Centers for Medicare & Medicaid Services
Federally Facilitated Exchange
Contract HHSM-500-2015-00246C

FFE Plan Management Benefits and Service Area Module User Guide

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1 Introduction

This document provides an overview and step-by-step guide for using the *Benefits & Service Area module.*

The Plan Management (PM) *Benefits & Service Area Module* is a web application built in the Health Insurance Oversight System (HIOS) where Issuers can submit benefit, cost sharing, service area, network, prescription drug, and transparency in coverage data associated with their Qualified Health Plan (QHP) Application.

1.1 Referenced Documents

The Center for Consumer Information and Insurance Oversight (CCIIO) has provided additional information detailing specific policy and submission criteria for each of the templates within the Benefits & Service Area Module. Please use the following link for more information: https://www.qhpcertification.cms.gov.

2 Overview

The *Benefits and Service Area Module* consists of business processes for acquiring plan-related data including benefits, cost sharing, service areas, provider networks, prescription drugs, and transparency in coverage data from Issuers that offer plans within the Exchange. Specifically, the module provides:

- Data submission templates (Microsoft Excel-based) allowing issuers or their representatives to download, populate, validate, and upload data into the Plan Management (PM) system.
- A user interface (UI) for Issuers to submit, review, modify, and validate information uploaded via the data collection templates or supporting documentation to support the benefits collection process for the FFE.

2.1 Document Conventions

Modules or systems are indicated by *italics*. User roles or data collection templates of the *Benefits & Service Area Module* are indicated in **bold**. Fields or buttons to be acted upon are indicated in ***bold italics***; links to be acted upon are indicated as links in underlined blue text.

Where fields are grayed out, they are considered read-only, and the default values cannot be changed.

NOTE: The term ‘user’ is used throughout this document to refer to a person who has acquired access to the *Benefits & Service Area Module*.

3 Getting Started

This section provides guidance on setup and system access.

3.1 Setup Considerations

To optimize user experience within the *Benefits & Service Area Module*:

1. Please ***disable pop-up blockers*** prior to attempting access to the PM system.
2. Use one of the following browsers for optimum usability:
   - Internet Explorer 11 (latest version available for supported operating systems as of 2/20/2020)
   - Firefox 73.0.1
3. Recommended Excel Versions include Excel 2013, Excel 2016, and Excel 2019.

NOTE: The Module complies with Health and Human Services (HHS) design standards; all associated webpages are designed for viewing at a minimum screen resolution of 1024 x 768.

3.2 Accessing the System

Users can access the module by logging into the CMS Enterprise Portal. The user will be directed to their "My Portal" page and should then select the ***HIOS*** application. Once in the HIOS portal, choose the ***QHP Benefits and Service Area Module*** and select ***Launch this Module***. Then, select the Access QHP Benefits and Service Area Module link on the ***QHP Benefits and Service Area Module*** landing page.

3.3 User Access Considerations

All users must have a Centers for Medicare and Medicaid Services (CMS) Enterprise Portal Identifier (ID) and HIOS user role to access the system. To access the *Benefits & Service Area Module*, users are required to have a **Submitter** and/or **Validator** role:

- **Benefits Submitter**:

  Users assigned the user access role of **Benefits Submitter** will submit the data and information necessary to complete the Benefits Module. They also can cross validate data elements to ensure consistency throughout the application.

- **Benefits Validator**:

  Users assigned the user access role of **Benefits Validator** will be responsible for validating the correctness of the data and information necessary to complete the Benefits Module. They will have the ability to validate that data elements are consistent throughout an application and ***Submit*** the application after cross-validation has passed. Validators are also responsible for triggering the resubmission process, if necessary.

3.4 System Organization and Navigation

The *Benefits & Service Area Module* consists of the Summary, Data Submitter, Data Validator, and Final Submission pages.

The Summary page is the first page a user sees when navigating to the *Benefits & Service Area Module*. It provides the user with the ability to start a new application, resume working on a pending application, or view a submitted application for Issuer IDs they have access to.

