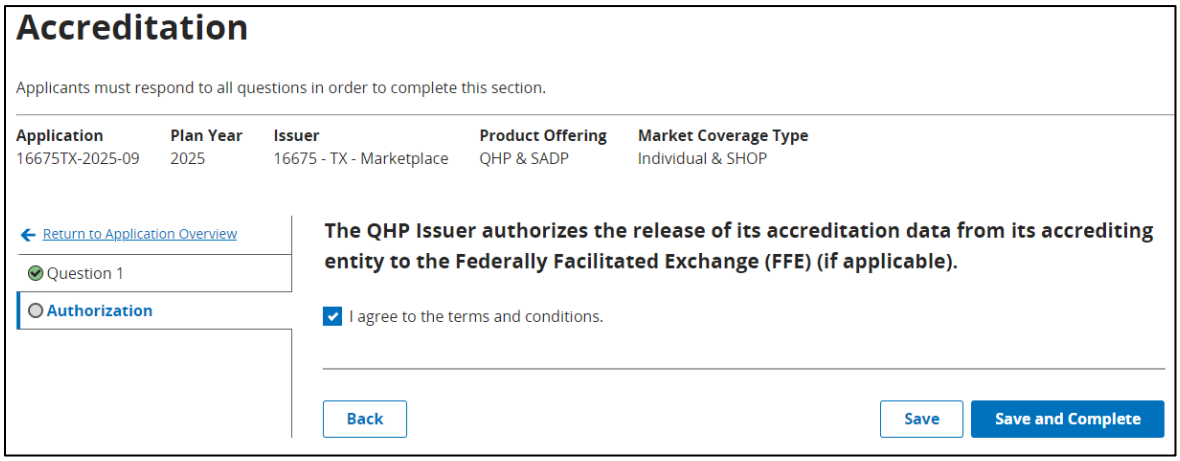


Figure 8-40. Accreditation Authorization Screen

Upon agreeing to the authorization statement, the user may select the 'Save and Complete' button, which redirects the user to Application Overview, and the Accreditation Section displays as Completed.

8.13 Transparency in Coverage Section

The Transparency in Coverage Section is required as part of all QHP Applications and requires the user to link a Transparency in Coverage template XML to their application, as well as provide a Transparency in Coverage URL.

Note: SERFF Issuers will only be able to edit the Transparency in Coverage URL in this section, and not link to a Transparency in Coverage template XML.

The URL must start with http:// or https:// and may only include alphanumeric characters and the special characters listed below:

- ~ (Tilde)
- ` (Grave)
- ! (Exclamation Mark)
- # (Pound)
- @ (At Sign)
- $ (Dollar)
- % (Percentage)
- ^ (Carat)
- & (Ampersand)
- * (Asterisk)
- ( ) (Open and Closed Parenthesis)
- _ (Underscore)
- + (Addition)
- - (Hyphen or Minus)
- = (Equals)
- [ ] (Open and Closed Bracket)
- \ (Backslash)
- {} (Open and Closed Braces)
- ; (Semicolon)
- : (Colon)
- " (Quotation Mark)
- . (Period)
- / (Forward Slash)
- ? (Question Mark)

Selecting the 'Save and Complete' button completes the section and returns the user to Application Overview. *See Figure 8-41.*

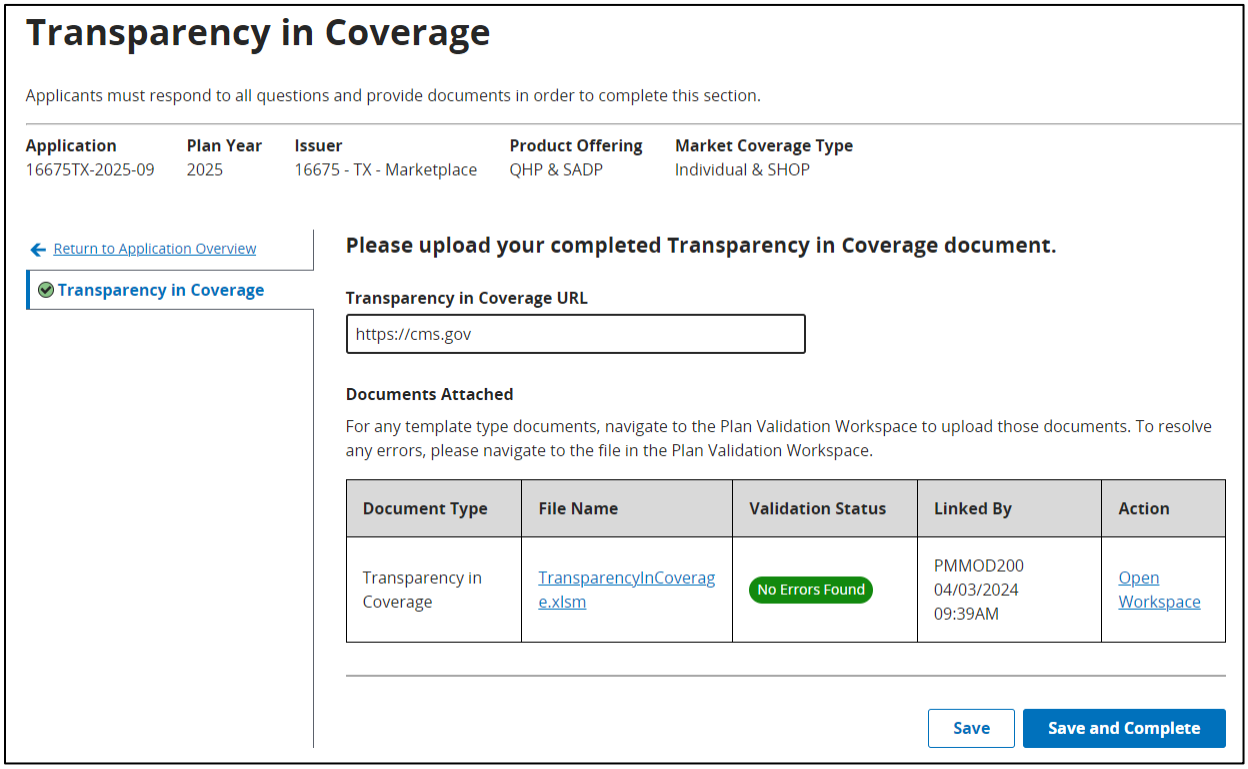


Figure 8-41. Transparency in Coverage Section

8.14 Rates Table Section

The Rates Table Section is required as part of all QHP Applications, and only requires a Rates Table template to be linked. *See Figure 8-42.*

Note: This section will not be editable by SERFF Issuers.

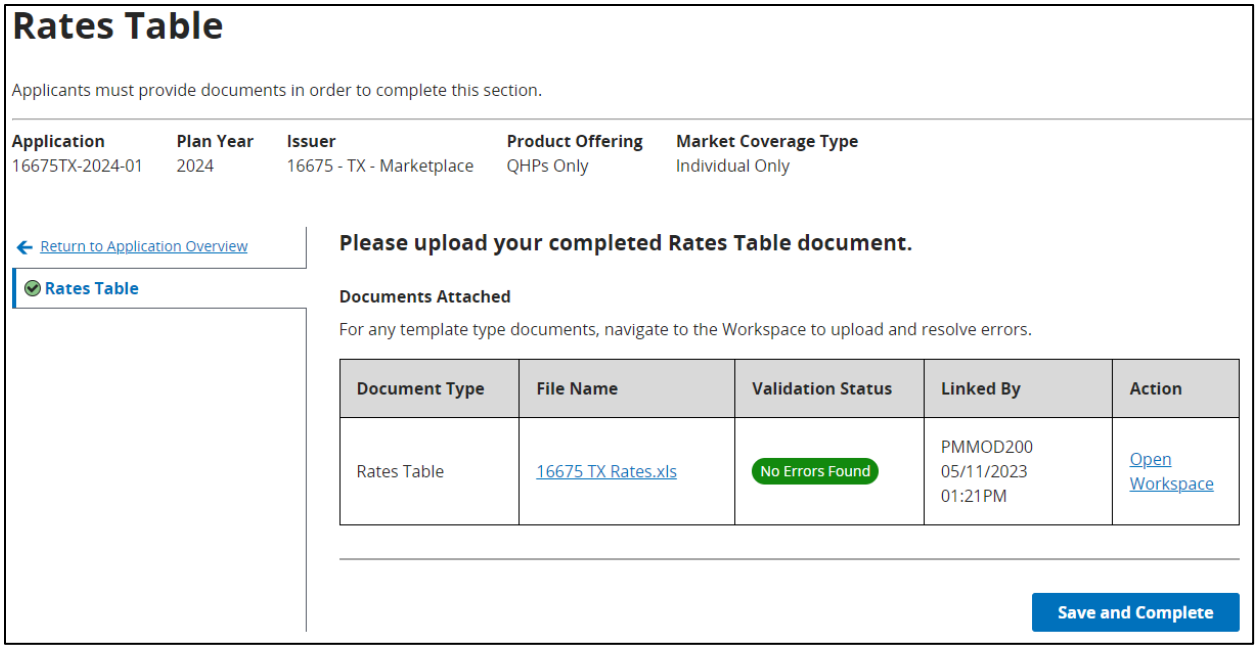


Figure 8-42. Rates Table Section

8.15 URL Section

The URL Section is required as part of all QHP Applications, and the user to update URLs either by linking a URL template or editing directly in the screen. The URL Section will only become available to edit once the Plans and Benefits Section has reached the status of 'Ready to Submit'.

Note: This section will become editable for SERFF Issuers once a successful plan transfer has been received.

8.15.1 Generating a URL Template

To generate a URL template, a user should select one or more URL types they wish to pre-populate and select the 'Generate and Download URL Template' button. *See Figure 8-43.* This action will download all required URL ID's the user must provide a URL for, as well as any URLs that have already been submitted for the application.

Note: If a user's Product Offering is SADPs Only, the Formulary URL option does not appear in the list.

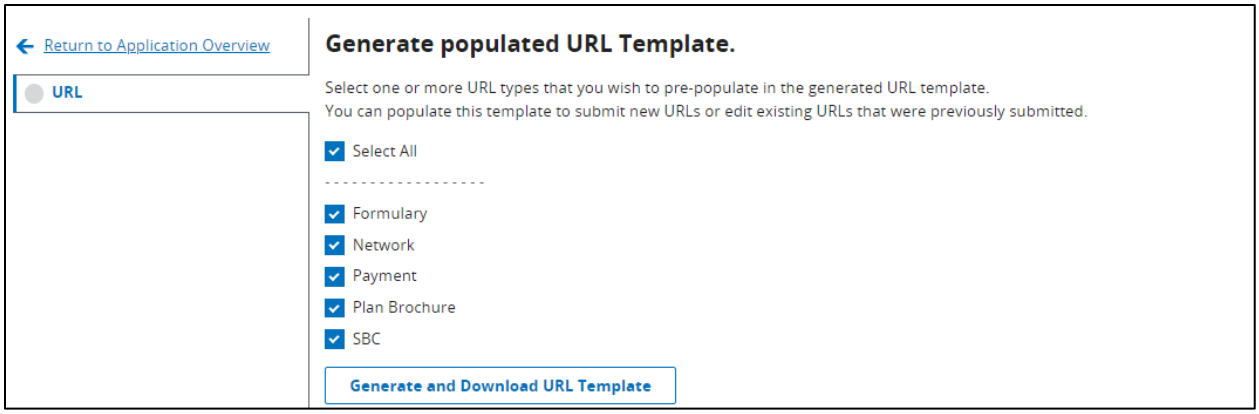


Figure 8-43. Generated Populated URL Template

8.15.2 Linking a URL template

A user may link a completed URL template from the Workspace on the Application Overview page or navigate to the Workspace by selecting the 'Open Workspace' link. *See Figure 8-44.* Once a template has been linked the green success banner will display.

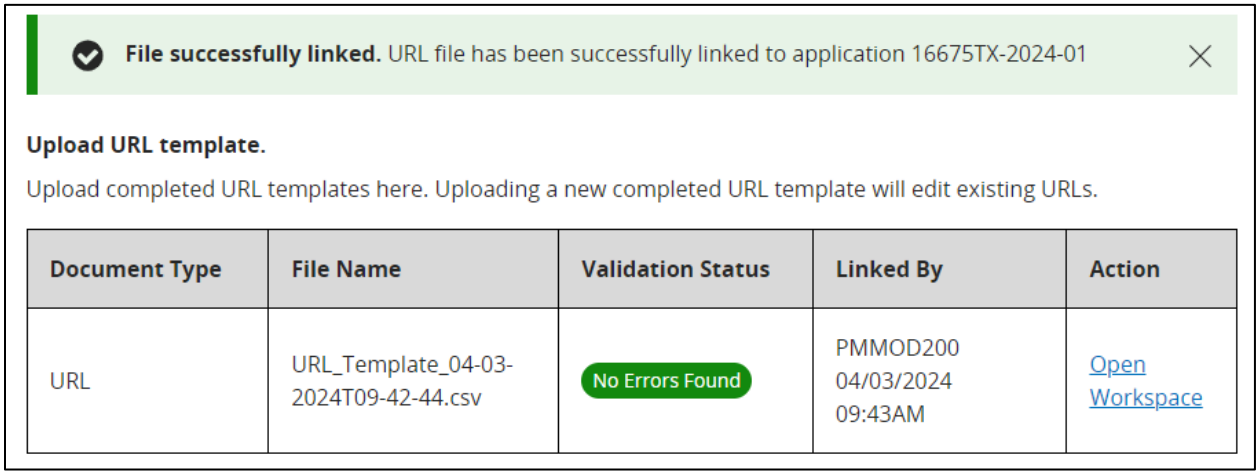


Figure 8-44. Upload URL Template

8.15.3 Editing single URLs

A user may also edit URLs individually by searching for either or both the URL Type using the drop-down menu, or by searching a URL ID. Once a URL is selected, the user may select the 'Search' button to find their URL.A user may input their new URL under the New URL column. *See Figure 8-45.*

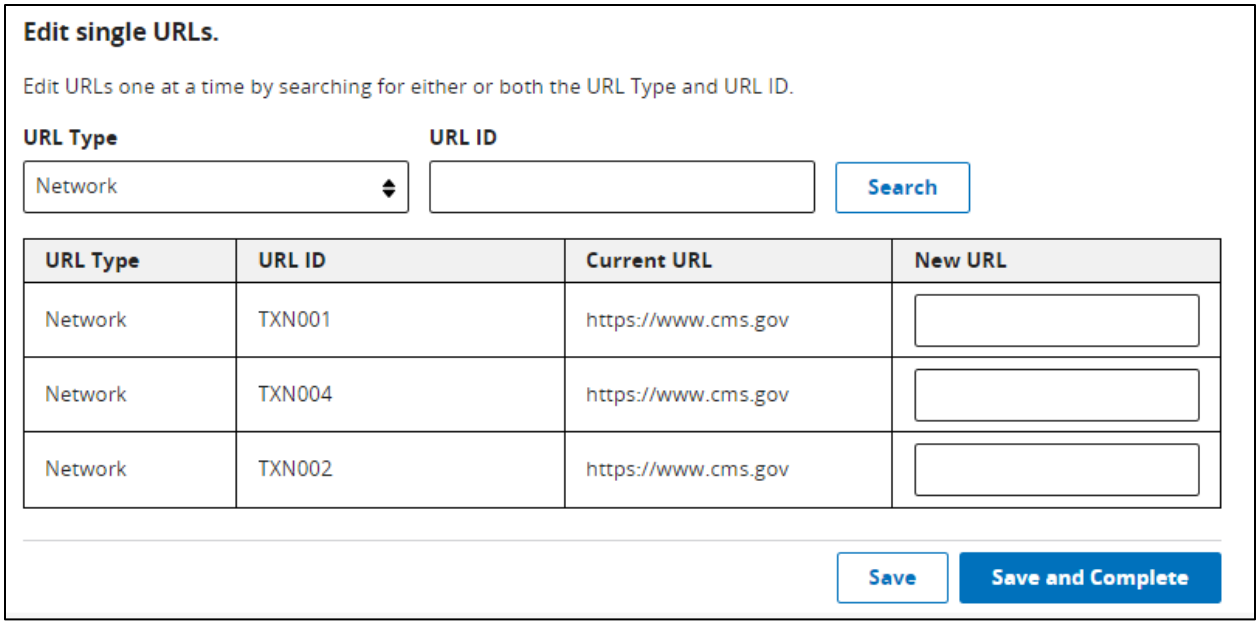


Figure 8-45. Edit Single URLs

8.15.3.1 SBC URL

SBC URL requires the domain to end in .pdf except for off-exchange variant. If the URL does not end in .pdf, a warning will message will appear on the UI informing the user they must correct the SBC URL to proceed with the change. *See Figure 8-46.*

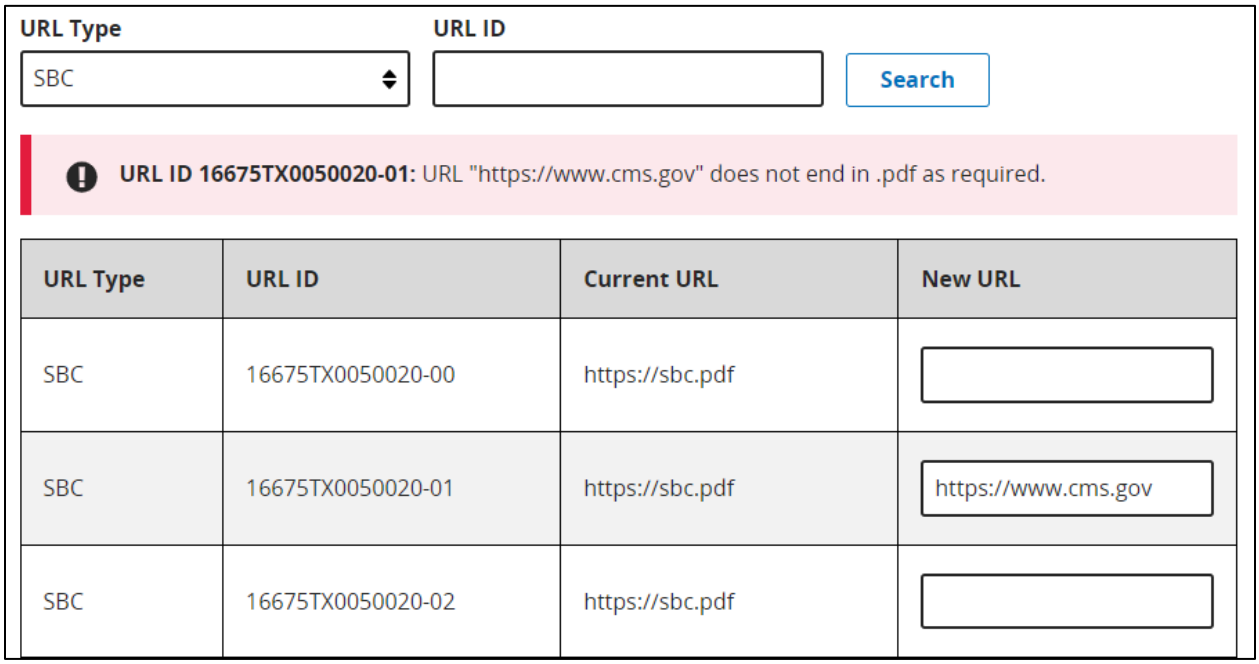


Figure 8-46. SBC URL

8.15.4 Deleting Optional URLs

For optional URLs, the user may also select the 'Delete' link under the Action column to remove a previously submitted URL from their application. The delete action will not be available when there is not a Current URL. *See Figure 8-47.*

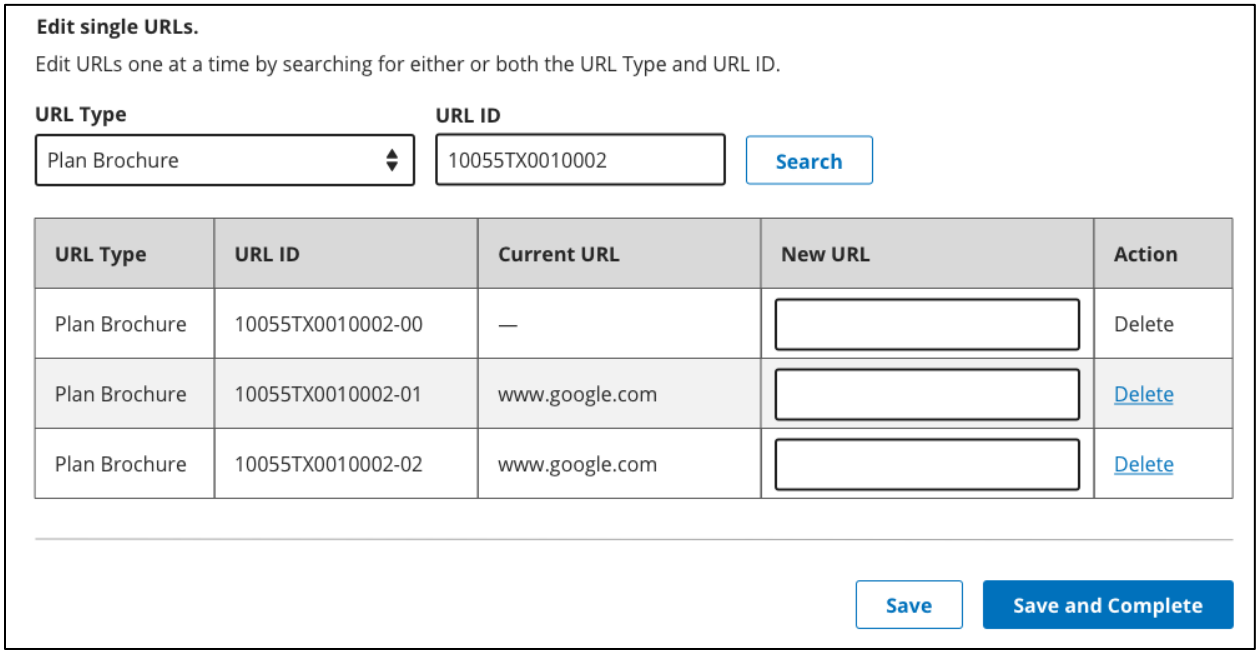


Figure 8-47. Deleting Optional URLs

9 Application Submission

9.1 Submitting an Application Group

After all sections within an application group have reached the status of 'Ready to Submit', the user can proceed with submitting the application group by selecting the blue 'Submit Group' button. *See Figure 9-1.*

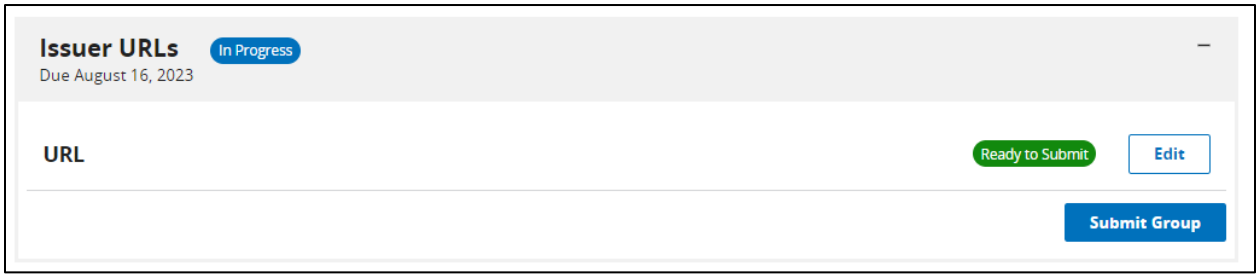


Figure 9-1. Submitting a Group

A pop-up window will appear notifying the user of what happens when an application group is submitted. If a user would like to make additional changes, or is not ready to submit, the user may select the 'Close' or 'No, continue editing' button. *See Figure 9-2.* Once a user is ready to submit the application group, select the 'Yes, submit this group' button. Selecting the 'Yes, submit this group' button cannot be undone.

Note: After a user selects the 'Yes, submit this group' button, the validation remains accessible in the Workspace to perform template checks.