The Data Submitter page allows users to upload completed **Plans and Benefits**, **Network ID**, **Service Area**, **Prescription Drug**, and **Transparency in Coverage** template XMLs to the system for validation, as well as additional supporting documents required when submitting a QHP Application.

The Data Validator page allows users to download and view the submitted data collection templates and supporting documents in order to verify the submitted data is accurate.

The Final Submission page allows users to cross validate data elements within a QHP Application as well as submit a completed application for further evaluation.

3.5 Exiting the System

To exit the system, select the ***Logout*** link located at the bottom right corner of the page header.

4 Using the System

The following sections provide instructions about using the *Benefits & Service Area Module*.

4.1 Benefits Submitter–Summary Page

The Submitter Summary page, shown in Figure 1, is the first page displayed after a user with the **Benefits Submitter** role successfully logs into the *Benefits & Service Area Module*. From the Summary page, the user can start a new submission, continue working on an existing submission, or view a completed submission.

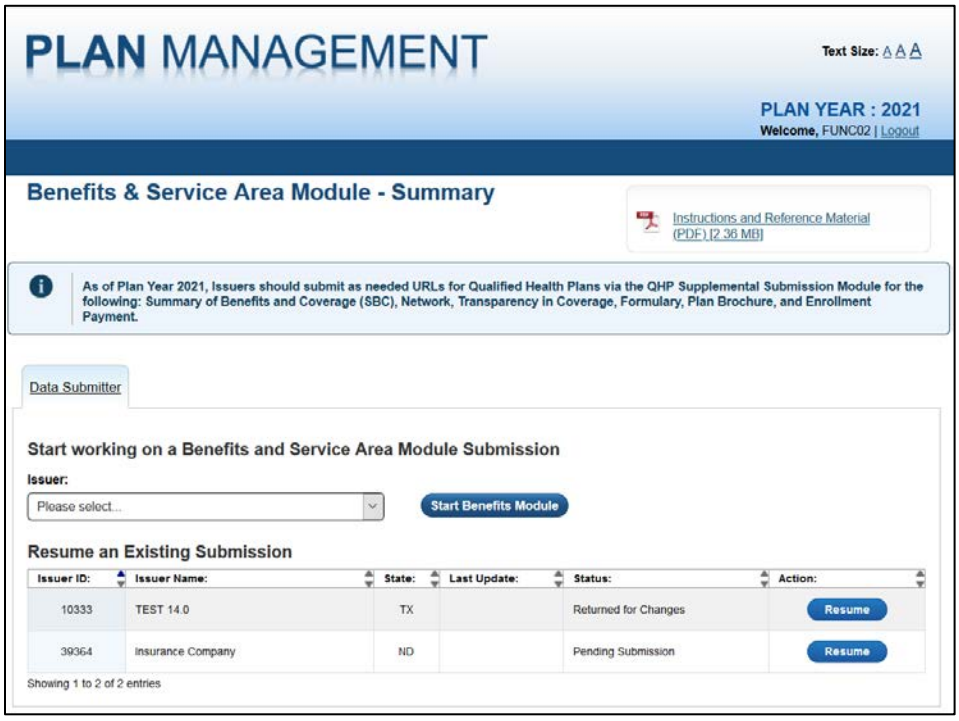


Figure 1: Benefits Submitter–Summary Page

To start a new application, select an Issuer from the Issuer drop-down list and select the ***Start Benefits Module*** button. The Benefits Submitter–Benefits & Service Area page is displayed.

To resume an existing submission, select the ***Resume*** button that corresponds with an issuer in the Resume an Existing Submission table. The user can also select ***View*** and proceed to the read-only access of the Benefits & Service Area page for completed submissions (see Figure 1).

NOTE: All columns are sortable by ascending or descending order, using the up and down carets.

Table 1 describes the fields in the Benefits Submitter Summary page and provides instructions about how to enter data in these fields.

Table 1: Benefits Submitter–Summary Page Fields

Name	User Action	Description
Issuer Drop-down	Select from drop-down list	Each drop-down entry contains the Issuer ID, Issuer Name, and State of Issuer. Drop-down is pre-populated with HIOS Issuer IDs associated with the user.
Start Benefits Module	Select button	Navigates to the Benefits & Service Area page for the selected Issuer. On selection, submission will be added to the Resume Existing Submission table with a status of "Pending Submission."
Resume	Select button	Navigates to the Benefits & Service Area page for the selected, existing submission. ***Resume*** button should appear only when submissions have a status of "Pending Submission."
View	Select button	Navigates to Benefits & Service Area page for the selected submission with read-only access. ***View*** button should appear only when submissions have statuses of "Submission Completed," "Pending Validation," or "Validation Completed."
Resume Existing Submission Table	N/A	Statuses with appropriate actions: Pending Submission–Resume Submission Completed–View Pending Validation–View Validation Completed–View Returned for Changes–Resume Cross Validation Completed–View

4.2 Benefits Submitter–Benefits & Service Area Page

The Benefits Submitter–Benefits & Service Area page (see Figure 2) allows the user to download templates, upload completed template .xml files, upload supplementary documentation, and view the validation statuses and/or error messages for submission. The templates that are available on this page are **Plans & Benefits**, **Network ID**, **Service Area**, **Prescription Drugs**, and **Transparency in Coverage**. The user must also download the **Plans & Benefits Template Add-In** File, which contains all the macros for the Plans & Benefits Template. The Actuarial Value (AV) Calculator is an additional required file, found on the CCIIO website, which is used to calculate and import an Actuarial Value for each medical plan in the Plans & Benefits Template.

NOTE: It is recommended to save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template. To ensure proper functionality, please download the latest Plans & Benefits Add-In File and AV Calculator and save to a new folder. Do **not** rename the Add-In File. See Appendix B for enabling the Add-In File and Appendix C for guidance on working with dual template versions.

The *Upload Documentation table* is where the user will upload the completed template-generated .xml files and supplementary documents. The documents required for submission are

marked with a red asterisk (*). Uploading multiple instances of the same supplementary documentation is possible. If uploading a second version of a **template .xml file**, the newest upload will replace the previously uploaded version; however, new versions of **supporting documentation** will not replace old versions.

When a Benefits Submitter uploads the **Plans & Benefits**, **Network ID**, **Service Area**, **Prescription Drug**, and **Transparency in Coverage** templates, the system validates that the data and information in the templates is accurate. No system validation is run on the supplementary documents.

Valid supporting documents must be in one of the following file formats:

- .doc
- .docx
- .jpg
- .jpeg
- .ppt
- .pptx
- .pdf
- .rtf
- .csv
- .txt

NOTE: Excel-template file names and supporting document file names cannot contain spaces. For example, “service_area” is a valid template file name, but “service area” is not a valid template file name.