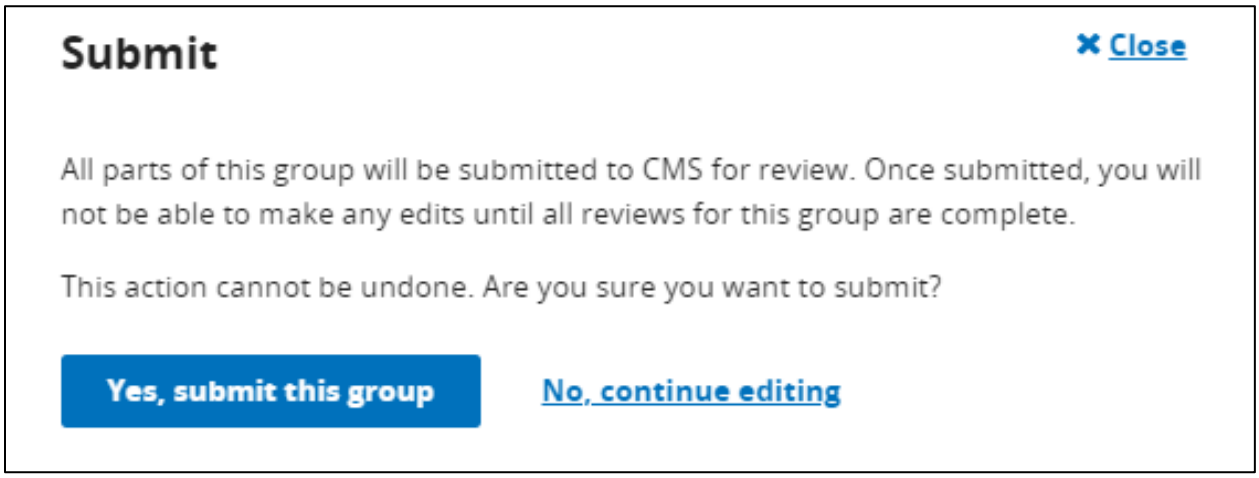


Figure 9-2. Final Submission Check

By selecting 'Yes, submit this group' the user is redirected to Application Overview. A green success banner displays at the top to confirm the application group was successfully submitted and is pending review. *See Figure 9-3.*

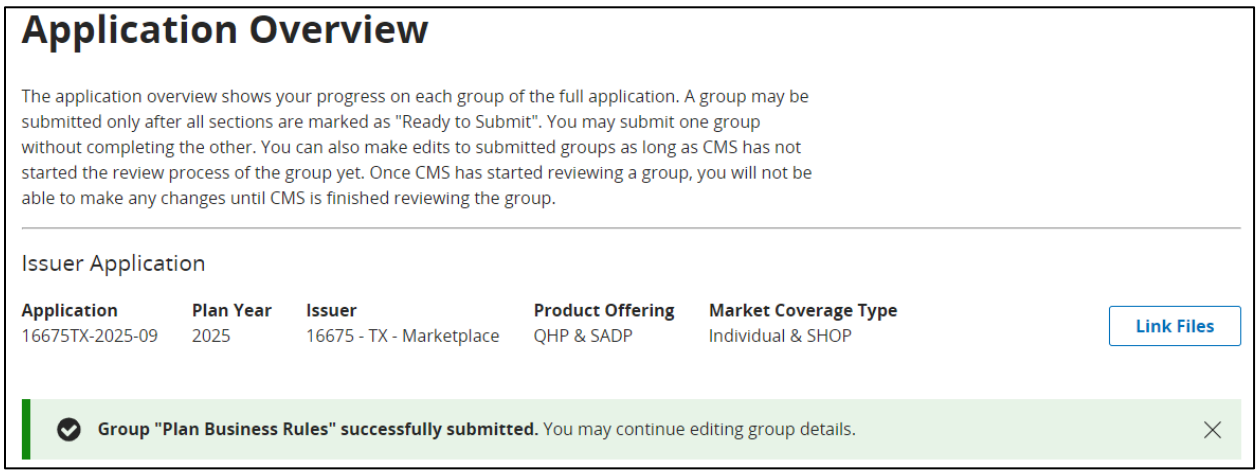


Figure 9-3. Successfully Completed Banner

9.2 Cross Validating Errors

If an element is missing or there is an issue when a user is trying to submit a group, a pop-up message will display to the user detailing the specific Error or Warning found. *See Figure 9-4.* One the user closes the pop-up; they must resubmit the group to see the message again. To download all errors in a CSV format, select the 'Download (CSV)' button. The user may make necessary corrections to resubmit the group for review and run cross validations.

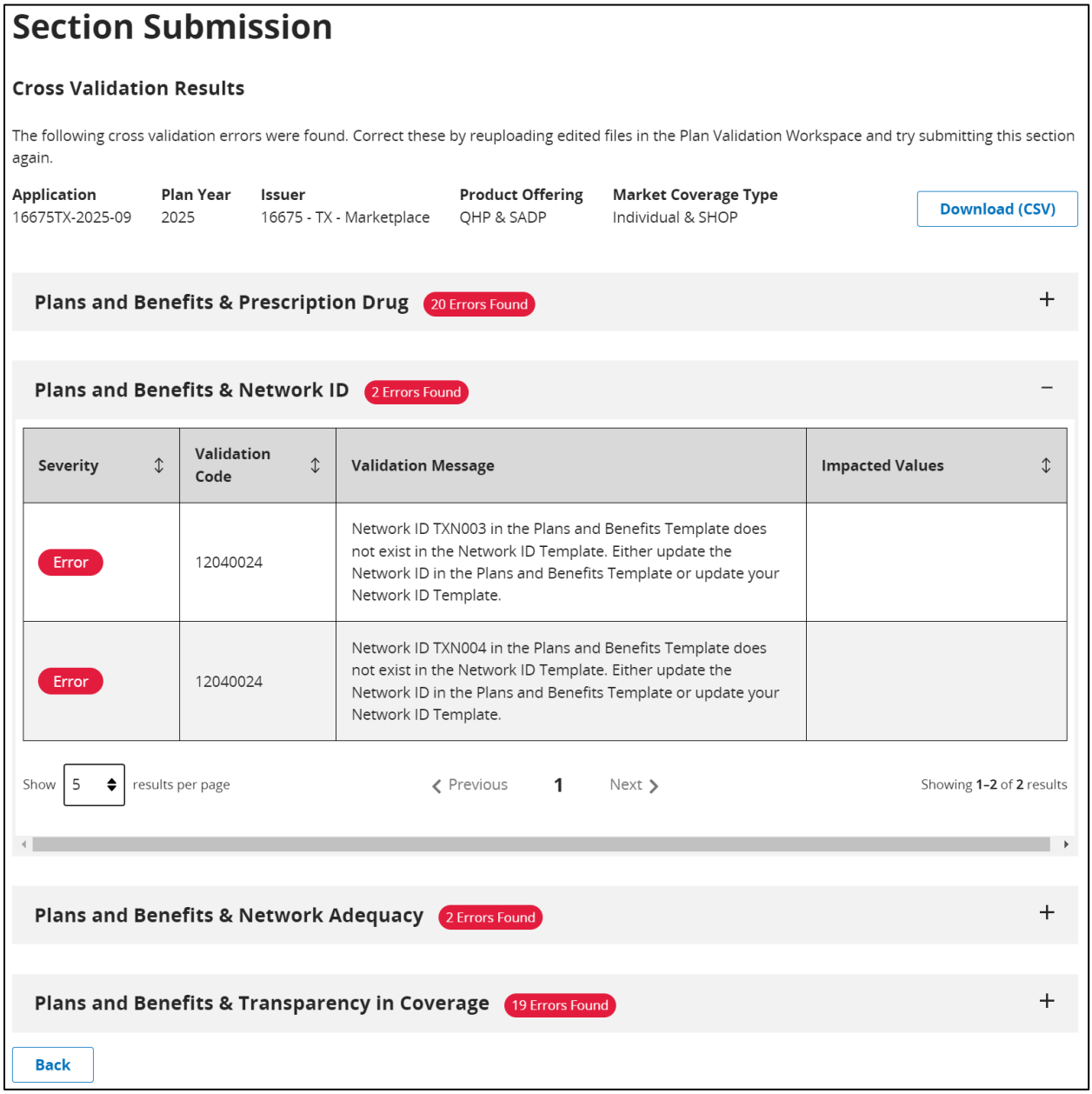


Figure 9-4. Cross Validation Errors

9.3 Review Results

After CMS performs QHP application group reviews, the user may be notified of required corrections. Corrections are available directly within the application. Corrections are marked by a red badge at the top of the application group. Select the 'View CMS Feedback' link to view the corrections. *See Figure 9-5.*

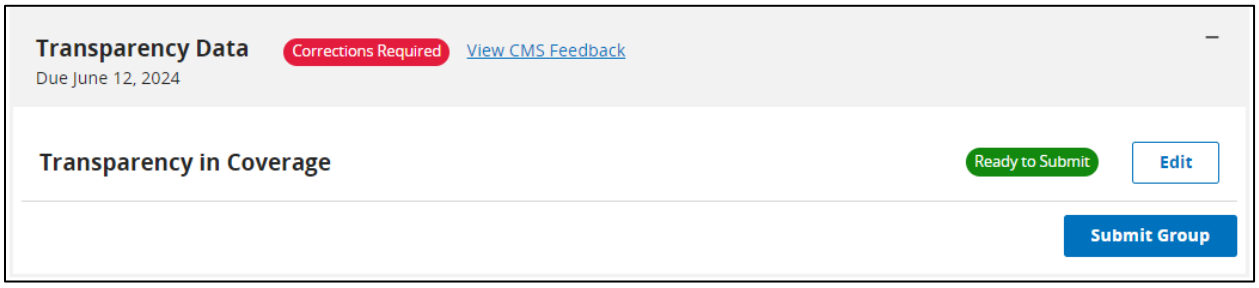


Figure 9-5. Review Results

This link displays the corrections found and a description detailing each correction. To download all corrections in a CSV format, select the 'Download All Reviews (CSV)' button. *See Figure 9-6*. The user may make necessary changes to their application and resubmit for review.

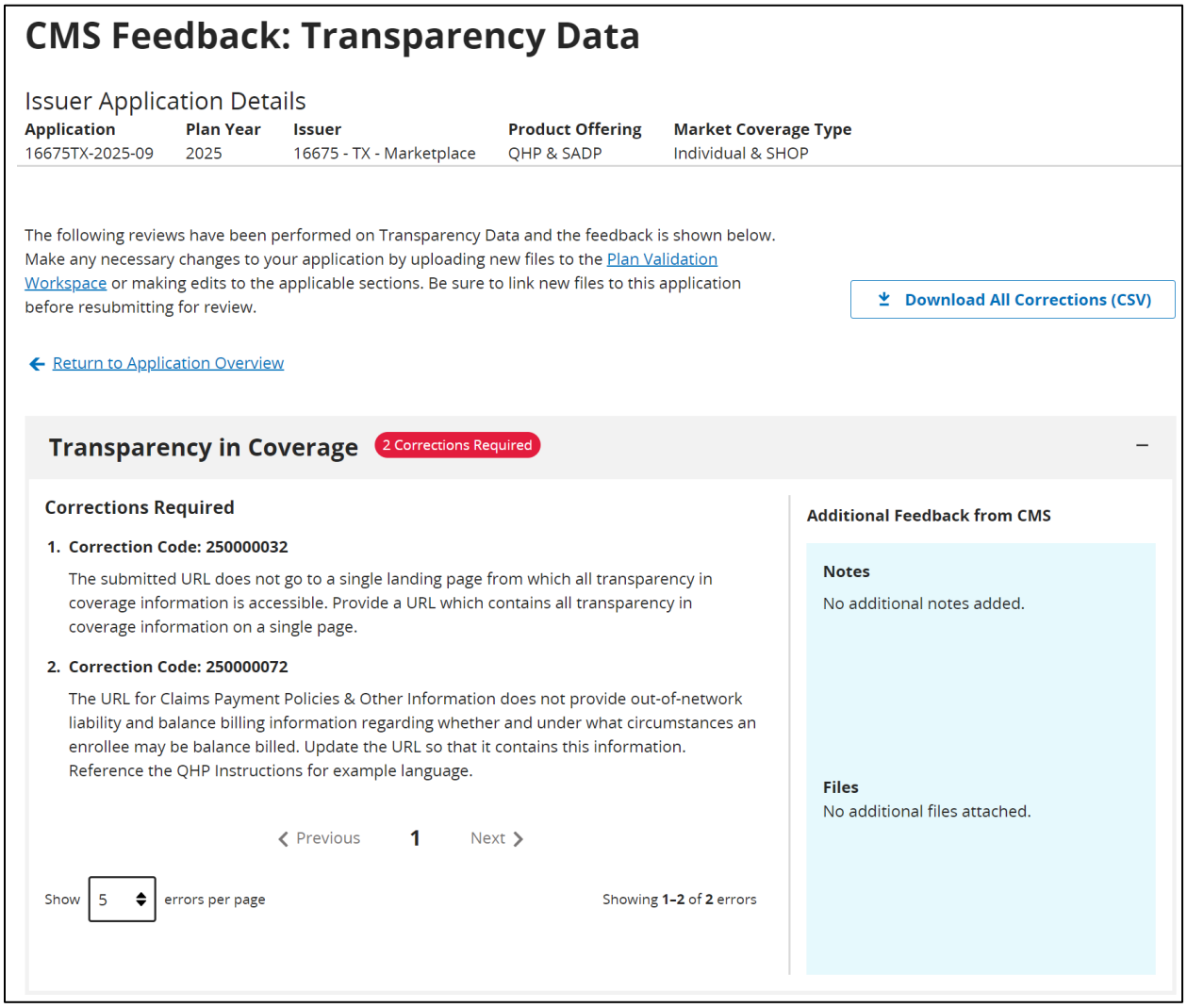


Figure 9-6. CMS Feedback

9.4 Resubmit an Application Group

A user may only edit and submit a group once all reviews for the group have been completed. A user may select a section they wish to update, make necessary changes, and select the 'Save and Complete" button. Once updates are saved, the user is redirected to Application Overview where they may select the 'Submit Group' button to resubmit the application group. *See Figure 9-7.*

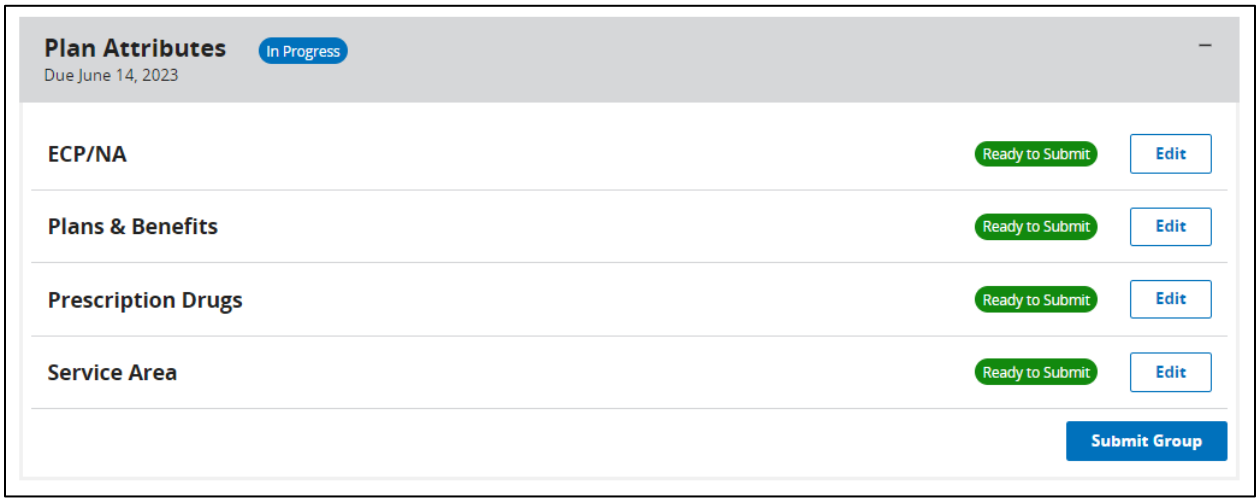


Figure 9-7. Resubmit Group

9.5 Completed Application

Once all application groups have reached a status of 'No Action Required', the application is complete. All sections will display the green "No Action Required" badge in Application Overview. *See Figure 9-8.*

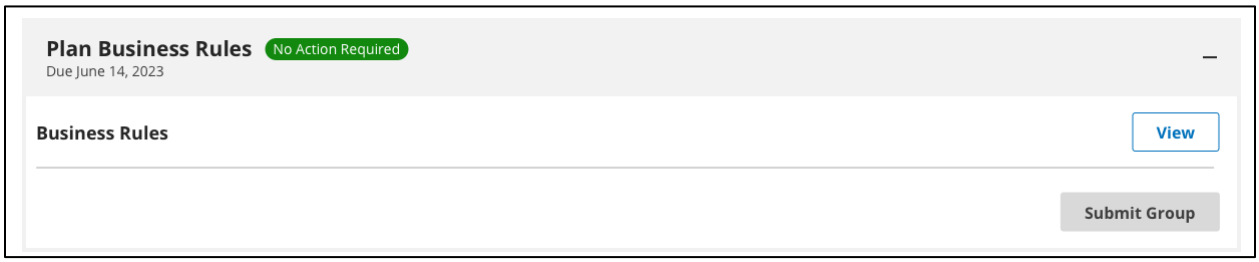


Figure 9-8. Completed Group

9.6 Group Status

The following table details various statuses an application group may have and a description of what triggers the status.

Table 9-1. Group Status & Trigger

Group Status	Trigger
Not Started	• When no sections in an application section have been started, the Grouping status will be Not Started.
In Progress	• When at least 1 section in the Grouping has a status of In Progress or Ready to Submit, the Grouping status will be In Progress. • When a Grouping is in No Action Required status, and the user updates one of their sections, the Grouping status will be updated to In Progress.
Submitted - Under Review	• When the Grouping has been successfully submitted (ie. The user clicked the Submit Group button and there were no errors), and there are reviews triggered for the Grouping, the Grouping status will be Submitted - Under Review. • When a Grouping is in Corrections Required status, and the Grouping is successfully submitted, the Grouping status will update to Submitted – Under Review.
Corrections Required	• When a review is completed for the Grouping, and the result or the review is Completed - Corrections Needed, then the Grouping status will be Corrections Required. • When a Grouping is in Corrections Required status, and the user updates one of their sections, the Grouping status will remain in Corrections Required status.
No Action Required	• When the Grouping has been successfully submitted (ie. The user clicked the Submit Group button and there were no errors), and there are no reviews triggered for the Grouping, the Grouping status will be No Action Required. • When all reviews have been completed for the Grouping, and there are no corrections needed, then the Grouping status will be No Action Required.

10 State Reviewer Role

A State Reviewer must have a PM State Reviewer role for Read-Only access. State Reviewers can access the Plan Validation Workspace and Issuer Application data submitted for their states in a read-only view. State Reviewers have a read-only view to support Issuers' application submission, download templates and supporting documents provided by the Issuer, as well as view warnings. A State Reviewer does not have the ability to edit or change content provided by an Issuer. Upon logging in, a banner alerts State Reviewers that content provided by an Issuer may be viewed but not changed.

State Reviewers will have access to download files CMS has shared with issuers via the Communications Table on the Issuer Dashboard. State Reviewers will access the Appointment Wait Time (AWT) Provider Population File (PPF) zips using the Communications Table for PY25. State Reviewers will be able to view and individually download the PPF zips for each Issuer ID they have access to, or download in bulk if applicable. *See Figure 10-1.*

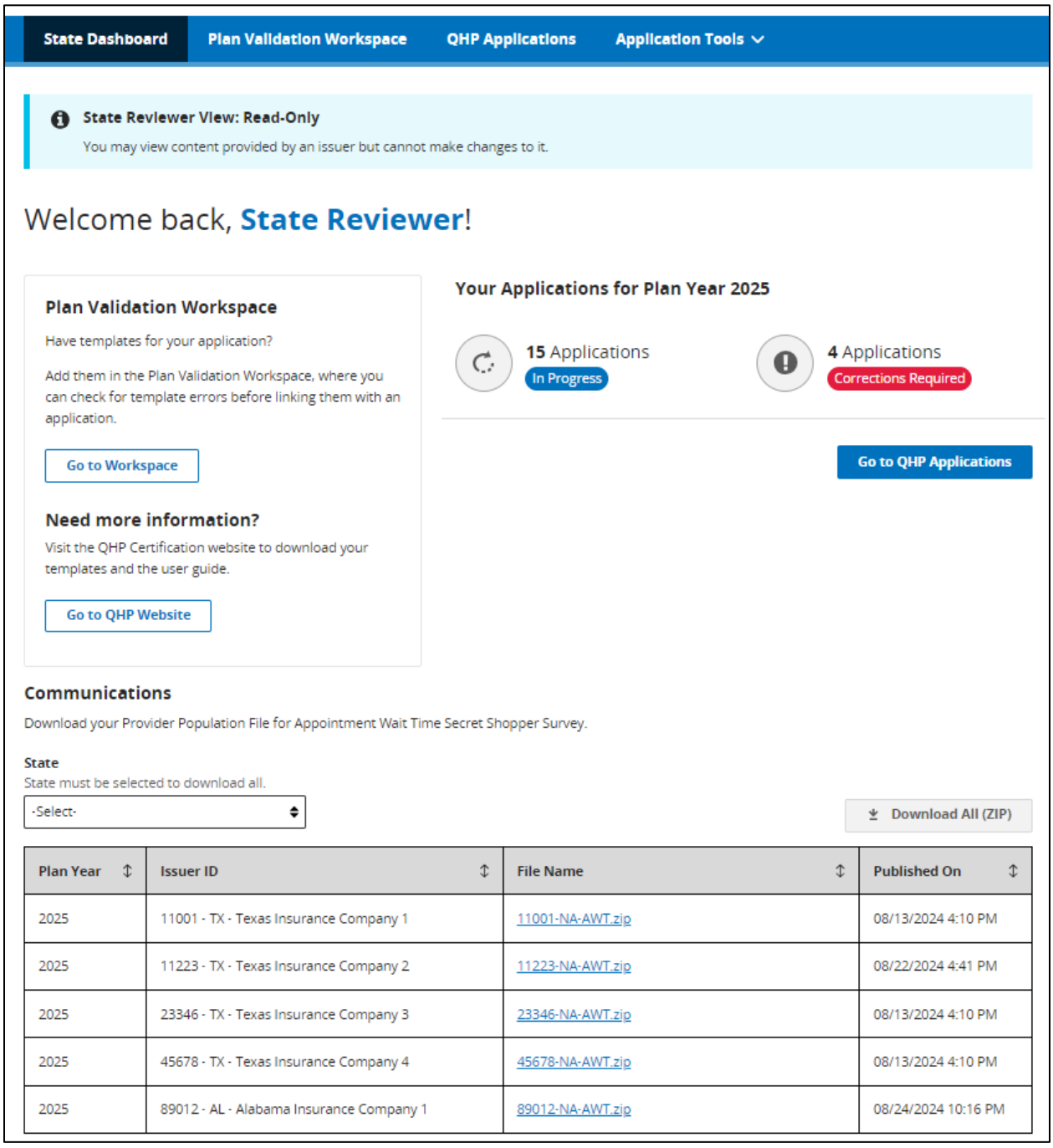


Figure 10-1. State Reviewer view of Issuer Dashboard for AWT Communications Table

Within the Plan Validation Workspace, a State Reviewer may view Warning and Error Results for an Issuer's template. *See Figure 10-2.*

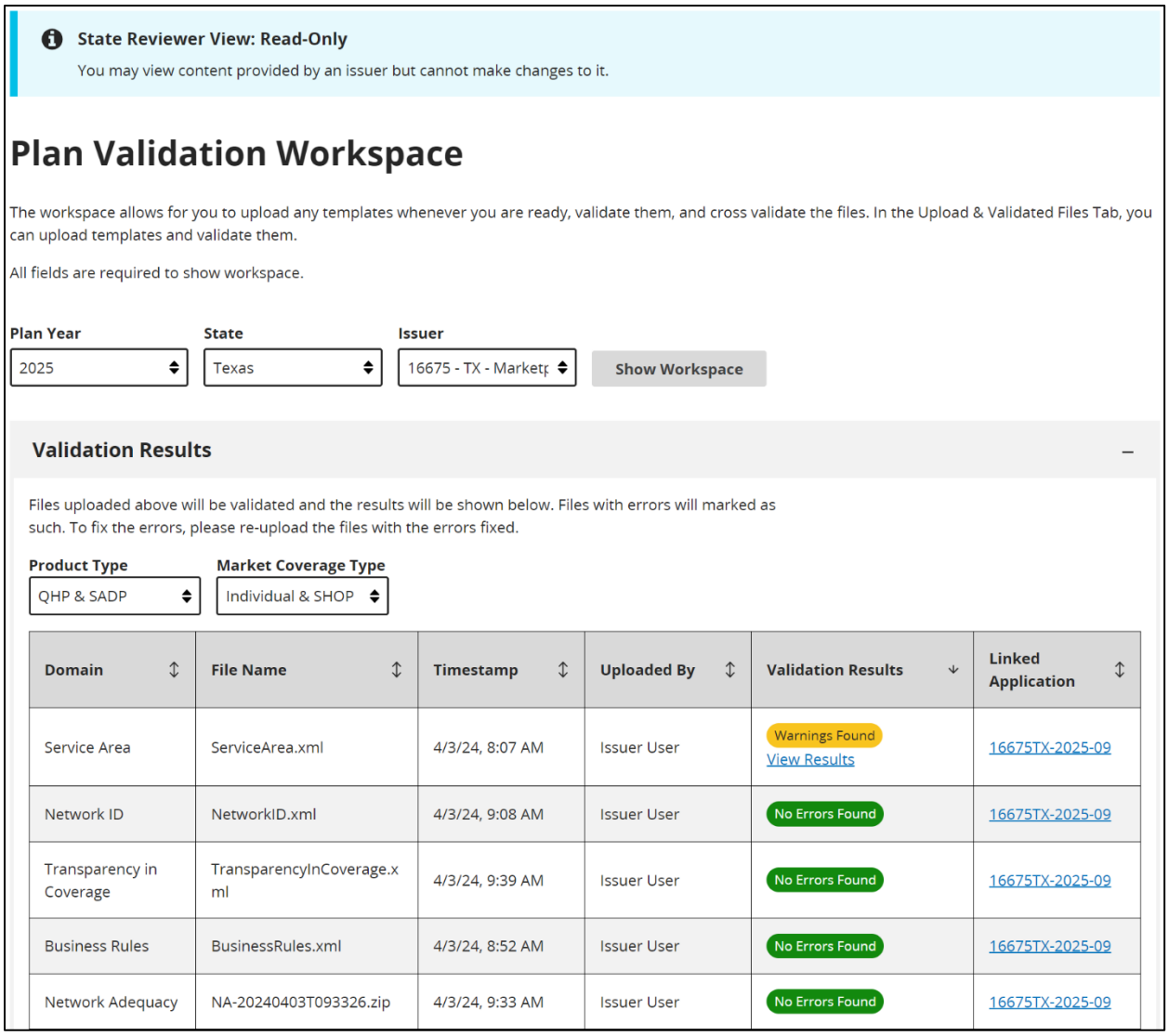


Figure 10-2. Plan Validation Workspace State Reviewer View

A State Reviewer also has the ability to access Application Overview. The same banner alerts the State Reviewer that they may view content provided by an Issuer, but not make any changes to it. *See Figure 10-3.*

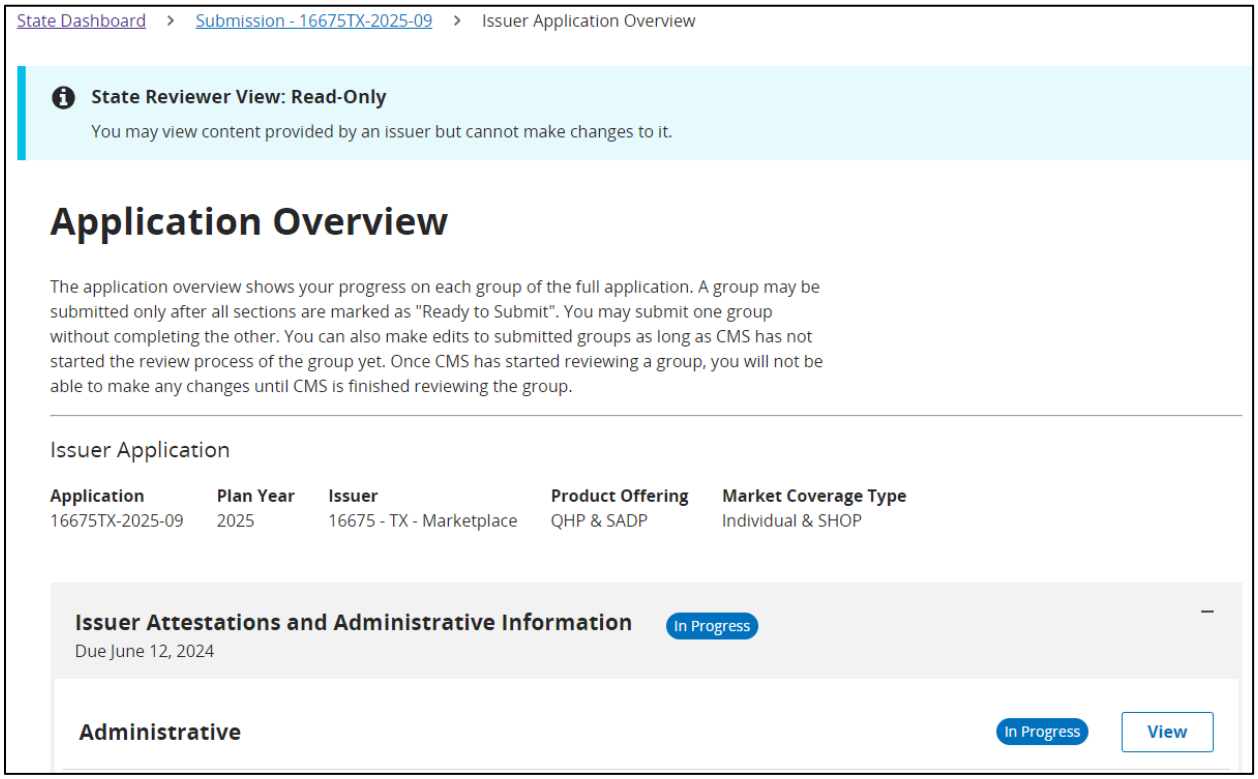


Figure 10-3. State Reviewer Role

When a State Reviewer selects the 'View' button in Application overview, they are able to view content provided by an Issuer. Content provided by the Issuer appears grey to indicate that the State Reviewer is unable to make any changes. *See Figure 10-4.*

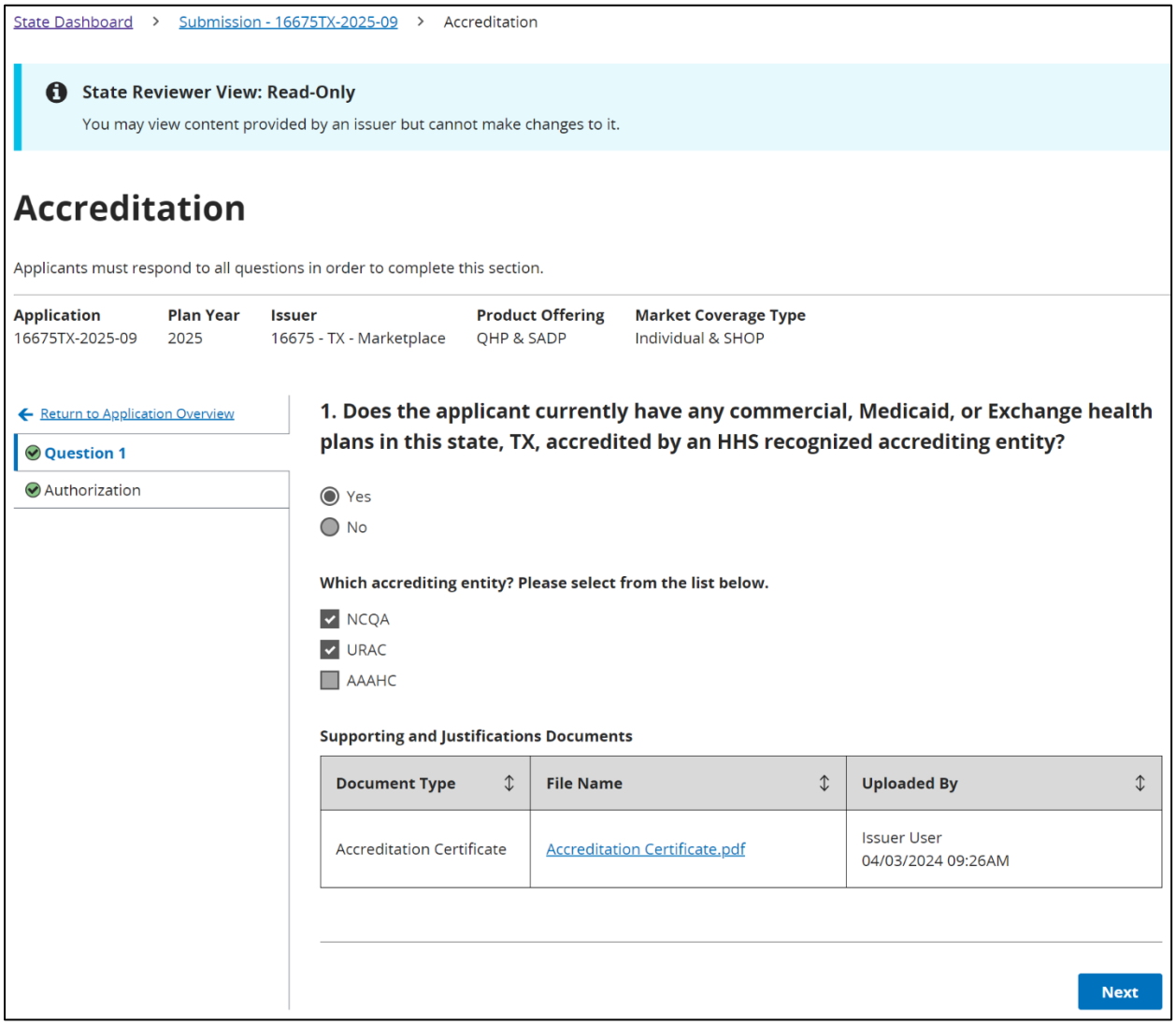


Figure 10-4. State Reviewer Read Only Banner

If corrections are required, a State Reviewer may select the 'View CMS Feedback' link in Application Overview which redirects them to the detailed CMS Feedback. A State Reviewer may select the 'Download All Corrections (CVS)' button to download all corrections in a CSV format. *See Figure 10-5.*

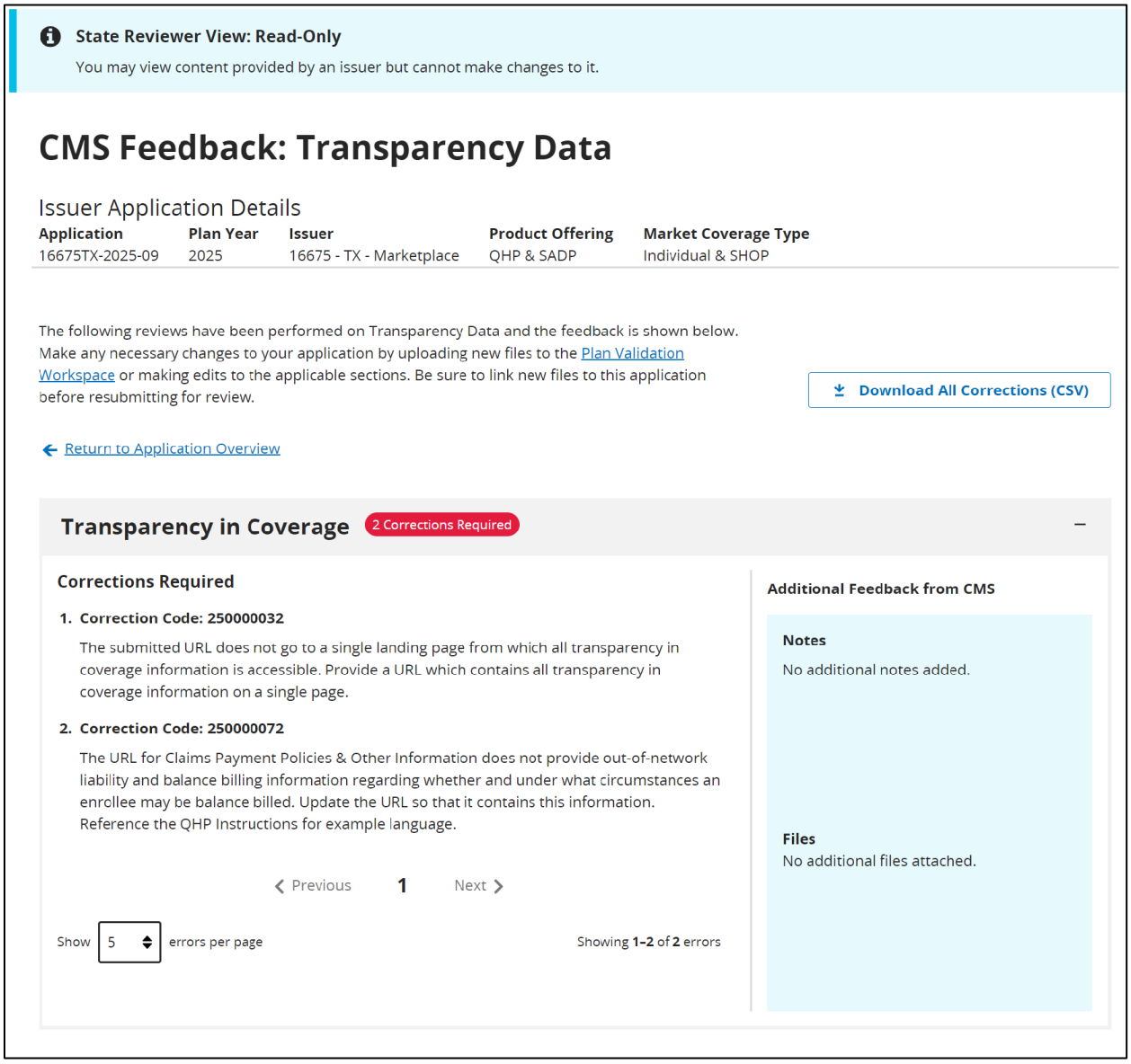


Figure 10-5. State Reviewer CMS Feedback

Additionally, State Reviewers are able to generate and download a URL template provided by an Issuer. Within the URL section, a State Reviewer may select one or more URL types and select the 'Generate and Download URL Template' button to download URLs in a CSV format. *See Figure 10-6.*

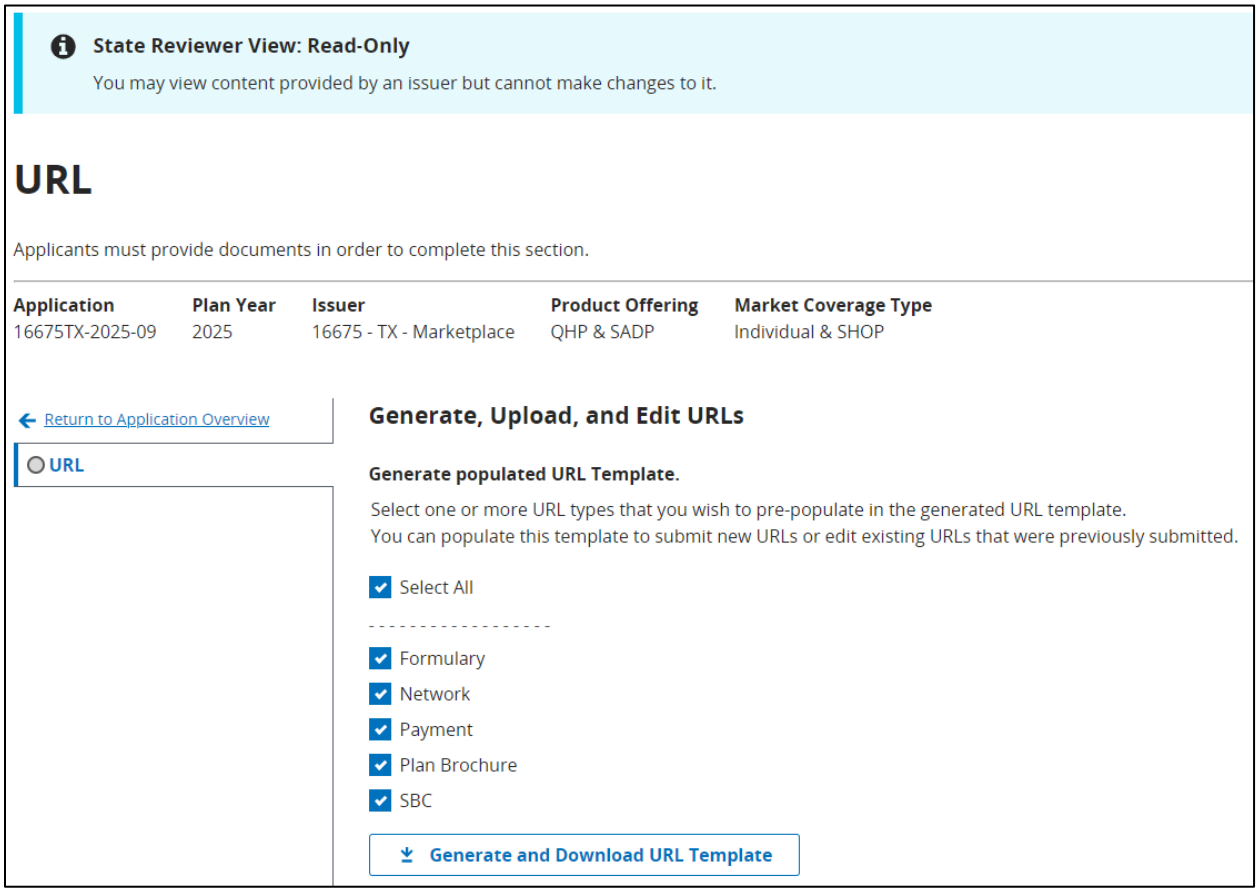


Figure 10-6. State Reviewer URLs

11 Application Tools

The Application Tools includes a section for application materials to support beginning an application with prior year data, issuer details for adding and editing Machine Readable URL data, and access to Plan Preview.

11.1 Application Materials

The Application Materials section provides users with the ability to download a pre-populated Network Adequacy template and/or Plan ID Crosswalk templates if they had a QHP application the previous year. This section is a tool to provide a starting point for filling out QHP application data.

11.1.1 Network Adequacy

The Network Adequacy section of the Application Materials page allows returning issuers to generate a PY25 Network Adequacy template with data from their PY24 application. Users can edit this file and submit as part of their PY25 application. *See Figure 11-1.*

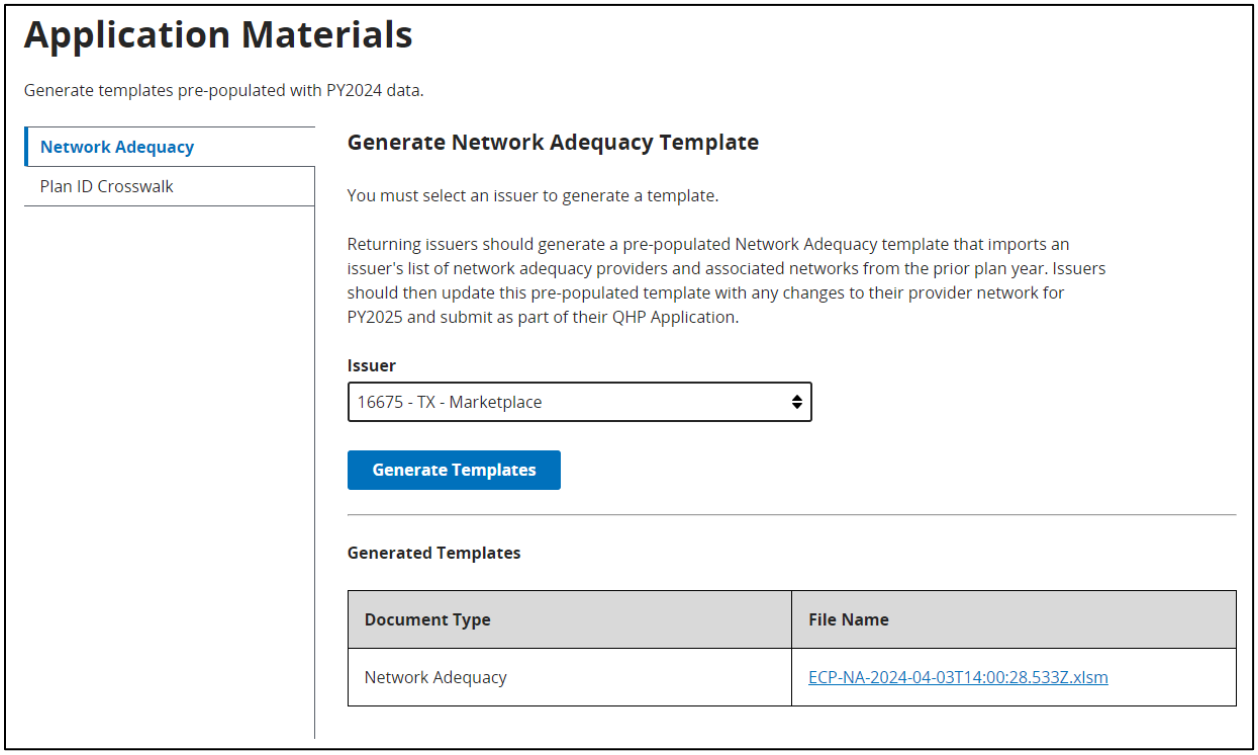


Figure 11-1. Generate Network Adequacy Template

11.1.2 Plan ID Crosswalk

The Plan ID Crosswalk section of the Application Materials page allows returning issuers to generate a PY25 Plan ID Crosswalk template with data from their PY24 application. Users can edit this file and submit as part of their PY25 application. *See Figure 11-2.*

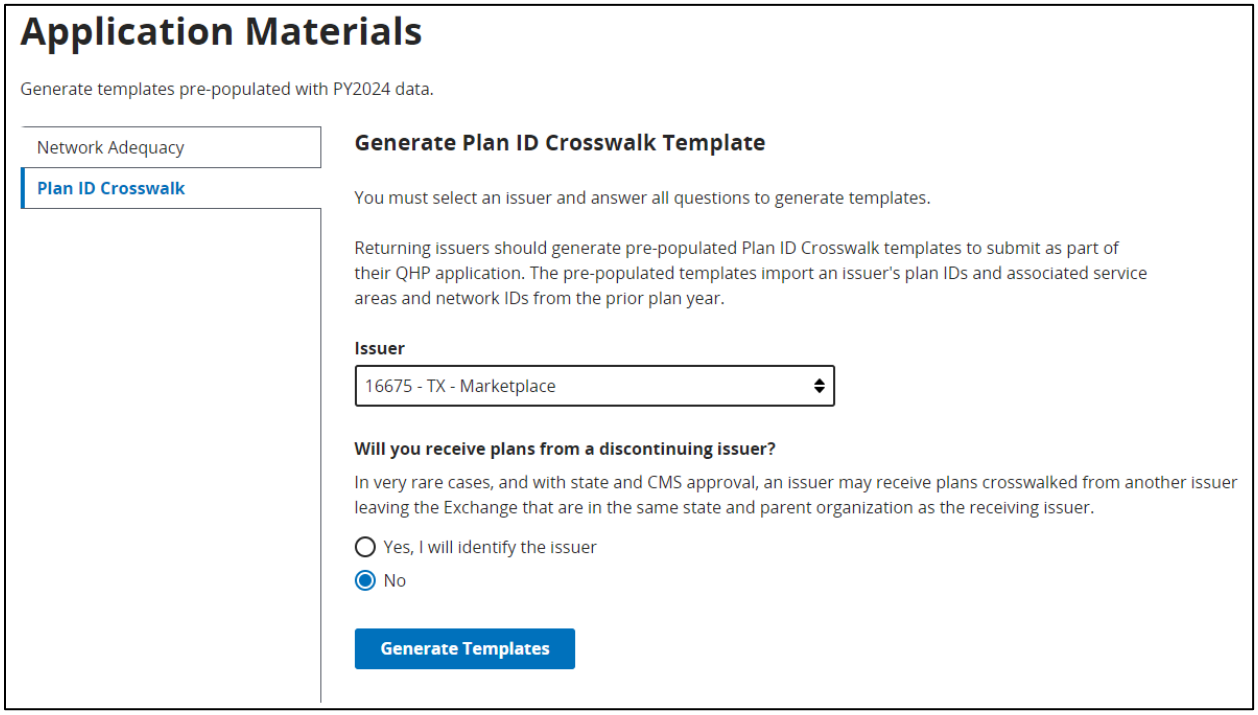


Figure 11-2. Generate Plan ID Crosswalk Template

11.2 Issuer Details

11.2.1 Machine-Readable Section

This section allows an Issuer Submitter user to edit a URL or email to maintain their Issuer URL Index. A user may select the State and Issuer from the dropdown menus and select the 'Search' button to populate the table. *See Figure 11-3.* The State and Issuer dropdown is only populated with the values that a user has access to. Other user roles, such as the State Reviewer role, will not be able to make any edits to the Machine-Readable section and the Action column will not be displayed. Only users with an Issuer Submitter role can make edits. A user may select the 'CMS Machine-Readable Tools' link which redirects the user to further instructions. A user may also contact the Help Desk for further assistance. A user may download the contents of the Machine-Readable table into a .csv file by clicking the 'Download (CSV)' button above the table. The .csv file will also contain two additional columns: 'SADP Only' and 'Last Modified Date Time'.

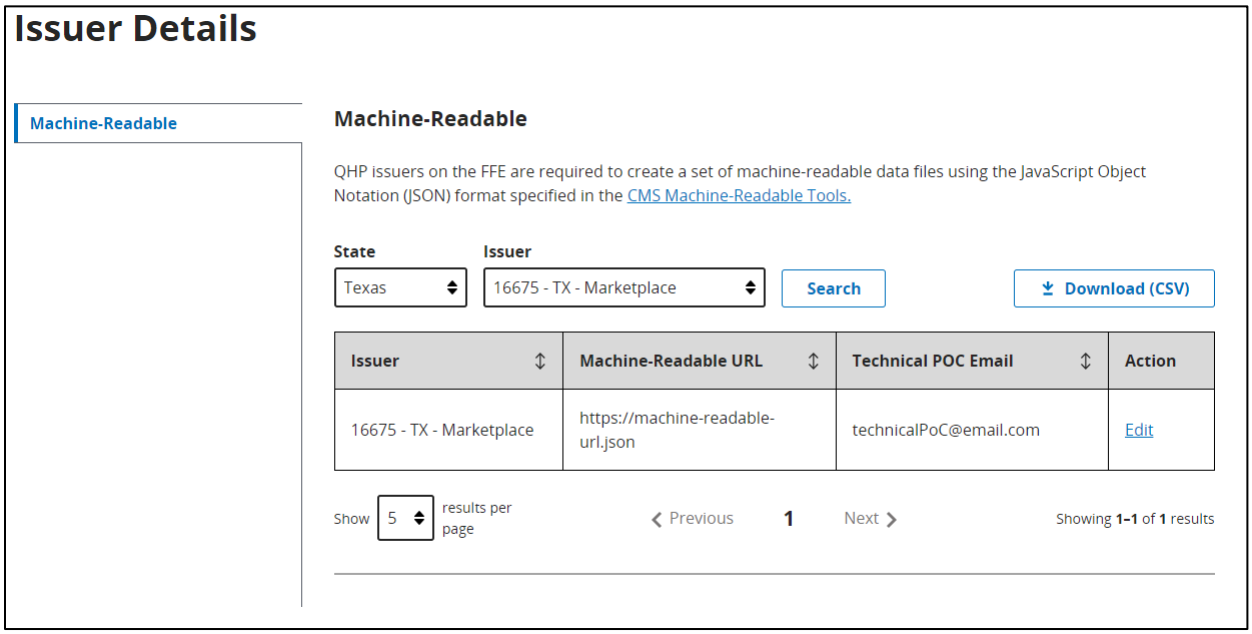


Figure 11-3. Machine-Readable Section

11.2.2 Edit Machine-Readable Section

By selecting the 'Edit' link under the Action column, a pop-up window will appear where a user may edit the Machine-Readable URL or email details. Once a user has made any updates they may select the 'Apply' button to save their changes. *See Figure 11-4.* A user may also select the 'Cancel' or 'Close' links if they no longer wish to make changes.