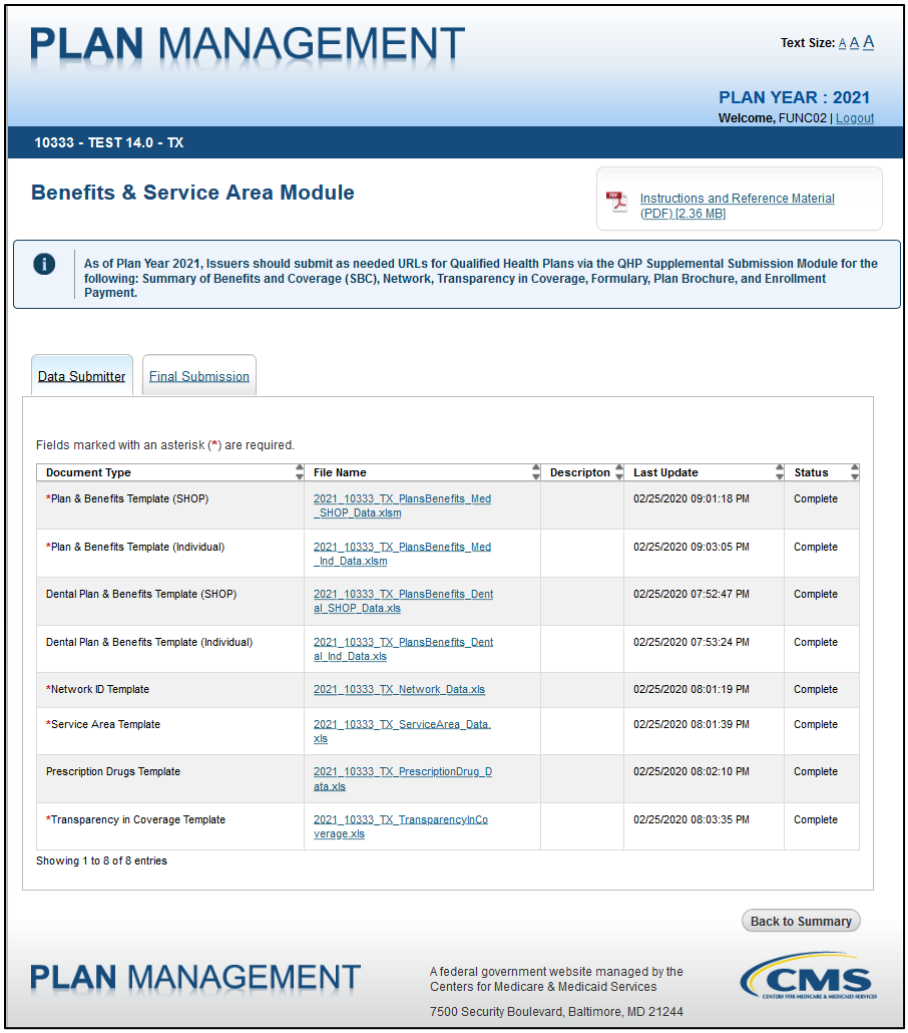


Figure 2: Benefits Submitter–Benefits & Service Area Page

Table 2 describes the fields in the Benefits Submitter Benefits & Service Area page and provides instructions about how to enter data in these fields.

Table 2: Submitter Benefits & Service Area Page Fields

Name	User Action	Description
Upload Documentation table	N/A	Table lists the following Document Type values: Plan & Benefits Template (SHOP) Plan & Benefits Template (Individual) Dental Plan & Benefits Template (SHOP) Dental Plan & Benefits Template (Individual) Network ID Template Service Area Template Prescription Drugs Template Transparency in Coverage Template Select a document type [drop-down]

Name	User Action	Description
Delete	Select button	After a supporting document is uploaded, allows deletion of the supporting document.
Upload	Select button	A file upload pop-up will appear.
Description	Enter a description	Please put information in description fields describing the type of supporting document and the HIOS Product and Plan IDs associated with it. Description fields are locked for a row until the user uploads a file into that row.
Add Another Document	Select link	Populates a new/blank row to the bottom of the Upload Documentation table. The user can add additional blank rows as necessary to upload all supplementary documents.

The table drop down within the Upload Documentation section is used to upload supporting documents. Supporting document types are listed and described in Table 3.

Table 3: Upload Documentation Drop Down Descriptions

Name	Description
Actuarial Memorandum	A signed and dated memorandum that the calculation was performed by a qualified actuary and complies with all applicable federal and state laws and all applicable Actuarial Standards of Practice. An Actuarial Memorandum should be submitted for each unique plan design
AV Calculator Screenshot	Screenshot generated from the AV Calculator
Unique Plan Design Justification	Document providing justification for a plan or group of plans that are indicated as Unique Plan Design in the Plans and Benefits template
SADP - Description of EHB Allocation	Document providing a description of the practice and methods used to determine Essential Health Benefit (EHB) allocation as entered in the Plans and Benefits template NOTE: All issuers offering **SADPs are required** to submit this document for QHP Certification.
SADP - AV Justification	Document providing justification for an actuarial value that falls outside the de minimis range. Document providing certified level of coverage of pediatric EHB. NOTE: All issuers offering **SADPs are required** to submit this document for QHP Certification
EHB - Substituted Benefit Justification	Document providing justification for a benefit substituted for an EHB
Service Area Justification	Document providing justification for why service area coverage must include one or more partial counties
Discrim - Cost Sharing Outlier Justification	Document providing justification for cost sharing data elements that were identified as outliers
Discrim - Language Justification	Document providing justification for data elements flagged for discriminatory language
Discrim - Prescription Drug Justification	Document providing justification for design deficiencies noted during review of Prescription Drug data