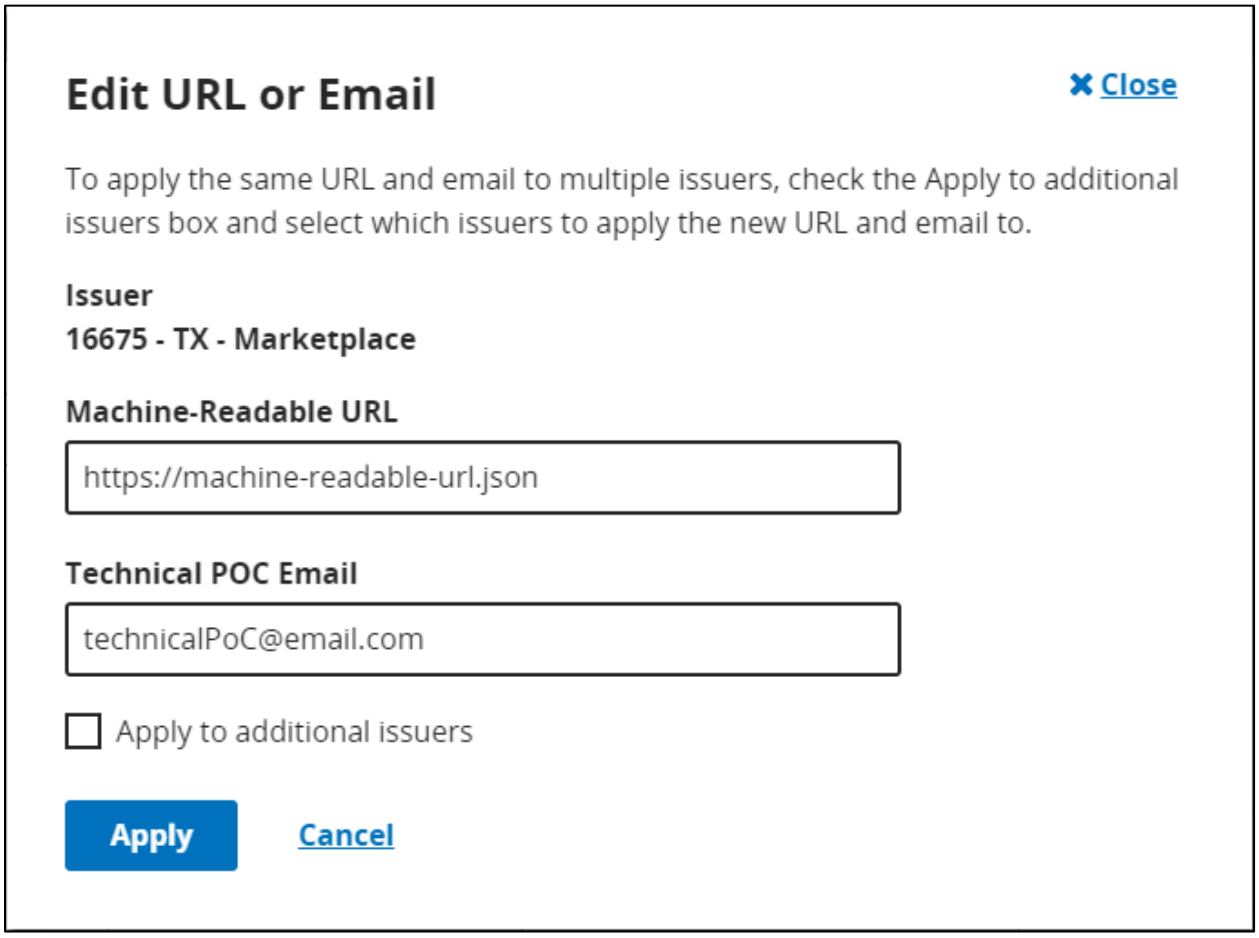


Figure 11-4. Edit URL or Email

If a user wishes to apply the same URL and email to multiple Issuers, they may select the Apply to additional Issuers check box and select which Issuers they would like to apply the new URL and email to. *See Figure 11-5.*

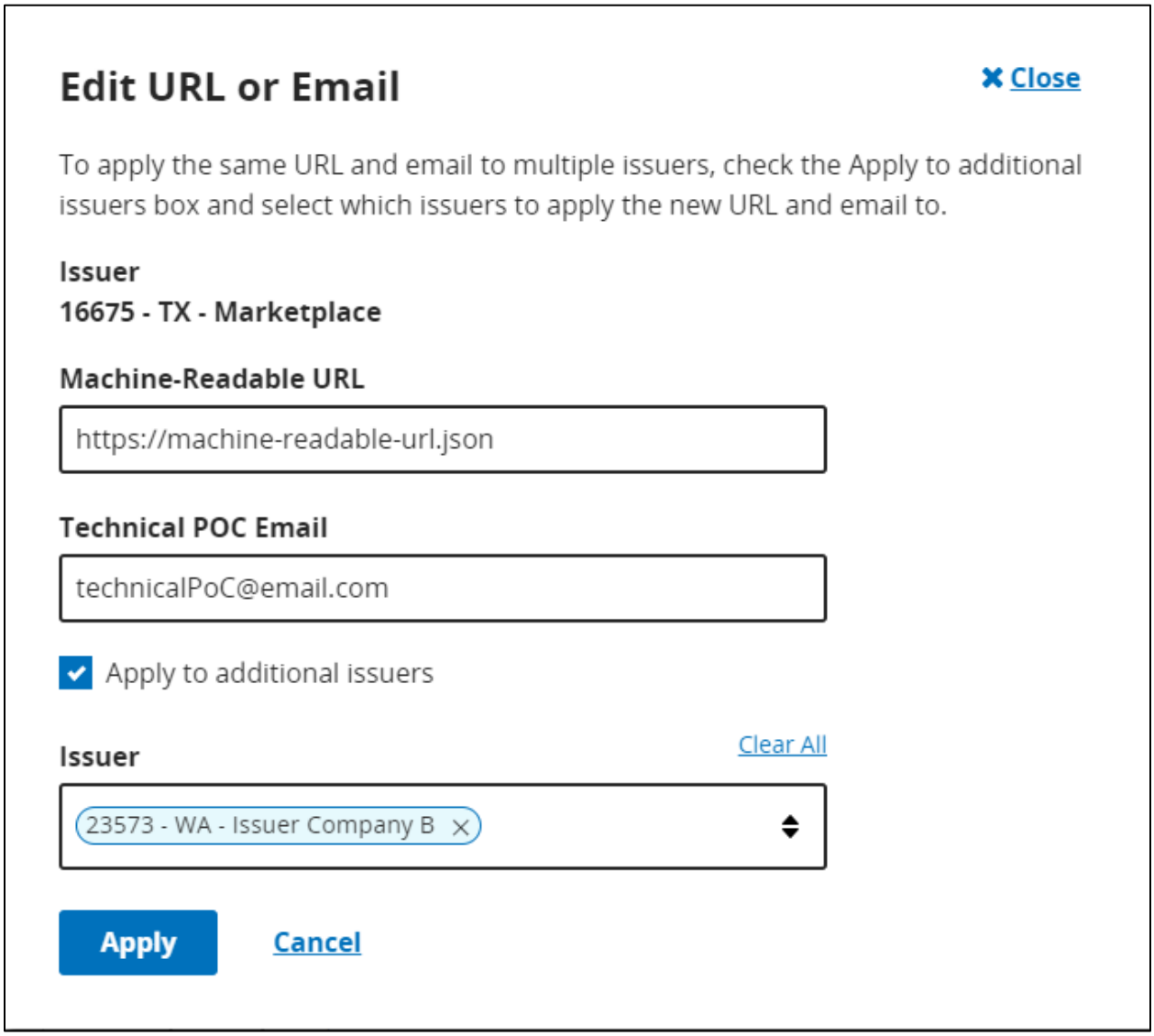


Figure 11-5. Apply to Additional Issuers

11.2.3 Warning and Error Validation

By selecting ‘Apply’ the validation process will begin. A pop-up window will appear to notify the user that the validation process has started. *See Figure 11-6.*

A user will receive an error if they do not use https:// at the start of their URL and .json at the end of their URL. For any in-line error, the ‘Apply’ button will be disabled.

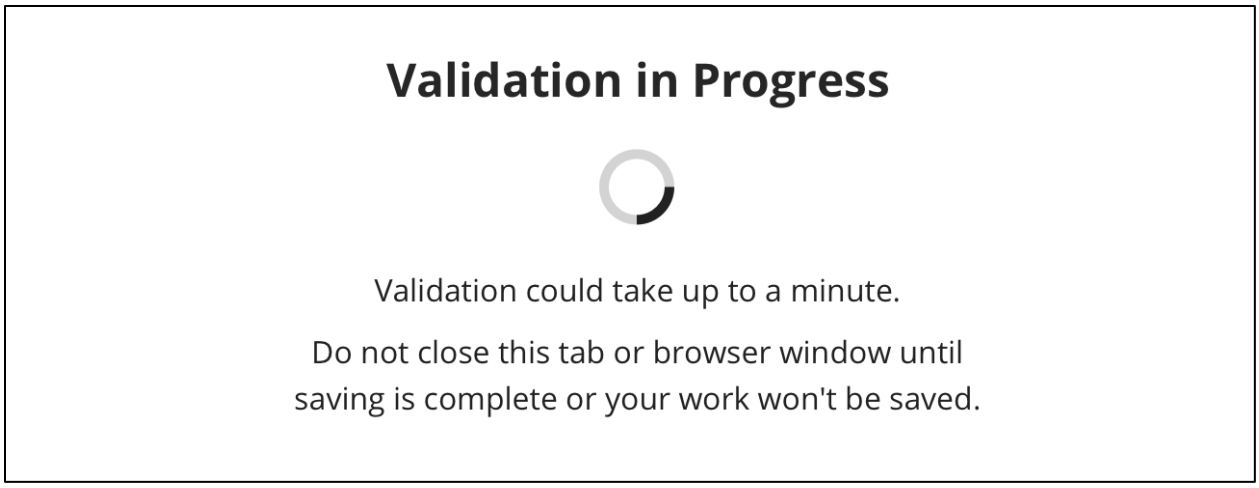


Figure 11-6. Validation in Progress

Any Validation Warnings or Errors will be displayed in a pop-up message. *See Figure 11-7.* Selecting the 'Continue Editing' or 'Close' button redirects the user back to the 'Edit URL or Email' pop-up to edit any data with validation errors. User can download the data from the Validation Results table into a .csv file by clicking the 'Download (CSV)' button above the table.

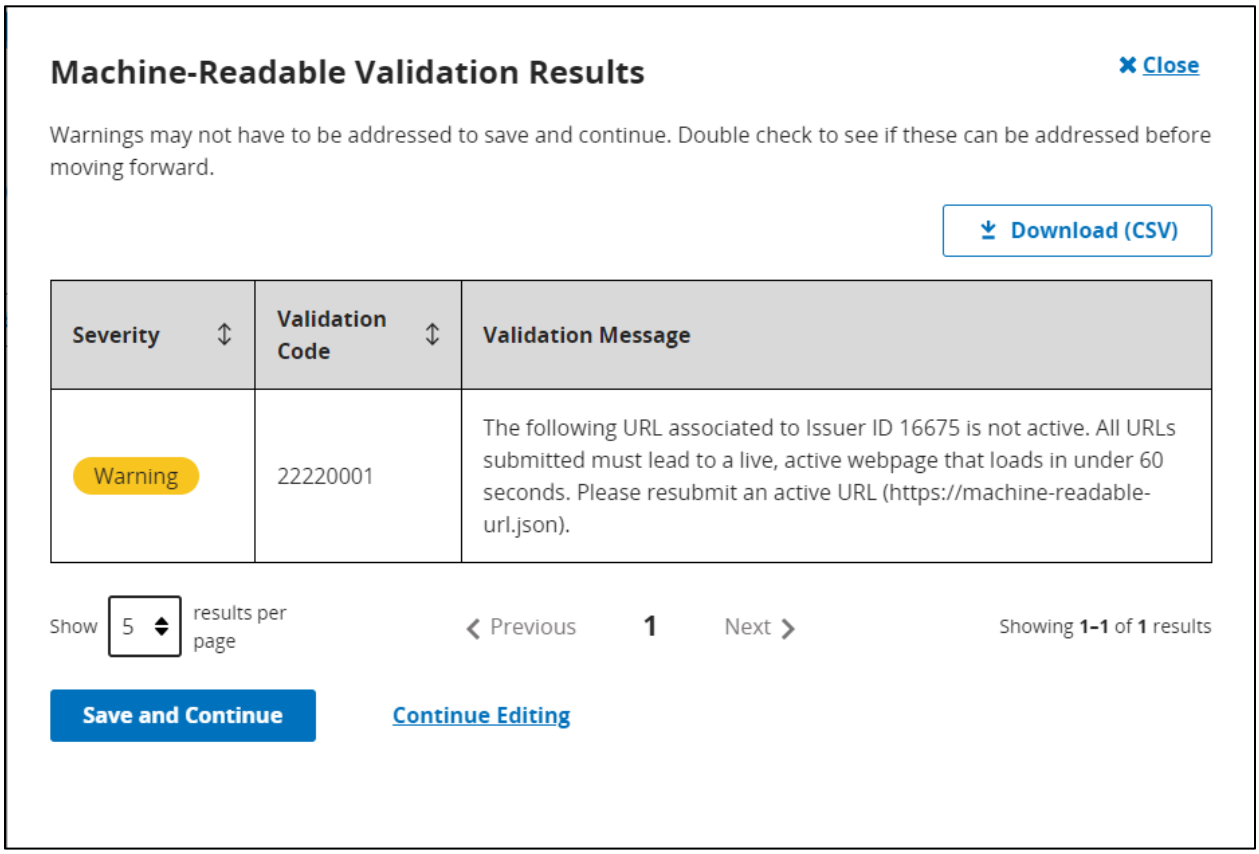


Figure 11-7. Machine-Readable Validation Results

If there are no Validation Results to review, the user is redirected to the Issuer Details page where the success banner displays confirming that the URL and email has been updated. *See Figure 11-8.*

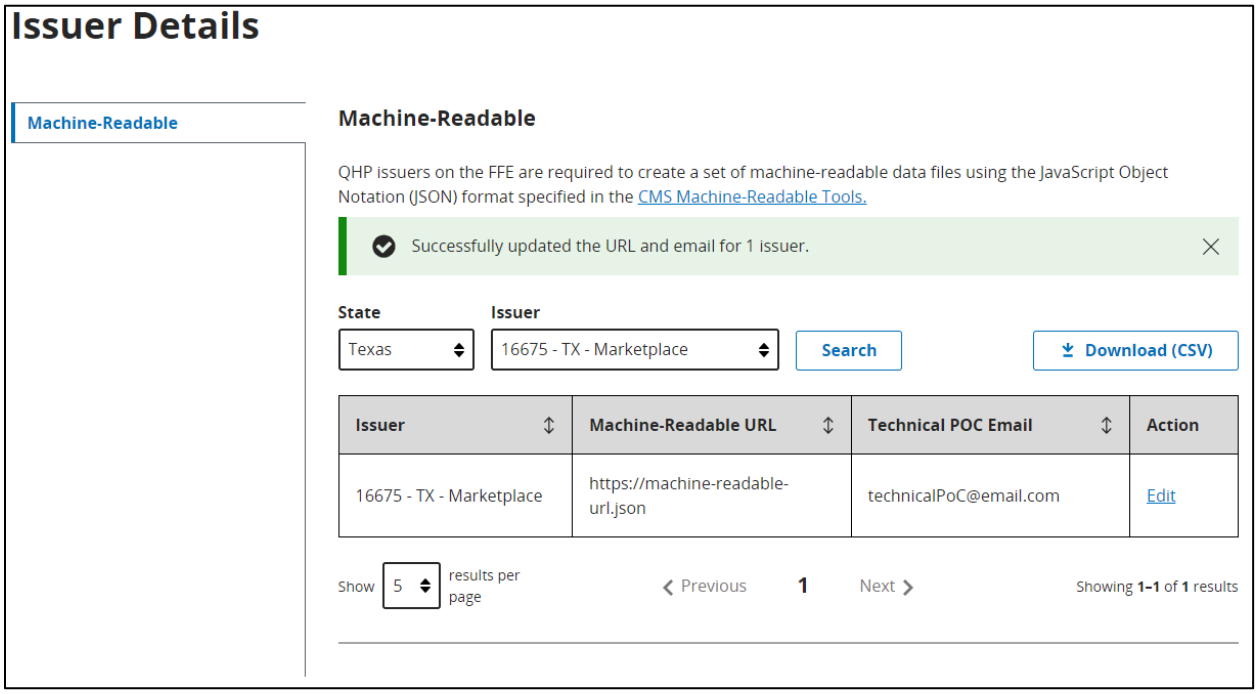


Figure 11-8. Machine-Readable Success Banner

11.3 Plan Preview

Issuers may use the Plan Preview Tool to review their submitted QHP Plan Data so they can validate that their plan data is correct and that it will display correctly on Healthcare.gov during Open Enrollment. Issuers can navigate to the Plan Preview Tool via the Application Tools header. *See Figure 11-9.*

Plan Preview displays all plans for Issuers as either available or unavailable for a particular Rating Scenario. Available and unavailable plans are displayed in a Plan Results table. All unavailable plans are labeled with a reason code for their unavailability. The Plan Card and Plan Details will show the information that will be displayed in the Exchange Portal.

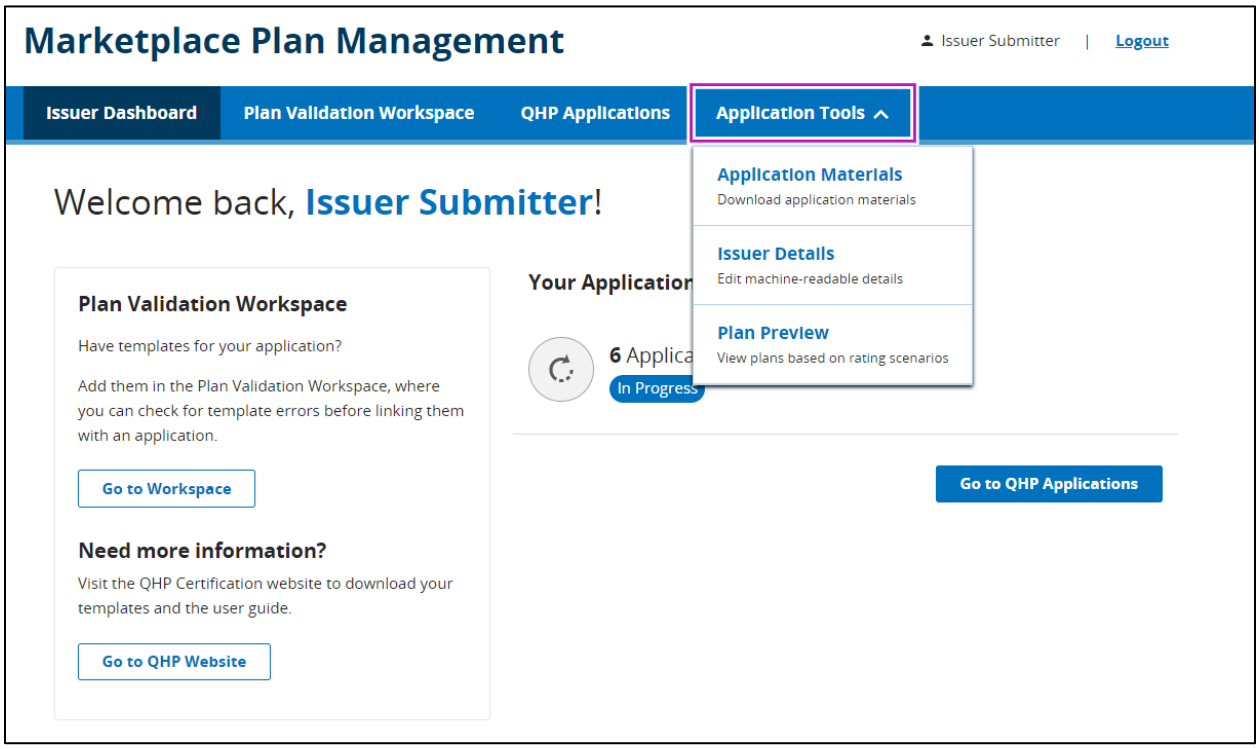


Figure 11-9. MPMS Home Page

11.3.1 Eligibility for Plan Preview

Plan Preview will only be available for QHP Applications where all groups (with the exception of the Plan Rates and Issuer URL groups) have reached a status of "Submitted - Under Review," "No Action Required," or "Corrections Required.". If the required templates have not been successfully submitted and linked to the application, a banner message stating No Plans Available will display. *See Figure 11-10.*

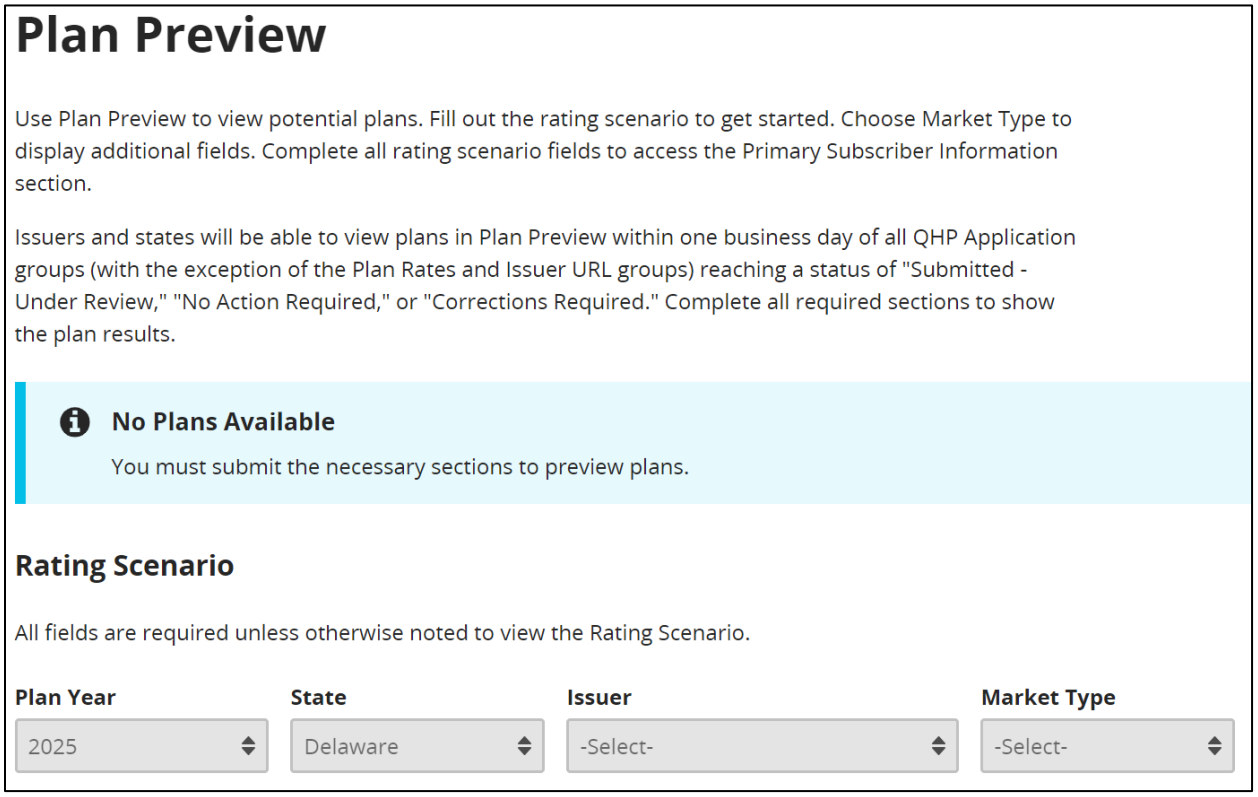


Figure 11-10. No Plans Available Banner

11.3.2 Begin Plan Preview

Upon landing on the Plan Preview page with available plans, a user will be presented with four dropdown menus. A user will be required to input values for each dropdown before being able to continue with the rating scenario. See *Figure 11-11* below. In the Rating Scenario section, dropdowns will dynamically display based on values the user has access to and inputs from dropdowns.