Name	Description
Discrim - Treatment Protocol Justification	Document providing justification for benefit designs identified as discriminatory in the Treatment Protocol Calculator review
Simple Choice Plan Documentation	Supporting documentation related to Simple Choice Plans. NOTE: Issuers are **not expected** to submit this supporting document
Other	Any other supporting document that is not listed

4.3 Benefits Submitter–Document Submission

After downloading and completing the templates, upload the supplementary documents and .xml files created by the templates by selecting the corresponding ***Upload*** button in the Upload Documentation table. The system will prompt the user with a file dialog box to browse the local computer to select the file.

NOTE: The user must submit a separate Plans & Benefits Template for each market and plan type:

- Health Small Group Health Options (SHOP)
- Health Individual
- Dental SHOP
- Dental Individual

Each template should include all plans within that category. Only one Plans & Benefits Template is required to be in **"Completed"** status to be eligible for submission, but it is possible to submit all four.

Templates will default to a status of "**Pending**" upon upload and will remain in a Pending status until system validation has been completed. To check the status of system validation, select the ***Update Status*** button (pictured in Figure 2) or refresh the page. (Note the changes in status from *Pending* to *Complete* between Figure 3 and Figure 4.) Closing the window will not interrupt the system validation process.

Once the system validates a template, the template's status will change to either "**Complete**" or "**Failed**." A template is "**Complete"** if it passes all system validations and "**Failed**" if there are errors identified during the system validation process. The "**Failed**" status indicator will appear as a link that, when selected, provides an error report for download. The user must download the report, fix all errors listed in the report, and re-upload the corrected template .xml. The user cannot submit the module successfully if any of the template statuses are "**Failed**" or "**Pending**." Because system validation is not run on supporting documents, they will default to a status of "**Complete**" upon upload. Once the status of a supplementary document is **"Complete,"** the user may delete the file by selecting the corresponding ***Delete*** button; the deleted document will no longer display in the Upload Documentation table.

Once all required documents have a "**Complete**" status, the user can complete the Benefits & Service Area section of the QHP Application by selecting ***Submit***.

Figure 3 shows the Upload Documentation table after documents have been uploaded.