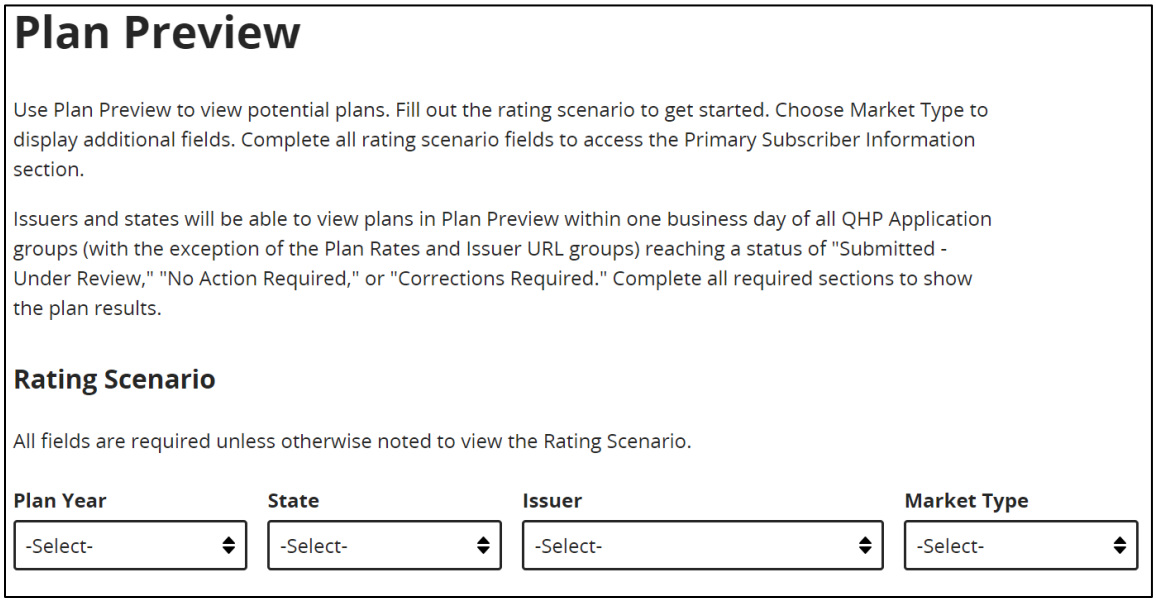


Figure 11-11. Plan Preview Landing Page

The Table 11-1 below describes the fields in the Rating Scenario section for Plan Preview and provides instructions on how to enter data in these fields.

Table 11-1. Plan Preview – Rating Scenario

Field Name	Description	Value
Plan Year	Allow the user to select the Plan Year to view	Dropdown • (YYYY)
State	Allow the user to select the State to view	Dropdown • List of States
Issuer	Allow the user to select the Issuer to view	Dropdown • List of Issuer
Market Type	Allow the user to select the Market Type to view	Dropdown • Individual • Small Group (SHOP)

11.3.3 Enter Rating Scenario

A user may input the Effective Date by selecting the calendar icon and selecting the chosen date from the calendar view, or by inputting the Effective Date in MM/DD/YYYY format. Once the user selects a Market Type, additional fields are displayed. Figure 11-12 below shows how Plan Preview will display for an Individual Market Type selection.

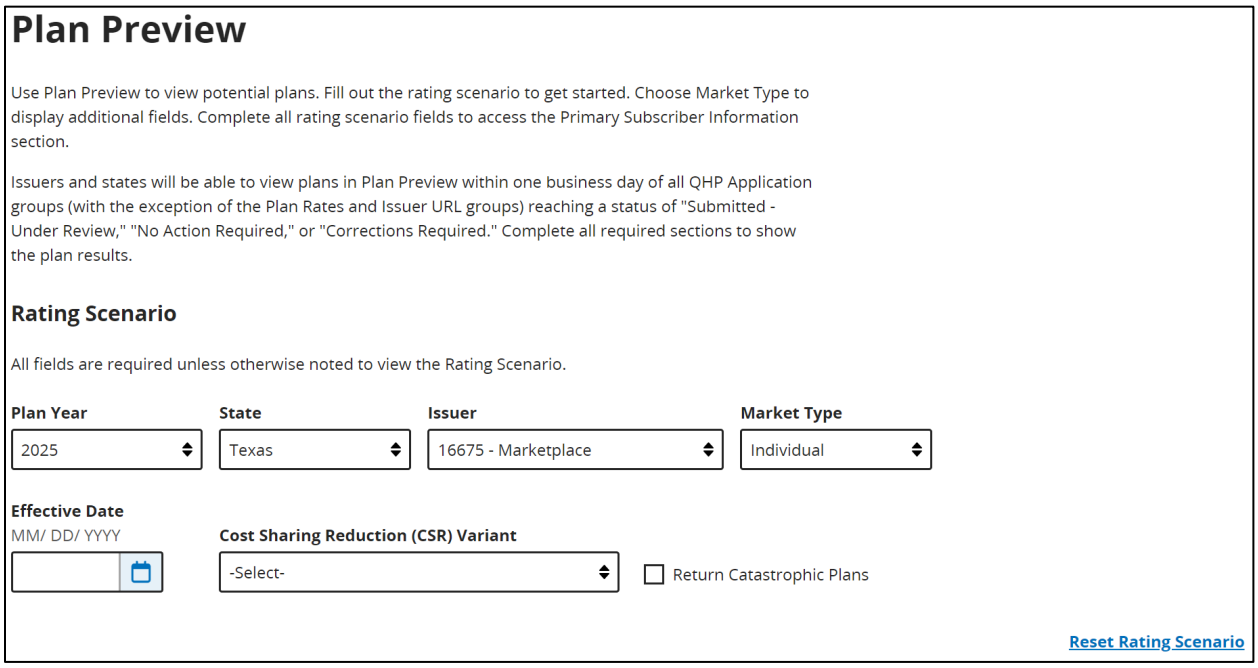


Figure 11-12. Plan Preview Individual Market Type

Figure 11-13 shows how Plan Preview will display for a SHOP Market Type selection.

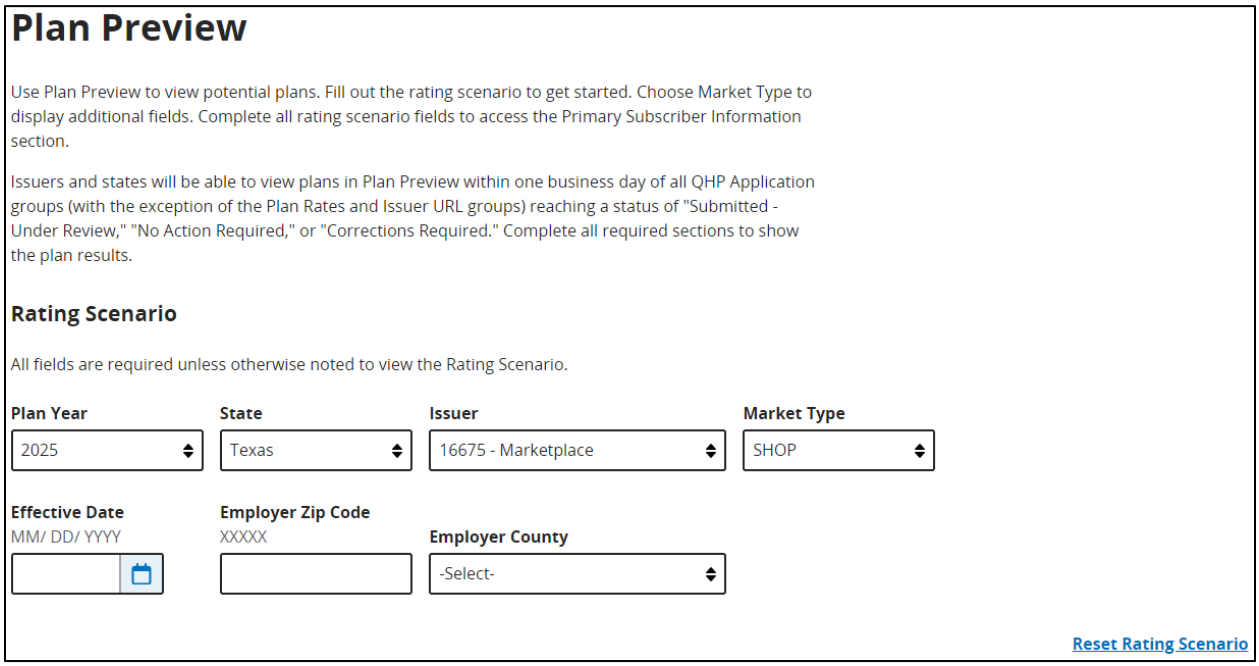


Figure 11-13. Plan Preview SHOP Market Type

The Table 11-2 below describes the fields in the Rating Scenario section for both Individual and SHOP Market Types and provides instructions on how to enter data in these fields.

Table 11-2. Rating Scenario – Apply Rating Scenario (Individual)

Field Name	Description	Value
Market Type	Allows the user to select the Market Type to View.	Dropdown • Individual • Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario.	Date-picker (MM/DD/YYYY)
Cost Sharing Reduction (CSR) Variant	Allows the user to select a CSR variation type to view. (Note: Does not appear for SHOP.)	Dropdown • Exchange variant (no CSR) • Zero Cost Sharing Plan Variation • Limited Cost Sharing Plan Variation • 73% AV Level Silver Plan CSR • 87% AV Level Silver Plan CSR • 94% AV Level Silver Plan CSR

Field Name	Description	Value
Return Catastrophic Plans Checkbox	Checking this box returns catastrophic plans as available. If the box is unchecked, catastrophic plans will return as unavailable. (Note: Does not appear for SHOP.)	Checkbox
Employer Zip Code	Allows the user to enter a 5-digit zip code. (Note: Does not appear for Individual.)	Numeric
Employer Country	Allows the user to select a county associated with the provided zip code. (Note: Does not appear for Individual.)	Populated by system (Based on zip code entry)

After entering the high-level details for the rating scenario, the user can fill out the details for the Primary Subscriber. See Figure 11-14 for an example of the view for the Individual Market.

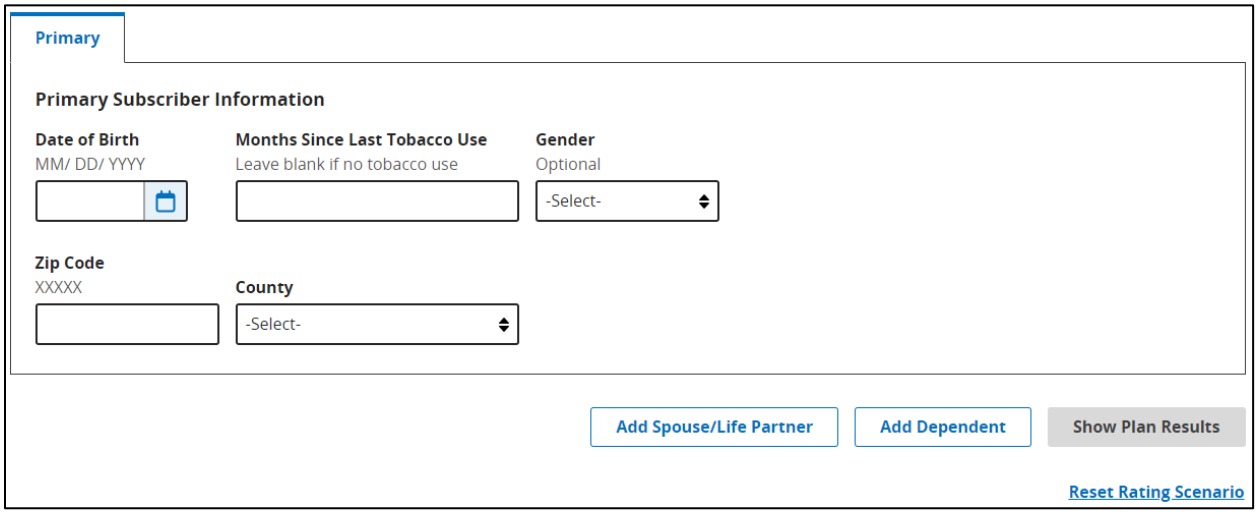


Figure 11-14. Primary Subscriber Information

The Table 11-3 below describes the fields in the Primary Subscriber section for Individual and SHOP Market Type and provides instructions about how to enter data in these fields.

Table 11-3. Rating Scenario – Primary Subscriber Fields (Individual)

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the primary subscriber	Date-picker (MM/DD/YYYY)
Number of Months since last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown • Male • Female
Zip Code	Allows the user to enter a 5-digit zip code. (Note: Does not appear for SHOP.)	Numeric
Country	Allows the user to select a county associated with the provided zip code. (Note: Does not appear for SHOP.)	Populated by system (Based on zip code entry)

A user may select the 'Add Spouse/Life Partner' button to display the Spouse/Life Partner tab and the 'Add Dependent' button to display the Dependent tab. *See* Figure 11-15 *and* Figure 11-16.

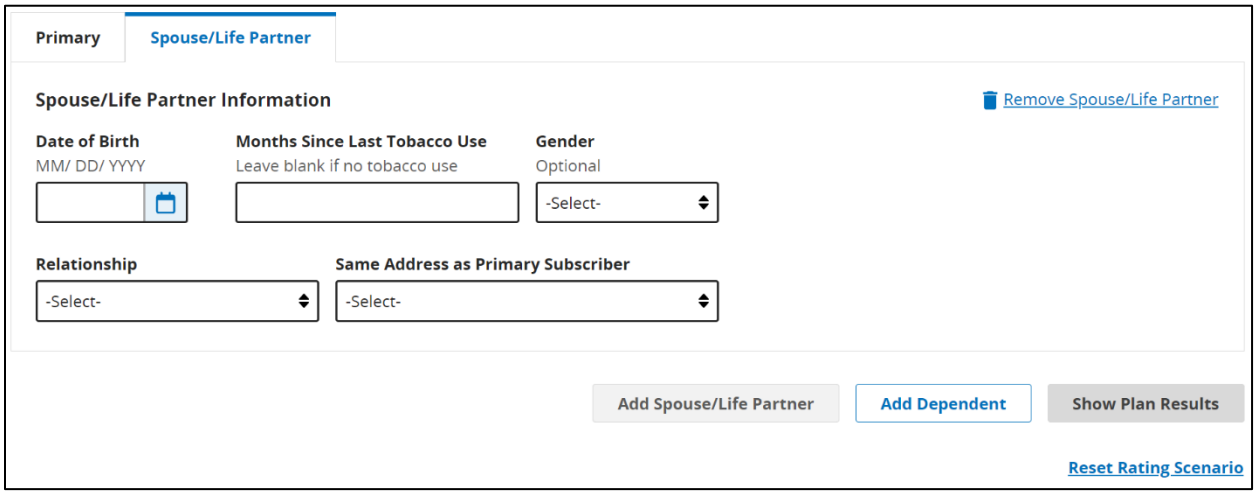


Figure 11-15. Spouse/Life Partner Information

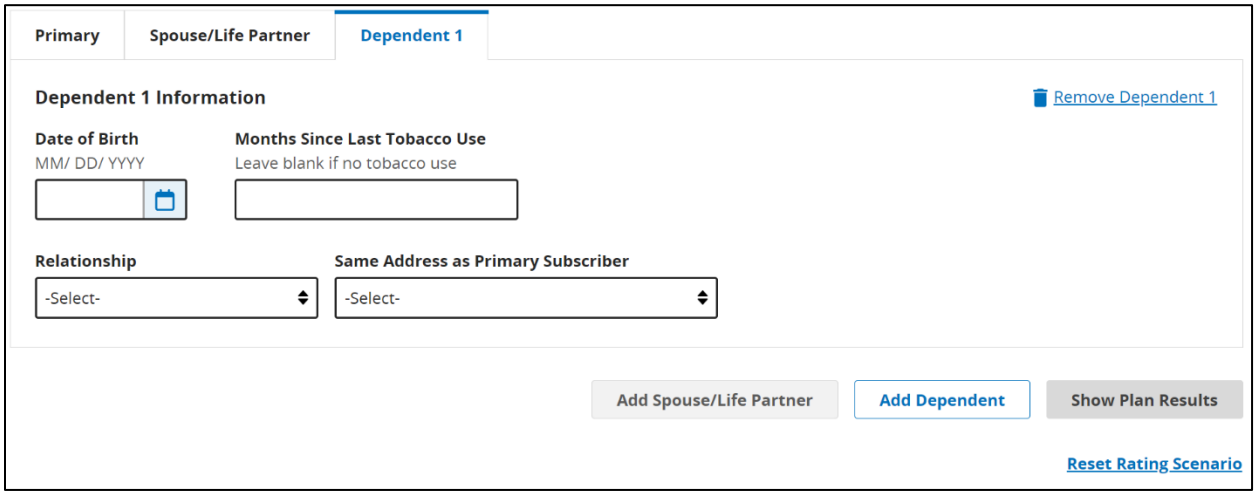


Figure 11-16. Dependent Information

The Table 11-4 below describes the fields in the Spouse/Life Partner section and provides instructions about how to enter data in these fields.

Table 11-4. Rating Scenario – Spouse/Life Partner Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the spouse/life partner.	Date-picker (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the spouse/life partner (not required).	Dropdown • Male • Female
Relationship	Allows the user to identify the relationship type.	Dropdown • Spouse • Ex-Spouse • Life Partner
Same address as Primary Subscriber	Allows the user to indicate whether or not the spouse/life partner's address is the same as the primary subscriber's address. (Note: Does not appear for SHOP.)	Dropdown • Yes • No

The Table 11-5 below describes the fields in the Dependent section and provides instructions on how to enter data in these fields.

Table 11-5. Rating Scenario – Dependent Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the dependent/	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Relationship	Allows the user to identify the relationship type.	Dropdown • Child • Brother or Sister • Ward • Stepson or Stepdaughter • Grandson or Granddaughter • Nephew or Niece • Collateral Dependent • Foster Child • Sponsored Dependent • Other Relationship • Other Relative
Same address as Primary Subscriber	Allows the user to indicate whether or not the spouse/life partner's address is the same as the primary subscriber's address. (Note: Does not appear for SHOP.)	Dropdown • Yes • No

11.3.4 Reset Rating Scenario

If a user needs to reset the Rating Scenario, they may select the 'Reset Rating Scenario' link. A popup message will appear to confirm that selecting 'Continue' will clear all sections and the page will return to the initial state. Similar popup messages will appear when changing the Market Type and State. *See Figure 11-17.*

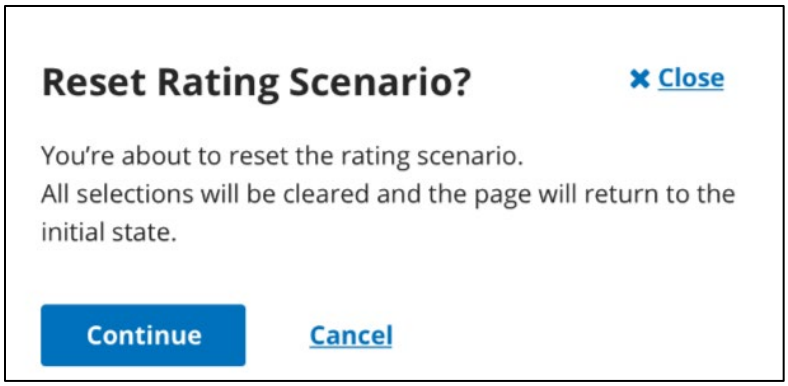


Figure 11-17. Reset Rating Scenario Popup

11.3.5 Submit Scenario for Plan Results

Selecting the 'Show Plan Results' button displays the Plan Results table. A user may view available and unavailable plans or use the search bar to search for a specific Plan ID. *See Figure 11-18.*

Plan Results

View available or unavailable plans?

Available Unavailable

Search

Plan ID	Plan Name	Product Type	Plan Type	Metal Level	SPO	View
16675TX0020020	PB Med Indl 1	HMO	MEDICAL	BRONZE	Non-SPO	Contact Info | Plan Card
16675TX0020021	PB Med Indl 2	HMO	MEDICAL	BRONZE	SPO	Contact Info | Plan Card
16675TX0020023	PB Med Indl 4	HMO	MEDICAL	GOLD	Non-SPO	Contact Info | Plan Card
16675TX0020024	PB Med Indl 5	HMO	MEDICAL	PLATINUM	Non-SPO	Contact Info | Plan Card
16675TX0020028	PB Med Indl 6	HMO	MEDICAL	SILVER	SPO	Contact Info | Plan Card
16675TX0020029	PB Med Indl 7	HMO	MEDICAL	GOLD	SPO	Contact Info | Plan Card
16675TX0020030	PB Med Indl 11	HMO	MEDICAL	PLATINUM	SPO	Contact Info | Plan Card

Show 25 results per page Previous 1 Next Showing 1–7 of 7 results

Figure 11-18. Plan Results

A user may search the list of available plans by Plan ID, Plan Name, Plan Type, Metal Level, or Product Type (see Table 11-6 below).

Table 11-6. Plan Results – Available Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text
Market Type (pre-populated)	Market Type.	• Individual • Small Group (SHOP)
Plan Type (pre-populated)	Network design for the plan.	• PPO • HMO • POS • EPO • Indemnity
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans: • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans: • High • Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	• Medical • Dental

11.3.6 Plan Contact Information

Selecting a 'Contact Info' link for Available Plans within the Plan Results section will display the Contact Info pop-up for the specific Plan ID. The contact information will detail the Plan ID, Payment URL, Customer Service Phone Number, Customer Service URL, and Billing Address. Select the 'close' button to return to Plan Preview or select another Plan ID. *See* Figure 11-19.

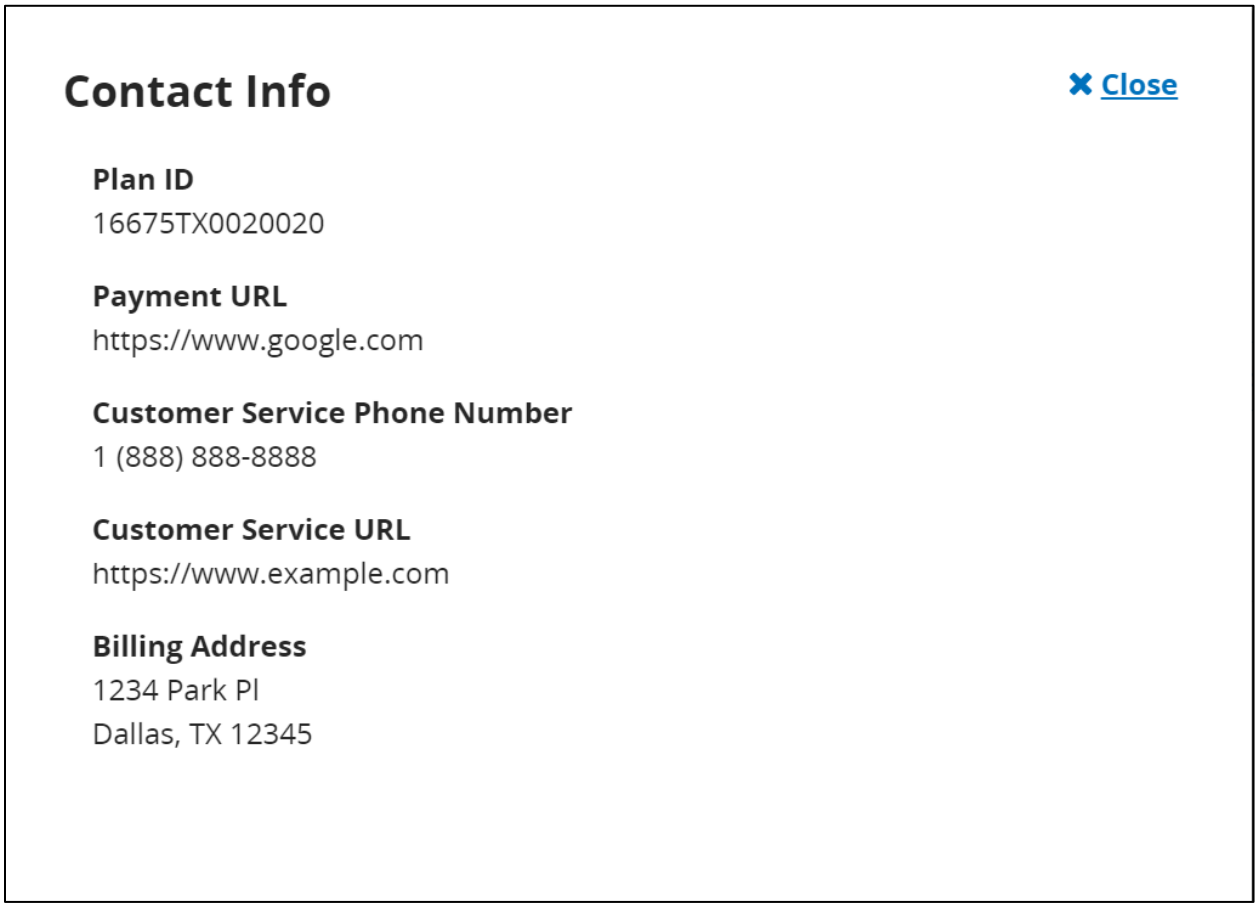


Figure 11-19. Plan Contact Information

11.3.7 Unavailable Reason Code

The Table 11-7 below describes the fields for unavailable plan results.

Table 11-7. Plan Results – Unavailable Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text
Plan Type (pre-populated)	Network design for the plan.	• PPO • HMO • POS • EPO • Indemnity
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans: • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans: • High • Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	• Medical • Dental
Code	Numerical value referencing why a plan shows as unavailable.	Numeric
Reason	Provides a description of the reason code for why plan is unavailable.	Text

A reason code will also be provided for unavailable plans. For reference a complete list of unavailable reasons and codes is provided in Table 11-8 below.

Table 11-8. Plan Results – Unavailable Plan Reason Codes

Reason Code	Unavailable Reason Text	Description
316	"Out of Service Area"	This reason code displays if the user input Zip-Code/County is not in the plan's service area
318	"Dependent X over max age" where X is the dependent number	This reason code displays if an included Child dependent is over the maximum age allowed by the plan's business rules
321	"X Relationship not allowed" where X is the dependent's relationship type, e.g. "Dependent 1 Relationship not allowed"	This reason code displays if an included dependent relationship is not included in the allowed relationships, or if an included dependent is required to reside with the primary subscriber but does not.
322	"No rate for X" where X is the subscriber, e.g. "No rate for Dependent 1"	This reason code displays if a rate is not found for a subscriber, e.g. if the user-input county is included in a plan's Service Area but not in the plan's Rating Area
600	"CSR Variant Mismatch"	This reason code displays if the user input CSR Variant is not found for a plan, e.g. a user-input CSR Variant of 87% AV Level Silver Plan would not be found for a Gold plan.
602	"Ineligible for Child-only"	This reason code displays if the enrollment group is not eligible for child-only plans but the plan is child only. • All enrollees must be under 21 years of age, and any dependents must have the 'brother or sister' relationship type • The group cannot include child, ward, spouse, life partner, stepson or stepdaughter, grandson or granddaughter, nephew or niece, collateral dependent, ex-spouse, foster child, sponsored dependent, other relationship, or other relative relationship types

Reason Code	Unavailable Reason Text	Description
603	“Ineligible for Adult only”	This reason code displays if the enrollment group is not eligible for adult-only plans but the plan is adult-only.
605	“Child-only plans are not available in the Small Group On-Exchange Market”	This reason code displays if the enrollment scenario Market Type is Small Group (SHOP) but the plan is child-only.
607	“Plan enrollment is closed”	Plan has a suppression status of closed

11.3.8 Plan Card

In the Plan Results section, selecting the 'Plan Card' link directs the user to the Plan Card page. *See Figure 11-20.* This section displays the rating scenario entered by the user and the initial view of the plan card that displays to consumers.

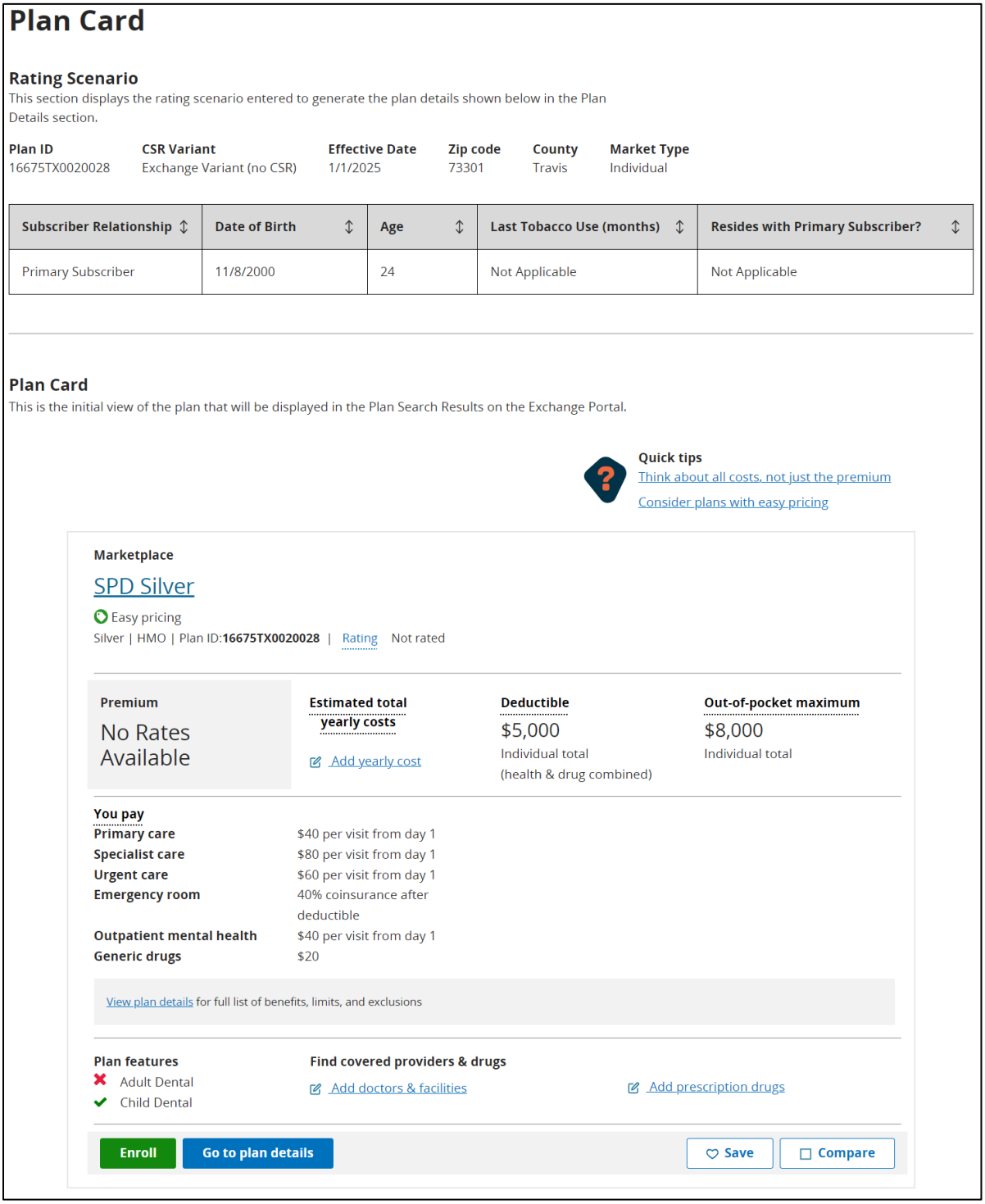


Figure 11-20. Plan Card

The following table provides the field name and a description for each field of the Plan Card section. Table 11-9 below describes the fields on the Plan Card section for Individual and Small Group (SHOP).

Table 11-9. Plan Details Page – Plan Card Fields

Field Name	Description
Plan Name	Displays the Issuer Marketing Name (pulled from HIOS “Marketplace” tab), plus the Plan Variant Marketing Name (pulled from the Cost Share Variances tab of the Plans and Benefits template). If the Issuer Marketing name is blank, displays the Issuer Legal Name (pulled from HIOS), plus the Plan Variant Marketing Name.
Plan Attributes	Displays the following details of the selected plan, in this order (if applicable): 1. Level of Coverage 2. Plan Type 3. “National Provider Network” displays if the “National Network” field in the Plans and Benefits template is equal to “Yes.” No text displays if the “National Network” field is equal to “No” 4. Plan ID 5. Rating (Quality Measures) displays the overall quality rating as 1-5 stars for the selected plan. 1. Note: If no quality data is available for the plan, the Rating will display ‘Not rated.’ If the plan is ineligible for scoring because it is a new plan, then ‘New Plan – Not Rated’ will display.
Premium	Displays the monthly premium amount that the rating engine calculates based on the individuals in the enrollment group and the plan effective date. For Stand Alone Dental Plans, displays “Estimated Rate” along with the premium amount. If the rate is guaranteed, then displays a checkmark and “Guaranteed Rate” based on the “Guaranteed vs. Estimated Rates” field in the Plans and Benefits template.
Estimated total yearly costs	This field is included to mimic what will display in Plan Compare, however, the “Add yearly cost" link will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display values for the costs.

Field Name	Description
Deductible	The deductible field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a. If Individual In-Network value is $X, display “$X Individual Total”; else, if this value is “Not Applicable” b. If Individual Combined In/Out Network value is $X, display “$X Individual Total” 2. .If the enrollment group size is greater than one (at least one dependent) a. If both Family Per Group and Family Per Person are $X (including $0), then display both as “$X Family Total” and “$X individual Total” i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out Network value. b. If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display “$X Family Total” and do not display a per person value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out Network value. c. If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display “$X Individual Total” and do not display a per group value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out Network value. If medical and drug deductibles are integrated, then the combined medical and drug deductible displays in the Highlights section. “Included in plan’s deductible” displays in the prescription drug coverage details section. If medical and drug deductibles are not integrated, medical and drug deductibles display in the Highlights section. The drug deductible will also display in the prescription drug deductible coverage details section In-Network Tier 2 and Out of Network deductibles do not display in Plan Preview or Plan Compare.

Field Name	Description
Out-of-Pocket Maximum	The Out-of-Pocket Maximum field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a. If Individual In-Network value is $X, display “$X Individual Total”; else, if this value is “Not Applicable”, b. If Individual Combined In/Out Network value is $X, display “$X Individual Total”. c. 2. If the enrollment group size is greater than one (at least one dependent) a. If both Family Per Group and Family Per Person are $X (including $0), then display both as “$X Family Total” and “$X Individual Total” i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out-Network value. b. If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out Network), then display “$X Family Total” and do not display a per person value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out-Network value. c. If Family Per Group is Not Applicable (for both In-Network and Combined In/Out Network) and Family Per Person is $X (including $0), then display “$X Individual Total” and do not display a per group value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out Network value. If medical and drug maximum out-of-pocket (MOOP) amounts are integrated, then the combined medical and drug maximum displays in the overview section. “Included in plan’s out-of-pocket maximum” displays in the prescription drug coverage details section. If medical and drug maximums are not integrated, only the medical amount displays on this part of the page. The drug MOOP displays in the prescription drug coverage details section. In-Network Tier 2 and Out of Network MOOP values do not display in Plan Preview or Plan Compare.

Field Name	Description
You pay	For Primary care, Specialist care, Urgent care, Emergency room, Outpatient mental health, or Generic drugs, displays cost-sharing information according to the Copay/Coinsurance mapping logic posted on the **QHP Certification Website**. Displays information from the following fields in the Plans and Benefits template: • Primary Care • Specialist Visit • Urgent Care Centers or Facilities • Emergency Room Services • Mental/Behavioral Health Outpatient Services • Generic drugs Note: Individual QHP plans, non-catastrophic, non-SADP with a blank or "No" in quantitative limit on service "per visit from day 1" will display.
View plan details for full list of benefits, limits, exclusions	Selecting this link will transition the display to the Highlights section.
Plan features	Indicates whether the plan includes dental coverage. If the plan offers Child Dental by covering all three child dental benefits, displays "Child dental" with a green checkmark. If the plan offers one or two of the child dental benefits, displays "Child dental" with a yellow checkmark. If the plan does not offer Child Dental, displays "Child dental" with a red X-mark. If the plan offers Adult Dental by covering all three adult dental benefits, displays "Adult dental" with a green checkmark. If the plan offers one or two of the adult dental benefits, displays "Adult dental" with a yellow checkmark. If the plan does not offer Adult Dental, displays "Adult dental" with a red X-mark. A plan is considered to cover adult dental benefits if it covers all three of the following benefits: • Routine Dental Services (Adult) • Basic Dental Care (Adult) • Major Dental Care (Adult) A plan is considered to cover child dental benefits if it covers all three of the following benefits: • Dental Check-Up for Children • Basic Dental Care (Child) Major Dental Care (Child)

Field Name	Description
Add doctors & facilities	This field is included to mimic what will display in Plan Compare, however, the “Add doctors & facilities” link will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display covered providers.
Add prescription drugs	This field is included to mimic what will display in Plan Compare, however, the “Add prescription drugs” link will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display covered drugs.
Enroll	This button is included to mimic what will display in Plan Compare, however, the “Enroll” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not perform any action.
Go to plan details	This field is included to mimic what will display in Plan Compare, however, the “Go to plan details” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not perform any action.
Save	This button is included to mimic what will display in Plan Compare, however, the “Save” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not perform any action.
Compare	This button is included to mimic what will display in Plan Compare, however, the “Compare” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not perform any action.

11.3.9 Plan Details

Additionally, this page displays a Plan Details section, which allows the user to view plan data in either a Consumer View (similar to how data may appear to a consumer on healthcare.gov) or a Data Validation View (as a point of reference for the data submitted in the QHP templates). A user may select various dropdowns to view additional information. *See Figure 11-21* for the Consumer View and *Figure 11-22* for the Data Validation View. For additional details on the fields displayed, reference *Appendix B: Additional Plan Preview Details*.

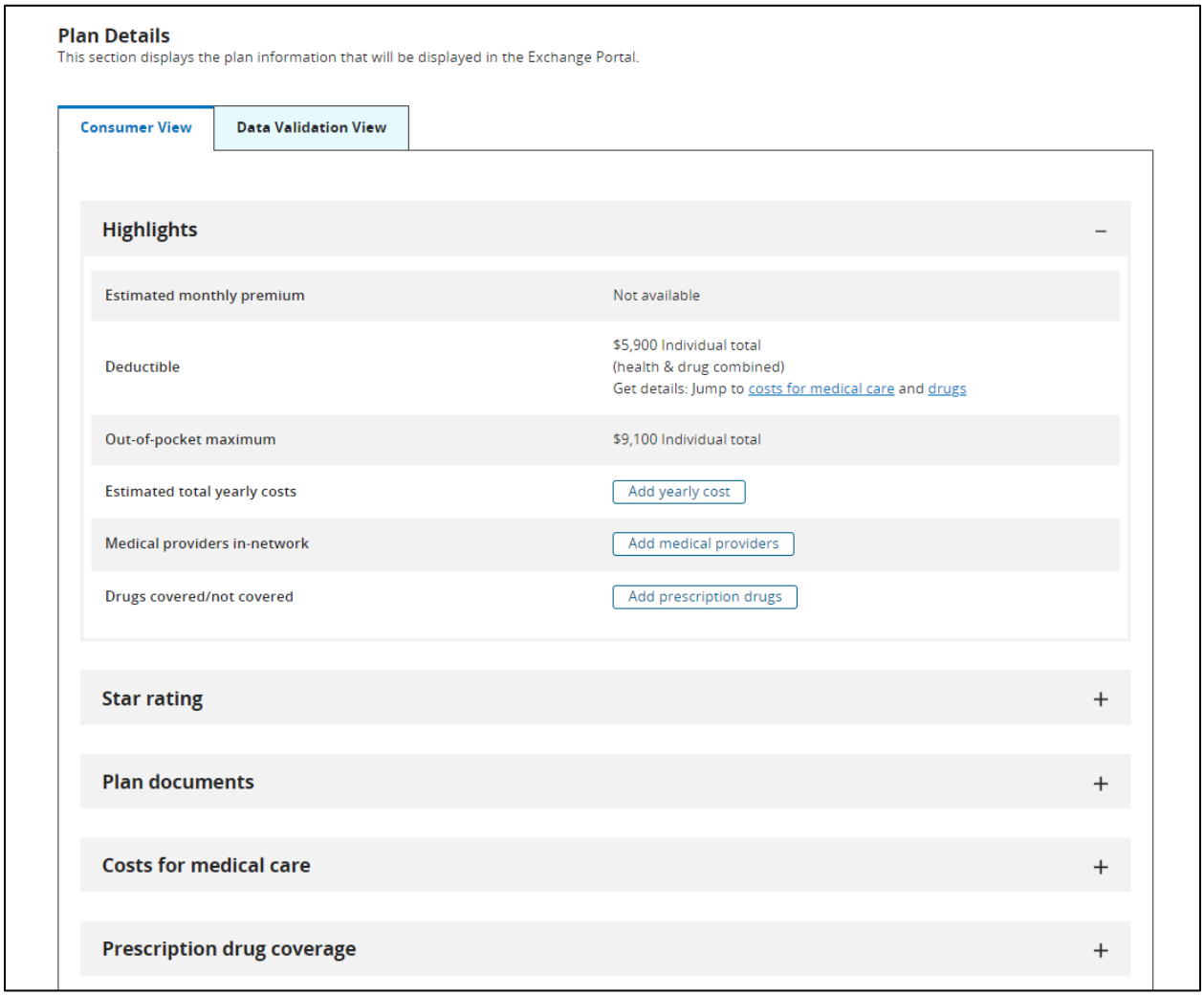
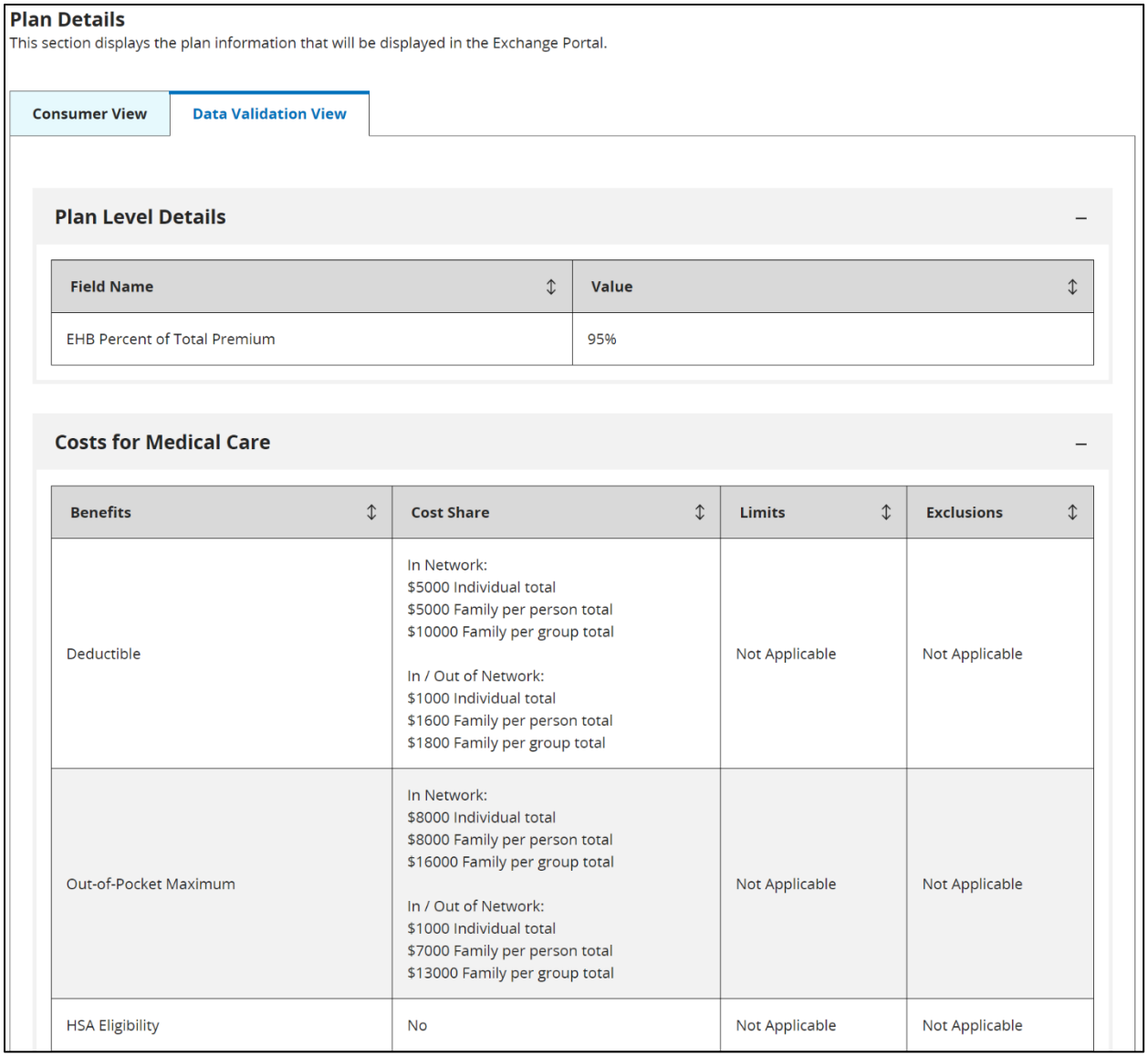


Figure 11-21. Plan Details Consumer View



Plan Details

This section displays the plan information that will be displayed in the Exchange Portal.

Consumer View | Data Validation View

Plan Level Details

Field Name	Value
EHB Percent of Total Premium	95%

Costs for Medical Care

Benefits	Cost Share	Limits	Exclusions
Deductible	In Network: $5000 Individual total $5000 Family per person total $10000 Family per group total In / Out of Network: $1000 Individual total $1600 Family per person total $1800 Family per group total	Not Applicable	Not Applicable
Out-of-Pocket Maximum	In Network: $8000 Individual total $8000 Family per person total $16000 Family per group total In / Out of Network: $1000 Individual total $7000 Family per person total $13000 Family per group total	Not Applicable	Not Applicable
HSA Eligibility	No	Not Applicable	Not Applicable

Figure 11-22. Plan Details Data Validation View

12 Closed QHP Application

When the Submission window is closed, a ‘Submission Window Closed’ banner will appear to alert the user. Issuers will not be able to edit their application when the Submission Window is Closed. *See Figure 12-1.*

Access to the Plan Validation Workspace, viewing the application, and updating the URL section will still be enabled when the window is closed.

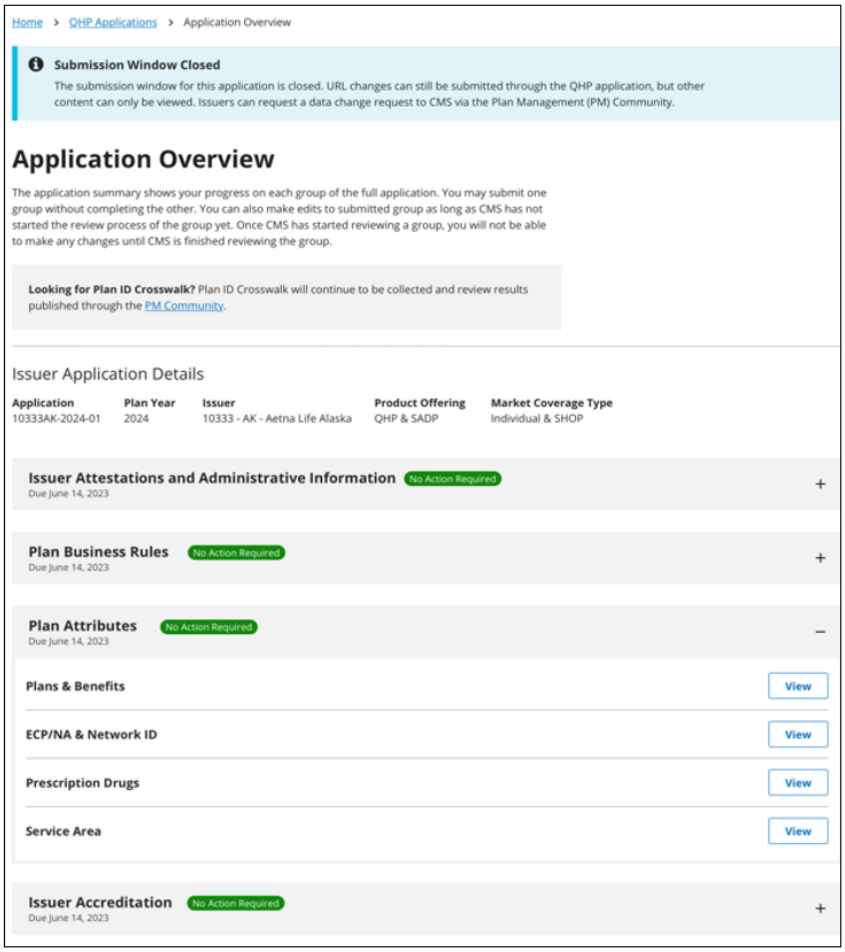


Figure 12-1. Submission Window Closed

13 Troubleshooting & Support

The following details error messaging to assist the user with troubleshooting and resolving issues, special considerations, and support contact information.

13.1 Error Messages

Table 13-1. Error Messages

Error Message	Trigger	Corrective Action
[Filename]: File uploaded is a not allowed file type.	When a user attempts to upload a file type that is not a DOCX, MSG, PDF, or PNG.	Re-upload a file that is one of the allowed file types listed in the instructional text. Upload only the following file types: DOCX, MSG, PDF or PNG.
[Filename]: File name contains special characters that are not allowed.	When a file is uploaded and includes an unallowable character in the file name.	Re-upload the file after removing restricted characters from the file name. Restricted characters include: • ‘ (Apostrophe) • / (Forward Slash) • ; (Semicolon) • # (Pound) • ((Open Parenthesis) •) (Closed Parenthesis) • : (Colon) • % (Percept) • = (Equal Sign) • < (Less Than • > (Greater Than • & (Ampersand) • \ (Backslash) • “ (Quotation Mark)
[Filename]: File selected is the same template type as another uploaded file. Upload only one file per template type for each validation request.	When a file is the same as a previously uploaded file.	Upload a file for a different template type or remove the file that was already uploaded for the same template type.
Unable to retrieve the Detailed Validation Results: Please try again in a few minutes. If the error persists, please contact the CMS Helpdesk.	When Detailed Validation Results are unable to be retrieved due to technical issues.	Refresh the page or log out and log back into the Submission System after a few minutes.

Error Message	Trigger	Corrective Action
Application already exists: A QHP Application for this plan year, Issuer, product offering, and market coverage type combination already exists. Resume the existing application or update one or more values to create a new application.	When an application with the specific plan year, Issuer, product offering, and market coverage type has already been created.	Edit the selected Issuer ID or the Plan Year value(s) or edit the application detail values for the existing application on the Application Overview page.
Unable to Complete Domain: Required data has not been submitted to complete this section of your QHP Application. Please provide all necessary documents and/or attestations.	When a Domain section has not been fully completed.	Submit all required data (files and/or attestations) for the domain page(s).
Technical issue encountered: Please try again in a few minutes. If the error persists, please contact the CMS Helpdesk.	When a general technical issue occurs.	Refresh the page or log out and log back into the Submission System after a few minutes.
NPI Invalid The NPI submitted is invalid. Correct the NPI or remove the record.	The NPI submitted does not follow the Luhn formula	Enter a valid NPI
Plan ID Crosswalk templates for the Small Group (SHOP) market are not accepted in MPMS. File was removed. • [FILENAME]	When a Plan ID Crosswalk template for the Small Group (SHOP) market is uploaded to the Plan Validation Workspace.	Submit only Plan ID Crosswalk templates for the Individual market.

13.2 Special Considerations

13.3 Support

The table below provides details to contact the Help Desk should users require further assistance.

Table 13-2. Support Points of Contact

Contact	Organization	Phone	Email	Role	Responsibility
Marketplace Service Desk (MSD)	CMS	1-855-CMS-1515 (1-855- 267-1515)	CMS_FEPS@cms.hhs.gov	Help Desk Support	Initial user support & problem reporting

Appendix A: Datepicker Operations

Users may operate a datepicker using their keyboard. Below are the available keyboard operations.

Table 13-3. Datepicker Keyboard Operation

Datepicker Status	Action
When a datepicker is hidden and focus is on the input field	• Arrow Down (↓) key: Displays the datepicker. • Enter key: Update the picker with the input field's value.
When a datepicker is displayed	• Enter key: Update the picker with the input field's value. • Esc key: Close the datepicker. • Arrow Left (←) or Arrow Right (→) key: Move focused date, month, year, or decade 1 step horizontally. • Arrow Up (↑) or Arrow Down (↓) key: Move focused date, month, year, or decade 1 step vertically. • Shift + Arrow Left (←) keys: Move to previous month, year, or decade. *(Shortcut of the "Prev" button).* • Shift + Arrow Right (→) keys: Move to next month, year, or decade. *(Shortcut of the "Next" button).* • Shift + Arrow Up (↑) keys: Change the view upward. *(Shortcut of the View switch).* • Enter key: When (Days View) is shown: Select the focused date. Otherwise, change the View switch downward for the focused decade, year, or month.

When the datepicker element is displayed, it captures any keypress events and uses them to control the datepicker element. Therefore, users cannot edit the text input field in this state. To resolve this issue, the datepicker enters the "Edit Mode". To enter "Edit Mode" a user may select any of the following keys:

- Backspace
- Delete
- Any alphanumeric character (without Ctrl)
- Any of the modifier keys:
    - Ctrl + Arrow keys (←/→/↑/↓)
    - Shift + Arrow down key (↓)
    - Except Shift + Arrow Left, Right, Up keys *(←/→/↑)*, as they are assigned to other shortcut keys.

To exit "Edit Mode" a user may select the following keys:

- Enter key is pressed.
- Ctrl + Arrow Down (↓) keys are pressed.

While datepicker is in edit mode, the outline of the text field element becomes more prominent to denote that it is in "Edit Mode". Additionally, keyboard operation become temporarily disable

Appendix B: Additional Plan Preview Details

This section provides additional details on Plan Preview display logic.

Plan Details Consumer View – Highlights

The screenshot below shows the fields displayed in the Highlights accordion of the Consumer View. *See Figure 13-1*. The Highlights section provides high level information about the Plan such as estimated premium and out-of-pocket maximum.

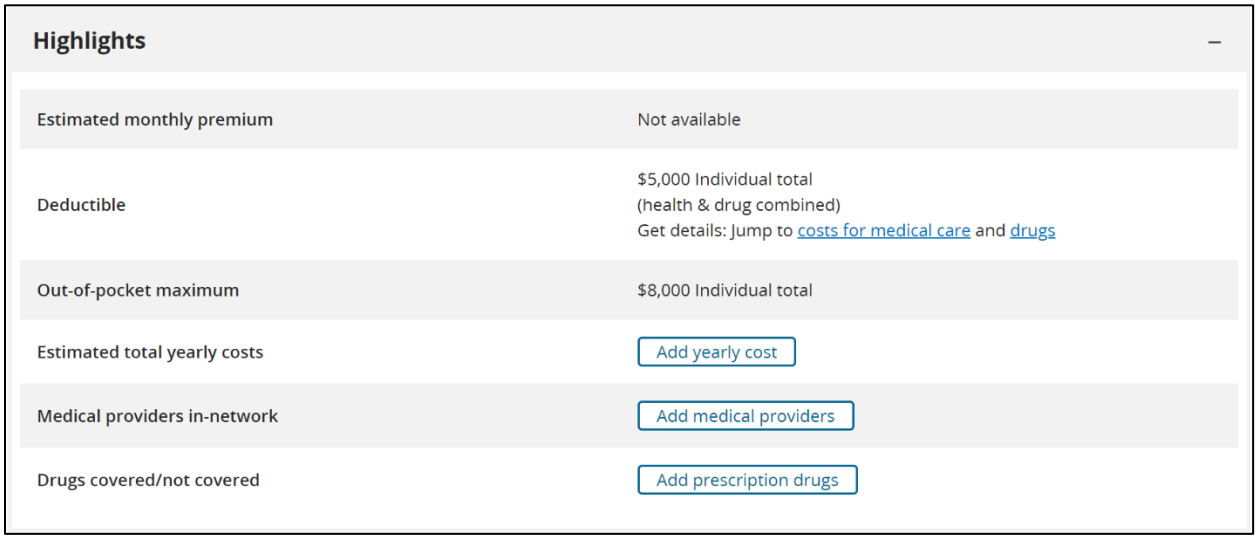


Figure 13-1. Plan Details Consumer View - Highlights Accordion

Table 13-4 describes the fields in the Highlights section of the Consumer View.

Table 13-4. Plan Details – Highlights Section Fields

Field Name	Description
Estimated monthly premium	Displays the monthly premium amount that the rating engine calculates based on the individuals in the enrollment group and the plan effective date. For Stand Alone Dental Plans, displays “Estimated Rate” along with the premium amount.
Deductible	The deductible field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a. If Individual In-Network value is $X, display “$X Individual Total”; else, if this value is “Not Applicable”, b. If Individual Combined In/Out-Network value is $X, display “$X Individual Total”. 2. If the enrollment group size is greater than one (at least one dependent) a. If both Family Per Group and Family Per Person are $X (including $0), then display both as “$X Family Total” and “$X individual Total” i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/OutNetwork value. b. If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display “$X Family Total” and do not display a per person value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out Network value. c. If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display “$X Individual Total” and do not display a per group value. i. Use In-Network value if it is $X ii. If In-network value is “Not Applicable”, use Combined In/Out-Network value. If medical and drug deductibles are integrated, then the combined medical and drug deductible displays in the Highlights section. “Included in plan’s deductible” displays in the prescription drug coverage details section. If medical and drug deductibles are not integrated, medical and drug deductibles display in the Highlights section. The drug deductible will also display in the prescription drug deductible coverage details section. In-Network Tier 2 and Out-of-Network deductibles do not display in Plan Preview or Plan Compare.

Field Name	Description
Out-of-pocket maximum	The Out-of-Pocket Maximum field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a. If Individual In-Network value is $X, display "$X Individual Total"; else, if this value is "Not Applicable", b. If Individual Combined In/Out-Network value is $X, display "$X Individual Total. 2. If the enrollment group size is greater than one (at least one dependent) a. If both Family Per Group and Family Per Person are $X (including $0), then display both as "$X Family Total" and "$X Individual Total" iii. Use In-Network value if it is $X iv. If In-network value is "Not Applicable", use Combined In/Out-Network value. b. If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display "$X Family Total" and do not display a per person value. iii. Use In-Network value if it is $X iv. If In-network value is "Not Applicable", use Combined In/Out-Network value. c. If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display "$X Individual Total" and do not display a per group value. iii. Use In-Network value if it is $X iv. If In-network value is "Not Applicable", use Combined In/Out-Network value. If medical and drug maximum out-of-pocket (MOOP) amounts are integrated, then the combined medical and drug maximum displays in the overview section. "Included in plan's out-of-pocket maximum" displays in the prescription drug coverage details section. If medical and drug maximums are not integrated, only the medical amount displays on this part of the page. The drug MOOP displays in the prescription drug coverage details section. In-Network Tier 2 and Out-of-Network MOOP values do not display in Plan Preview or Plan Compare.
Estimated total yearly costs	This field is included to mimic what will display in Plan Compare, however, the "Add yearly cost" button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display values for the costs.

Field Name	Description
Medical providers in-network	This field is included to mimic what will display in Plan Compare, however, the “Add medical providers” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display covered providers.
Drugs covered/not covered	This field is included to mimic what will display in Plan Compare, however, the “Add prescription drugs” button will be inactive in Plan Preview. Note: In Plan Preview this is a placeholder and will not display covered drugs.

Plan Details Consumer View – Star Rating

The screenshot below shows the fields displayed in the Star rating accordion of the Consumer View. *See Figure 13-2*.

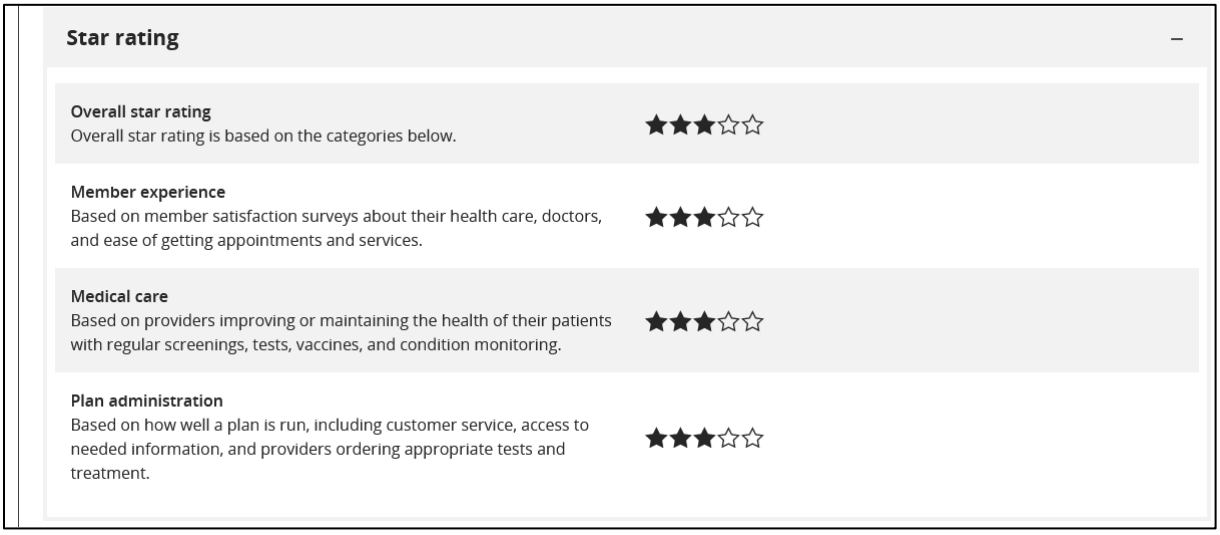


Figure 13-2. Plan Details Consumer View - Star Rating Accordion

Table 13-5 describes the fields in the Star rating section of the Plan Details section.

Table 13-5. Plan Details Page – Star Rating Fields

Field Name	Description
Overall star rating (Quality Measures)	Displays the overall quality rating as 1-5 stars for the selected plan. Note: If no quality data is available for the plan, the Rating will display 'Not rated.' If the plan is ineligible for scoring because it is a new plan, then 'New Plan – Not Rated' will display.
Other Rating (Other Quality Measures)	Displays the Member experience, Medical care, and Plan administration rating as 1-5 stars for the selected plan. Note: If no quality data is available for the plan, or if the plan is ineligible for scoring because it is a new plan, then 'Not rated' will display.

Plan Details Consumer View – Plan Documents

The screenshot below shows the fields displayed in the Plan documents accordion of the Consumer View. *See Figure 13-3*. NOTE: If there are no associated documents, the Plan Documents section displays 'No documents available.'

Figure 13-3. Plan Details Consumer View - Plan Documents Accordion

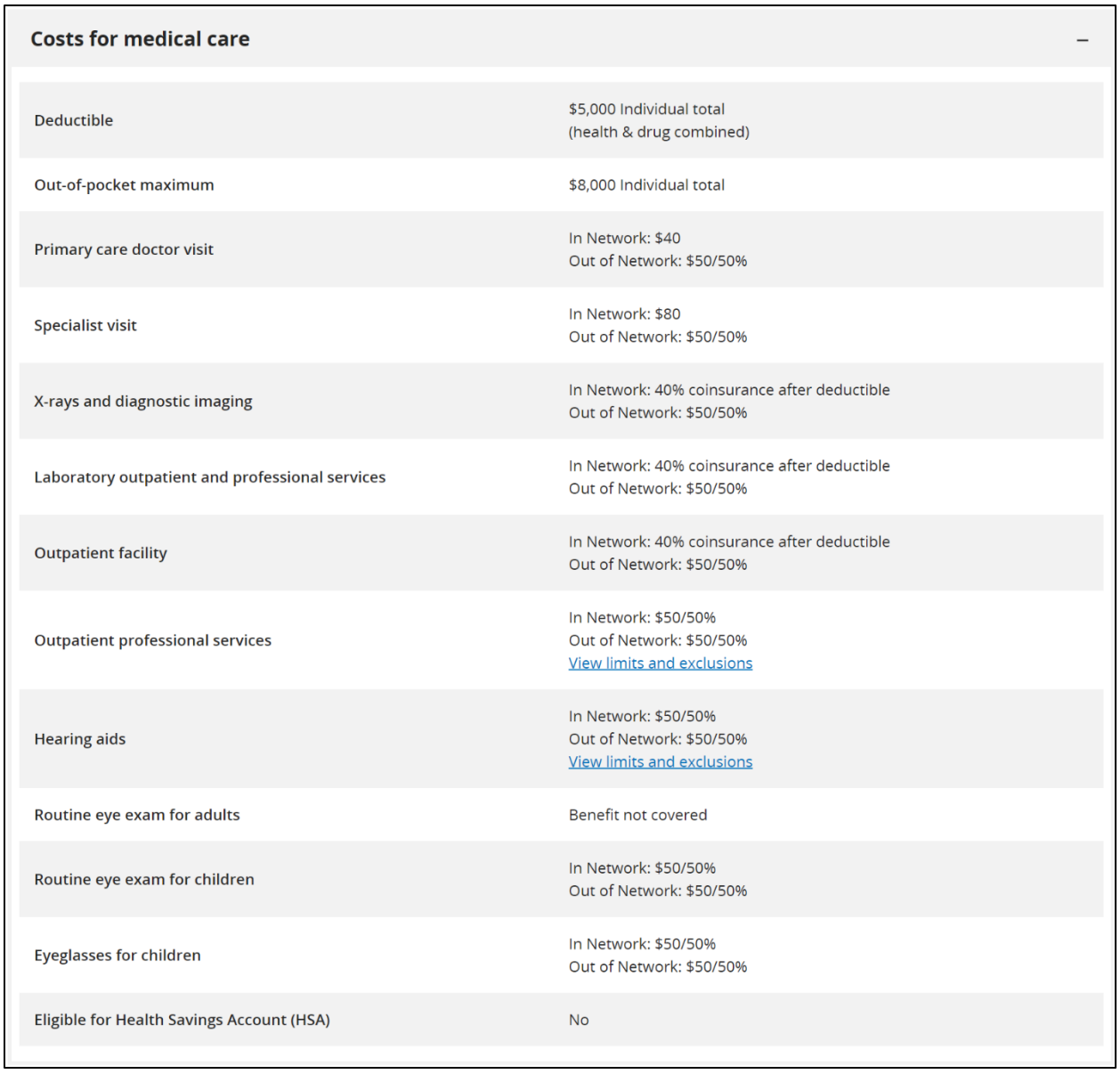
Table 13-6 describes the fields in the Plan Documents section of the Consumer View in Plan Details.

Table 13-6. Plan Details – Plan Documents Section Fields

Field Name	Description
List of covered drugs	Displays link the issuer submitted for the formulary URL associated with the plan. Note: If URL has been submitted, this document will not display.
Provider directory	Displays link to the provider directory
Plan brochure	Displays a link to the plan brochure
Summary of benefits	Displays link to the plan's costs, benefits, covered health care services, and other plan features

Plan Details Consumer View – Cost for Medical Care

The screenshot below shows the fields displayed in the Cost for medical care accordion of the Consumer View. *See Figure 13-4*.



Costs for medical care –

Deductible	$5,000 Individual total (health & drug combined)
Out-of-pocket maximum	$8,000 Individual total
Primary care doctor visit	In Network: $40 Out of Network: $50/50%
Specialist visit	In Network: $80 Out of Network: $50/50%
X-rays and diagnostic imaging	In Network: 40% coinsurance after deductible Out of Network: $50/50%
Laboratory outpatient and professional services	In Network: 40% coinsurance after deductible Out of Network: $50/50%
Outpatient facility	In Network: 40% coinsurance after deductible Out of Network: $50/50%
Outpatient professional services	In Network: $50/50% Out of Network: $50/50% View limits and exclusions
Hearing aids	In Network: $50/50% Out of Network: $50/50% View limits and exclusions
Routine eye exam for adults	Benefit not covered
Routine eye exam for children	In Network: $50/50% Out of Network: $50/50%
Eyeglasses for children	In Network: $50/50% Out of Network: $50/50%
Eligible for Health Savings Account (HSA)	No

Figure 13-4. Plan Details Consumer View - Costs for Medical Care Accordion

Table 13-7 describes the fields in the Cost for Medical Care section of the Plan Details section.

Table 13-7. Plan Details – Cost for Medical Care Section Fields

Field Name	Description
Deductible	For one-person enrollment groups (no dependents): • If the Individual In-Network value equals a dollar amount, then the Individual In-Network value displays (as '$X Individual Total'). • If the Individual In-Network value equals "Not Applicable" and the Individual Combined In/Out-Network value equals a dollar amount, then the Individual Combined In/Out-Network value displays (as '$X Individual Total'). For enrollment groups with more than one person (one or more dependents), displays both "Individual Total" and "Family Total" amount. Per Person Logic: • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as "$X Individual Total"). • If the Family In-Network Per Person value equals "Not Applicable," and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as "$X Individual Total"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal "Not Applicable," then "Not Applicable" displays. Per Group Logic: • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as "$X Family Total"). • If the Family In-Network Per Group value equals "Not Applicable" and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as "$X Family Total"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal "Not Applicable," then "Not Applicable" displays. In-Network Tier 2 deductibles display in Plan Preview or Plan Compare.

Field Name	Description
Out-of-pocket maximum	For one-person enrollment groups (no dependents): • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as "$X Individual Total"). • If the Individual In-Network maximum equals "Not Applicable" and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as "$X Individual Total"). For enrollment groups with more than one person (one or more dependents), displays both "Individual Total" and "Family Total" amount. Per Person Logic: • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as "$X Individual Total"). • If the Family In-Network Per Person maximum equals "Not Applicable", and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as "$X Individual Total"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal "Not Applicable", then "Not Applicable" displays. Per Group Logic: • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as "$X Family Total"). • If the Family In-Network Per Group maximum equals "Not Applicable" and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as "$X Family Total"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal "Not Applicable," then "Not Applicable" displays. In-Network Tier 2 and out-of-network maximums do not display in Plan Preview or Plan Compare.
Primary care doctor visit	Provides cost sharing information for the benefit "Primary Care Visit to Treat an Injury or Illness", found in the Plans and Benefits template.
Specialist visit	Provides cost sharing information for the benefit "Specialist Visit", found in the Plans and Benefits template.
X-rays and diagnostic imaging	Provides cost sharing information for the benefit "X-rays and Diagnostic Imaging", found in the Plans and Benefits template.
Laboratory outpatient and professional services	Provides cost sharing information for the benefit "Laboratory Outpatient and Professional Services", found in the Plans and Benefits template.

Field Name	Description
Outpatient facility	Provides cost sharing information for the benefit “Outpatient Facility Fee (e.g. Ambulatory Surgery Center)”, found in the Plans and Benefits template.
Outpatient professional services	Provides cost sharing information for the benefit “Outpatient Surgery Physician/Surgical Services”, found in the Plans and Benefits template.
Hearing aids	Provides cost sharing information for the benefit “Hearing Aids”, found in the Plans and Benefits template.
Routine eye exam for adults	Provides cost sharing information for the benefit “Routine Eye Exam (Adults)”, found in the Plans and Benefits template.
Routine eye exam for children	Provides cost sharing information for the benefit “Routine Eye Exam for Children”, found in the Plans and Benefits template.
Eyeglasses for children	Provides cost sharing information for the benefit “Eyeglasses for Children”, found in the Plans and Benefits template.
Eligible for Health Savings Account (HSA)	Indicates whether this plan is HSA-eligible, based on the “HSA Eligible” field in the Plans and Benefits template.

Plan Details Consumer View – Prescription Drug Coverage

The screenshot below shows the fields displayed in the Prescription drug coverage accordion of the Consumer View. *See Figure 13-5*.

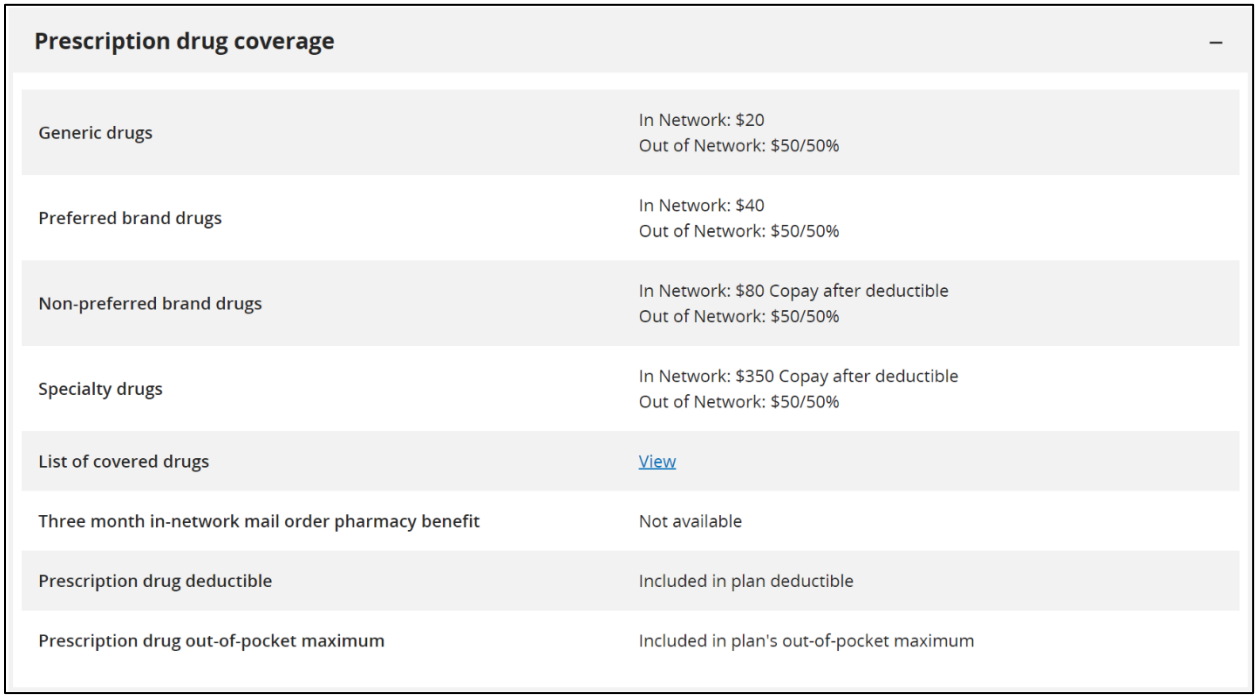


Figure 13-5. Plan Details Consumer View - Prescription Drug Coverage Accordion

Table 13-8 describes the fields in the Prescription Drug Coverage section.

Table 13-8. Plan Details – Prescription Drug Coverage Section Fields

Field Name	Description
Generic drugs	Provides cost sharing information for the benefit “Generic Drugs,” found in the Plans and Benefits template.
Preferred brand drugs	Provides cost sharing information for the benefit “Preferred Brand Drugs,” found in the Plans and Benefits template.
Non-preferred brand drugs	Provides cost sharing information for the benefit “Non-Preferred Brand Drugs,” found in the Plans and Benefits template.
Specialty drugs	Provides cost sharing information for the benefit “Specialty Drugs,” found in the Plans and Benefits template.
List of covered drugs	Provides a link to the plan’s list of covered drugs from the “Formulary URL” in MPMS.
Three month in-network mail order pharmacy benefit	Indicates whether this plan offers three month In-Network mail order pharmacy benefits. If either the “3 Month In Network Mail Order Pharmacy Benefit Offered?” or “3 Month Out of Network Mail Order Pharmacy Benefit Offered?” fields are listed as “Yes” in the Prescription Drug template, displays “Yes”; otherwise, displays “No.”

Field Name	Description
Prescription drug deductible	If medical and drug deductibles are integrated, displays “Included in plan deductible.” Otherwise, the logic below applies. If medical and drug deductibles are not integrated, display depends on the enrollment group size. If the enrollment group size is one (no dependents): • If the Individual In-Network prescription drug deductible equals a dollar amount, then the Individual In-Network deductible displays (as “$X Individual Total”). • If the Individual In-Network prescription drug deductible equals “Not Applicable” and the Individual Combined In/Out-Network prescription drug deductible equals a dollar amount, then the Individual Combined In/Out Network deductible displays (as “$X”). If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” amount. Per Person Logic: • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as “$X Individual Total”). • If the Family In-Network Per Person value equals “Not Applicable,” and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as “$X Individual Total”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal “Not Applicable,” then “Not Applicable” displays. Per Group Logic: • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as “$X Family Total”). • If the Family In-Network Per Group value equals “Not Applicable” and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as “$X Family Total”). If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal “Not Applicable,” then Family Per Person value will display.

Field Name	Description
Prescription drug out-of-pocket maximum	If medical and drug maximums are integrated, displays “Included in plan’s out-of-pocket maximum” Otherwise, the logic below applies. If medical and drug maximums are not integrated, display depends on the enrollment group size. If the enrollment group size is one (no dependents): • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as “$X Individual Total”). • If the Individual In-Network maximum equals “Not Applicable” and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as “$X Individual Total”). • If Individual In-Network and Combined In/Out-Network maximums both equal “Not Applicable,” “Not Applicable” displays. If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” maximum. Per Person Logic: • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as “$X Individual Total”). • If the Family In-Network Per Person maximum equals “Not Applicable,” and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as “$X Individual Total”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal “Not Applicable,” then “Not Applicable” displays. Per Group Logic: • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as “$X Family Total”). • If the Family In-Network Per Group maximum equals “Not Applicable” and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as “$X Family Total”). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal “Not Applicable,” then “Not Applicable” displays.

Plan Details Consumer View – Access to Doctors and Hospitals

The screenshot below shows the fields displayed in the Access to doctors and hospitals accordion of the Consumer View. *See Figure 13-6*.

Figure 13-6. Plan Details Consumer View - Access to Doctors and Hospitals Accordion

Table 13-9 describes the fields in the Access to Doctors and Hospitals section.

Table 13-9. Plan Details – Access to Doctors and Hospitals Section Fields

Field Name	Description
Provider directory	Provides a link to the plan's provider directory from the "Network URL" field in MPMS.
National provider network	Indicates whether this plan is a national provider network, based on the "National Network" field found in the Plans and Benefits template.
Need referral to see a specialist	Indicates whether this plan requires a referral to see a specialist, based on the "Is a Referral Required for Specialist?" field in the Plans and Benefits template.
Size of provider network, compared to other plans	Displays the network breadth values
Hospitals	Displays whether the plan's hospital network is "About the same as other plans in the area", "Smaller than other plans in the area", or "Larger than other plans in the area", as fit.
Primary care doctors	Displays whether the plan's primary care network is "About the same as other plans in the area", "Smaller than other plans in the area", or "Larger than other plans in the area", as fit.
Pediatricians	Displays whether the plan's pediatric network is "About the same as other plans in the area", "Smaller than other plans in the area", or "Larger than other plans in the area", as fit.

Plan Details Consumer View – Urgent Care and Hospital Services

The screenshot below shows the fields displayed in the Urgent care and hospital services accordion of the Consumer View. *See Figure 13-7.*

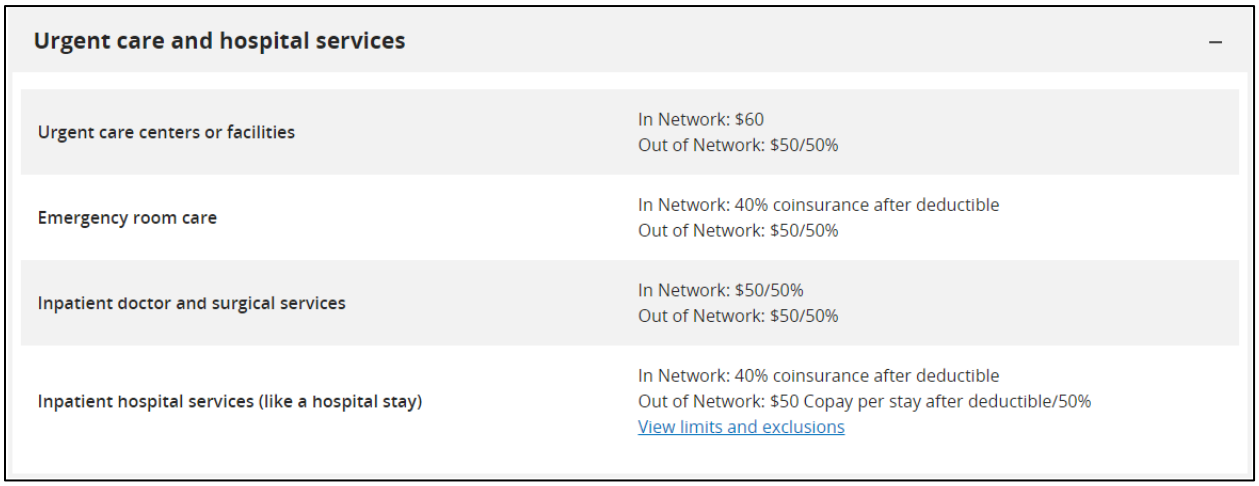


Figure 13-7. Plan Details Consumer View - Urgent Care and Hospital Services Accordion

Table 13-10 describes the fields in the Urgent Care and Hospital Services section.

Table 13-10. Plan Details – Urgent Care and Hospital Services Section Fields

Field Name	Description
Urgent care centers or facilities	Provides cost sharing information for the benefit “Urgent Care Centers or Facilities,” found in the Plans and Benefits template.
Emergency room care	Provides cost sharing information for the benefit “Emergency Room Services,” found in the Plans and Benefits template.
Inpatient doctor and surgical services	Provides cost sharing information for the benefit “Inpatient Physician and Surgical Services,” found in the Plans and Benefits template.
Inpatient hospital services (like a hospital stay)	Provides cost sharing information for the benefit “Inpatient Hospital Services (e.g., Hospital Stay)” found in the Plans and Benefits template

Plan Details Consumer View – Cost & Coverage Examples

The screenshot below shows the fields displayed in the Cost & coverage examples accordion of the Consumer View. *See Figure 13-8*.

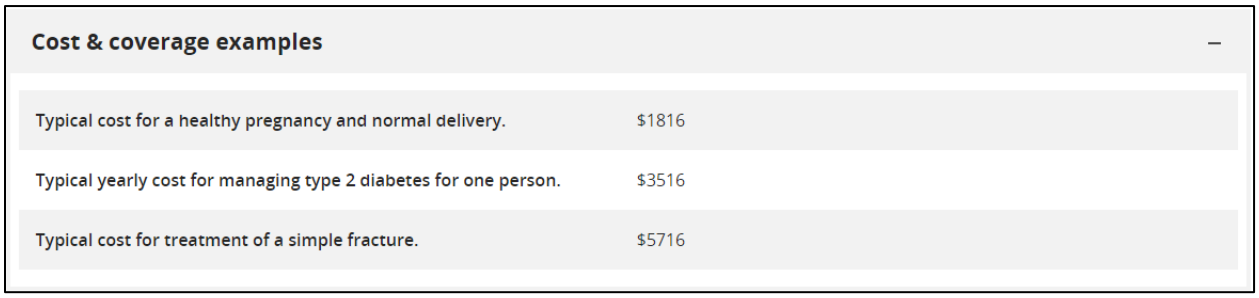


Figure 13-8. Plan Details Consumer View - Cost & Coverage Examples Accordion

Table 13-11 describes the fields in the Cost & Coverage Examples section.

Table 13-11. Plan Details – Cost & Coverage Examples Section Fields

Field Name	Description
Typical cost for a healthy pregnancy and normal delivery	Displays the sum of the following four values from the Plans and Benefits template: • Having a Baby – Deductible • Having a Baby – Copayment • Having a Baby – Coinsurance • Having a Baby – Limit
Typical yearly cost for managing type 2 diabetes for one person	Displays the sum of the following four values from the Plans and Benefits template: • Having Diabetes – Deductible • Having Diabetes – Copayment • Having Diabetes – Coinsurance • Having Diabetes – Limit
Typical cost for treatment of a simple fracture	Displays the sum of the following four values from the Plans and Benefits template: • Treatment of a Simple Fracture – Deductible • Treatment of a Simple Fracture – Copayment • Treatment of a Simple Fracture – Coinsurance • Treatment of a Simple Fracture – Limit

Plan Details Consumer View – Adult Dental Coverage

The screenshot below shows the fields displayed in the Adult dental coverage accordion of the Consumer View. *See Figure 13-9*.

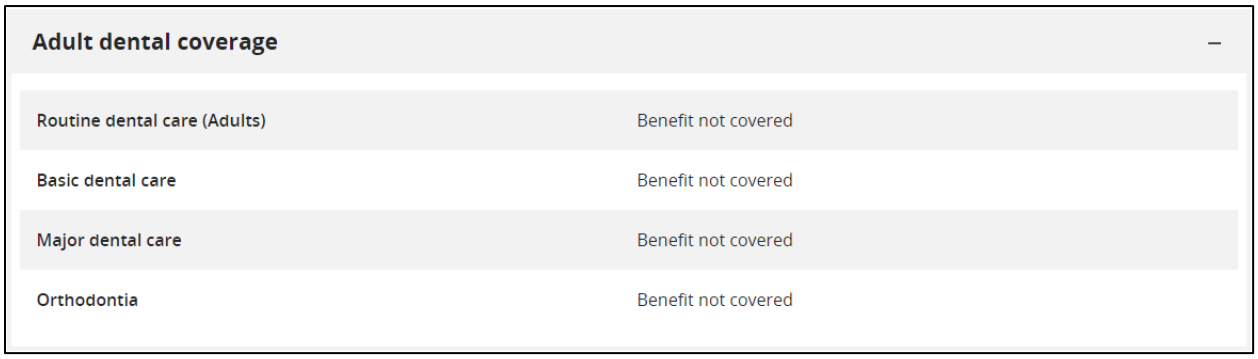


Figure 13-9. Plan Details Consumer View - Adult Dental Coverage Accordion

Table 13-12 describes the fields in the Adult Dental Coverage section of the Plan Details page.

Table 13-12. Plan Details – Adult Dental Coverage Section Fields

Field Name	Description
Routine dental care (adults)	Provides cost sharing information for the benefit “Routine Dental Services (Adult),” found in the Plans and Benefits template.
Basic dental care	Provides cost sharing information for the benefit “Basic Dental Care – Adult,” found in the Plans and Benefits template.
Major dental care	Provides cost sharing information for the benefit “Major Dental Care – Adult,” found in the Plans and Benefits template.
Orthodontia	Provides cost sharing information for the benefit “Orthodontia – Adult,” found in the Plans and Benefits template.

Plan Details Consumer View – Child Dental Coverage

The screenshot below shows the fields displayed in the Child dental coverage accordion of the Consumer View. *See Figure 13-10.*

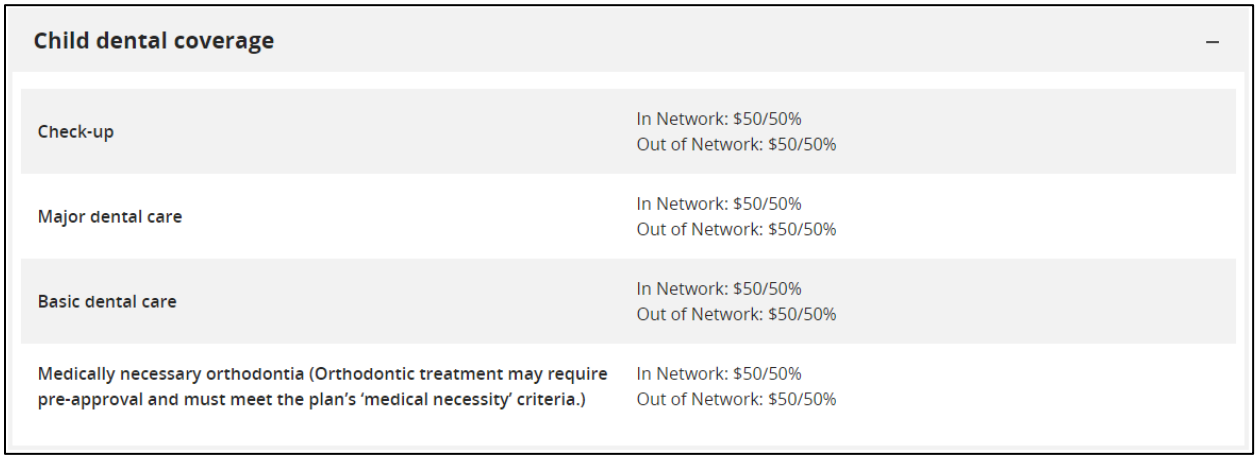


Figure 13-10. Plan Details Consumer View - Child Dental Coverage Accordion

Table 13-13 describes the fields in the Child Dental Coverage section of the Plan Detail page.

Table 13-13. Plan Details – Child Dental Coverage Section Fields

Field Name	Description
Check-up	Provides cost sharing information for the benefit "Dental Check-Up for Children," found in the Plans and Benefits template.
Major dental care	Provides cost sharing information for the benefit "Major Dental Care – Child," found in the Plans and Benefits template.
Basic dental care	Provides cost sharing information for the benefit "Basic Dental Care – Child," found in the Plans and Benefits template.
Medically necessary orthodontia (Orthodontic treatment may require pre-approval and must meet the plan's 'medical necessity' criteria)	Provides cost sharing information for the benefit "Orthodontia – Child," found in the Plans and Benefits template.

Plan Details Consumer View – Medical Management Programs

The screenshot below shows the fields displayed in the Medical management programs accordion of the Consumer View. *See Figure 13-11.*

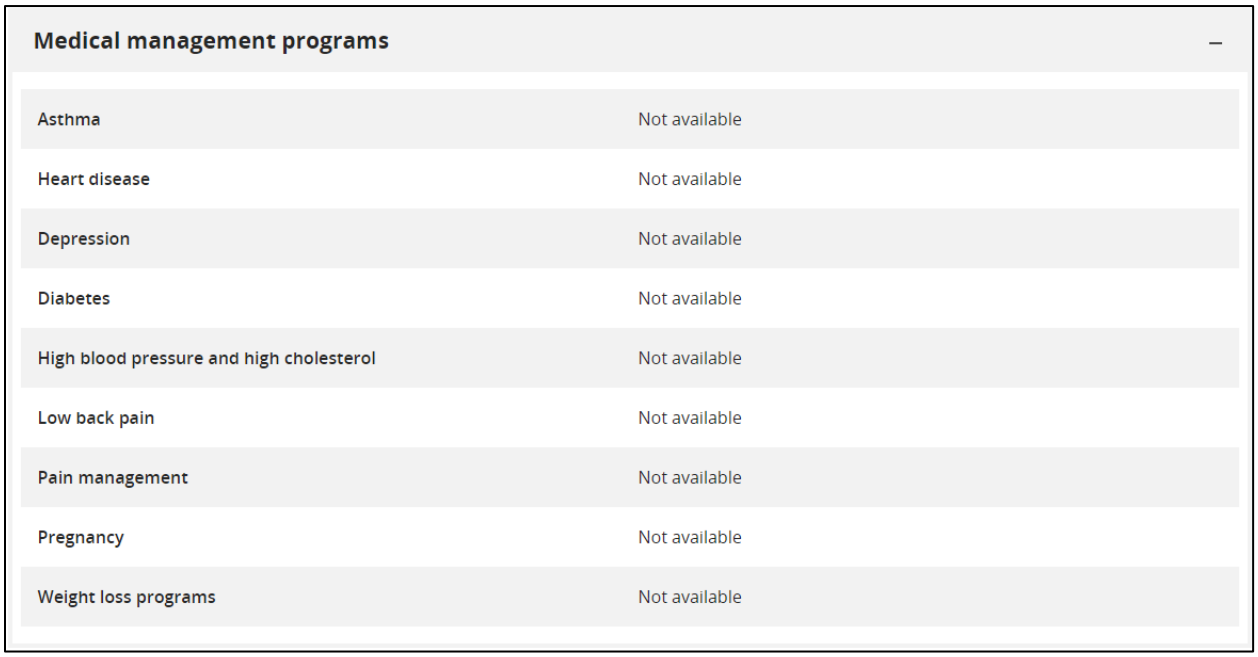


Figure 13-11. Plan Details Consumer View - Medical Management Programs Accordion

Table 13-14 describes the fields in the Medical Management Programs section of the Plan Details page.

Table 13-14. Plan Details – Medical Management Programs Section Fields

Field Name	Description
Asthma	Indicates whether or not this plan offers an asthma medical management program.
Heart disease	Indicates whether or not this plan offers a heart disease medical management program.
Depression	Indicates whether or not this plan offers a depression medical management program.
Diabetes	Indicates whether or not this plan offers a diabetes medical management program.
High blood pressure and high cholesterol	Indicates whether or not this plan offers a high blood pressure and high cholesterol medical management program.
Low back pain	Indicates whether or not this plan offers a low back pain medical management program.
Pain management	Indicates whether or not this plan offers a pain management medical management program.
Pregnancy	Indicates whether or not this plan offers a pregnancy medical management program.
Weight loss program	Indicates whether or not this plan offers a weight loss medical management program.

Plan Details Consumer View – Other Services

The screenshot below shows the fields displayed in the Other services accordion of the Consumer View. *See Figure 13-12*.

Other services –

Acupuncture	Benefit not covered
Chiropractic care	In Network: $25 Copay after deductible Out of Network: $25 Copay after deductible View limits and exclusions
Infertility treatment	Benefit not covered
Mental/Behavioral health outpatient services	In Network: $30 Out of Network: $25 Copay after deductible View limits and exclusions
Mental/Behavioral health inpatient services	In Network: 25% coinsurance after deductible Out of Network: $25 Copay after deductible View limits and exclusions
Habilitative services	In Network: $25 Copay after deductible Out of Network: $25 Copay after deductible View limits and exclusions
Bariatric services	Benefit not covered
Outpatient rehabilitation services	In Network: $25 Copay after deductible Out of Network: $25 Copay after deductible View limits and exclusions
Skilled nursing facility care	In Network: 25% coinsurance after deductible Out of Network: $25 Copay per stay after deductible View limits and exclusions
Private-duty nursing	Benefit not covered
Outpatient facility fee (e.g., Ambulatory surgery center)	In Network: 25% coinsurance after deductible Out of Network: $25 Copay after deductible
Outpatient surgery physician/surgical services	In Network: 25% coinsurance after deductible Out of Network: $25 Copay after deductible

Figure 13-12. Plan Details Consumer View - Other Services Accordion

Table 13-15 describes the fields in the Other Benefits section of the Plan Details page.

Table 13-15. Plan Details – Other Services Section Fields

Field Name	Description
Acupuncture	Provides cost sharing information for the benefit "Acupuncture," found in the Plans and Benefits template.
Chiropractic care	Provides cost sharing information for the benefit "Chiropractic Care," found in the Plans and Benefits template.
Infertility treatment	Provides cost sharing information for the benefit "Infertility Treatment," found in the Plans and Benefits template.
Mental/behavioral health outpatient services	Provides cost sharing information for the benefit "Mental/Behavioral Health Outpatient Services," found in the Plans and Benefits template.
Mental/behavioral health inpatient services	Provides cost sharing information for the benefit "Mental/Behavioral Health Inpatient Services," found in the Plans and Benefits template.
Habilitative services	Provides cost sharing information for the benefit "Habilitative Services," found in the Plans and Benefits template.
Bariatric services	Provides cost sharing information for the benefit "Bariatric Surgery," found in the Plans and Benefits template.
Outpatient rehabilitation services	Provides cost sharing information for the benefit "Outpatient rehabilitation services," found in the Plans and Benefits template.
Skilled Nursing Facility care	Provides cost sharing information for the benefit "Skilled Nursing Facility," found in the Plans and Benefits template.
Private-duty nursing	Provides cost sharing information for the benefit "Private-Duty Nursing," found in the Plans and Benefits template.
Outpatient facility fee (e.g., Ambulatory surgery center)	Provides cost sharing information for the benefit "Outpatient Facility Fee (e.g., Ambulatory Surgery Center)," found in the Plans and Benefits template.
Outpatient surgery physician/surgical services	Provides cost sharing information for the benefit "Outpatient Surgery Physician/Surgical Services," found in the Plans and Benefits template.

Plan Details Data Validation View – Plan Level Details

The screenshot below shows the fields displayed in the Plan Level Details accordion of the Data Validation View. *See Figure 13-13*.

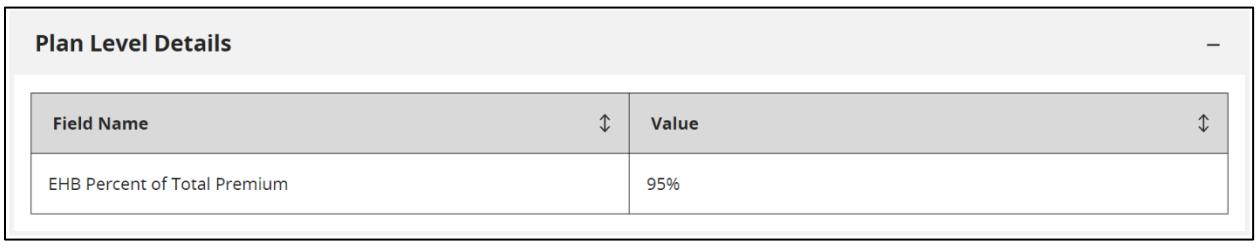


Figure 13-13. Plan Details Data Validation View - Plan Level Details Accordion

The Plan Details table below, Table 13-16, displays some of the values submitted by the issuer in their Plans and Benefits template.

Table 13-16. Plan Details – Plan Level Details Section Fields

Field Name	Description
EHB Percent of Total Premium	Displays the EHB Percent of Total Premium submitted by the issuer in the Plans and Benefits template (Note: Only displays for QHPs)
EHB Apportionment for Pediatric Dental	Displays the EHB Apportionment for Pediatric Dental submitted by the issuer in the Plans and Benefits template (Note: Only displays for SADPs)

Plan Details Data Validation View – Other Sections

The remaining 5 sections on the Data Validation View use the same table structure, and display the Cost Share, Limits, and Exclusions for each value. Table 13-17 below describes the typical table structure.

Table 13-17. Plan Details – Data Validation View Fields

Field Name	Description
Benefits	Displays the benefits or field name from the issuers template
Cost Share	Displays the value submitted by the issuer in their templates for the field listed in the Benefits column
Limits	Displays any Limits submitted in the issuer's templates for the benefit
Exclusions	Displays any exclusions submitted in the issuer's templates for the benefit

Appendix C: Acronyms and Abbreviations

Table 13-18. Acronyms and Abbreviations

Acronym / Abbreviation	Definition
AV	Actuarial Value
AWT	Appointment Wait Time
CMS	Centers for Medicare and Medicaid Service
CSV	Comma-separated Values
ECP	Essential Community Providers
EHB	Essential Health Benefit
FFE	Federally-Facilitated Exchange
HHS	Health and Human Services
HIOS	Health Insurance Oversight System
ID	Identifier
MPMS	Marketplace Plan Management System
MR	Machine Readable
NA	Network Adequacy
NPI	National Provider Identifier
NSPOLE	Non-Standardized Plan Option Limit Exceptions
QHPs	Qualified Health Plans
PPF	Provider Population File
PY	Plan Year
SADPs	Stand-Alone Dental Plans
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SHOP	Small Business Health Options Program
SPE	State Partnership Exchange
SERFF	System for Electronic Rate and Form Filing
URL	Uniform Resource Locators
XML	Extensible Markup Language

Appendix D: Glossary

Table 13-19. Glossary

Term	Definition
N/A	N/A

Appendix E: Referenced Documents

Table 13-20. Referenced Documents

Document Name	Document Number and/or URL	Issuance Date
CMS Machine Readable Tools	Coverage Portal (cms.gov)	N/A
Enterprise Portal User Guide	CMS Enterprise Portal – User Guide	N/A
HIOS User Manual	HIOS Portal User Manual (cms.gov)	12/2019
Identity Management User Guide	User Manual Template (cms.gov)	06/17/2022

Appendix F: Record of Changes

Table 13-21. Record of Changes

Version Number	Date	Author/Owner	Description of Change
1.1	03/31/2023	Accenture	Addressed CMS Feedback
2.0	05/19/2023	Accenture	Updated for alignment with Release 4.0
2.1	05/25/2023	Accenture	Addressed CMS Feedback
2.2	06/06/2023	Accenture	Addressed CMS Feedback
2.3	06/09/2023	Accenture	Addressed CMS Feedback
3.0	07/26/2023	Accenture	Updated sections 8.12.3.1, 11.1, 11.3, 12.9, 13, and 14 for alignment with Release 5.0
3.1	09/05/2023	Accenture	Addressed CMS Feedback to section 1 and 6.2
4.0	10/05/2023	Accenture	Updated figures 2-1, 4-1, 5-1, 12-1, table 12-3, and section 13 for Release 6.0
5.0	03/26/2024	Accenture	Updated sections 1, 2.1, 2.2, 3.4, 6.2, 6.3, 8.2, 8.5, 8.6, 8.6.3, 8.9, 8.10, 8.11, 8.12, 11, 11.1, 11.1.1 and 11.1.2 for Release 8.0
5.1	04/08/2024	Accenture	Addressed CMS Feedback with removal of PY24 content and updates to figures, including sections 8.5.3, 8.9, 8.11.1, 8.11.2, 13.1.
5.2	05/15/2024	Accenture	Updated sections 11.3.1 – 11.3.4 for Maintenance Release 8.3
6.0	05/28/2024	Accenture	Updated sections 11.3.1, 11.3.3, 11.3.8, 11.3.9, and Appendix B (Additional Plan Preview Details) in alignment with Release 9.0 and feedback for updates to Maintenance Release 8.3
6.1	06/06/2024	Accenture	Updated Table 11-9 and 13-4 to address CMS Feedback
7.0	08/26/2024	Accenture	Updated sections 4.1 and 10 for Release 10.0
7.1	09/05/2024	Accenture	Updated sections 4.1 and 10 to address CMS Feedback