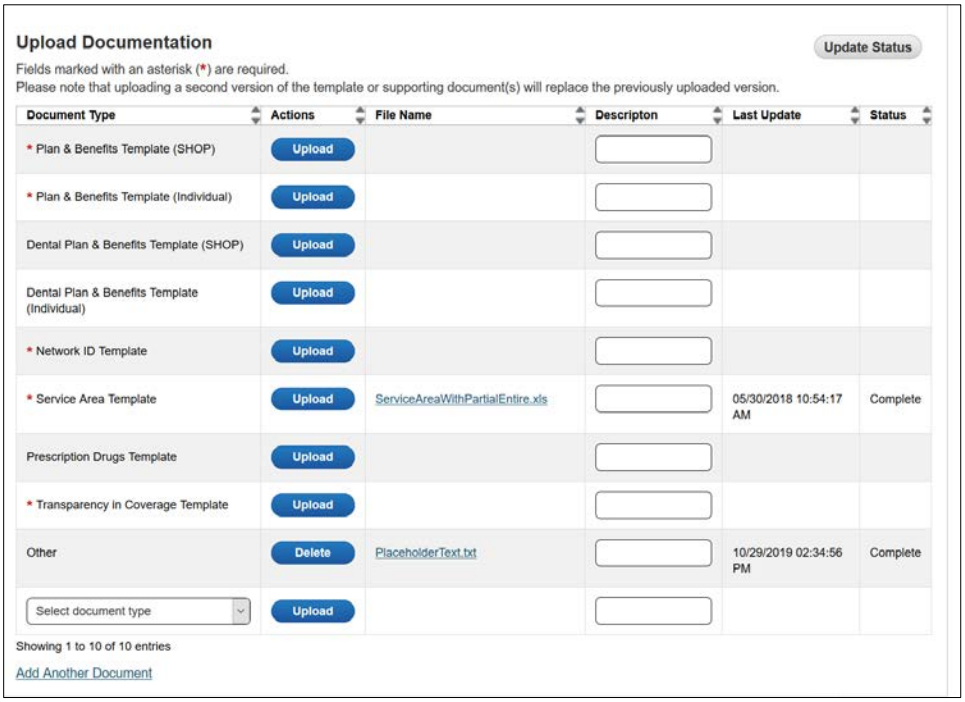


Figure 3: Upload Documentation Table–Documents Uploaded

Figure 4 shows the *Upload Documentation* table after documents have been uploaded and statuses are refreshed. Note how some of the files have changed from **Pending** to **Complete** or **Failed**.

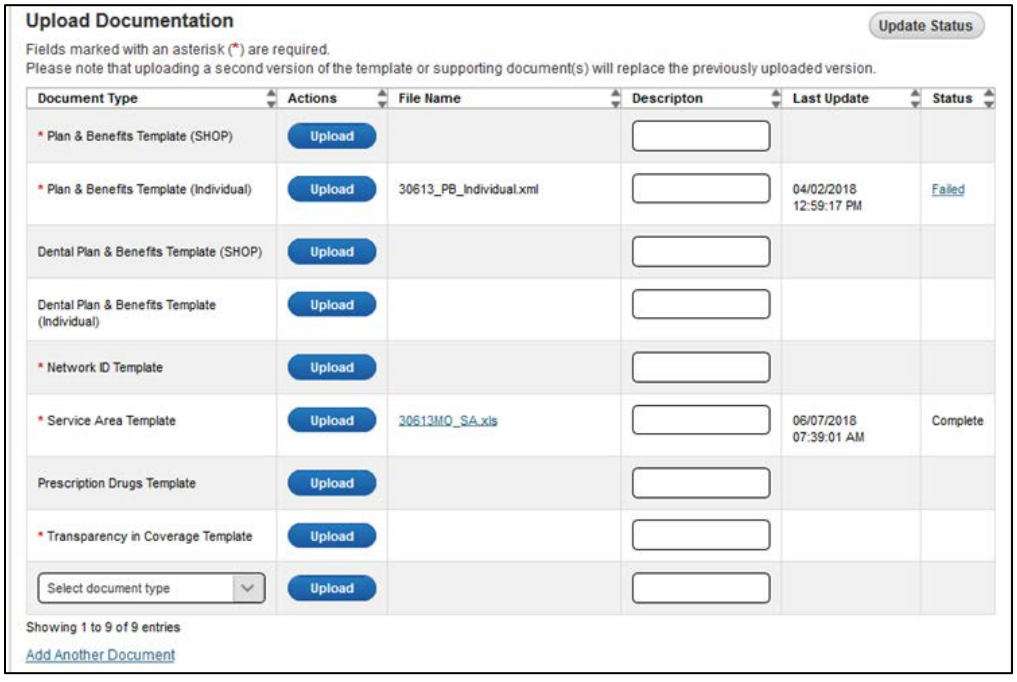


Figure 4: Upload Documentation Table–Statuses Refreshed

4.4 Benefits Submitter–Benefits & Service Area page–Submission Failed

If the user submits the Benefits & Service Area page without uploading any or all required documents, the system will return an error message listing the specific documents to upload.

Figure 5 shows the Benefits Submitter Benefits & Service Area page after a Failed Submission.

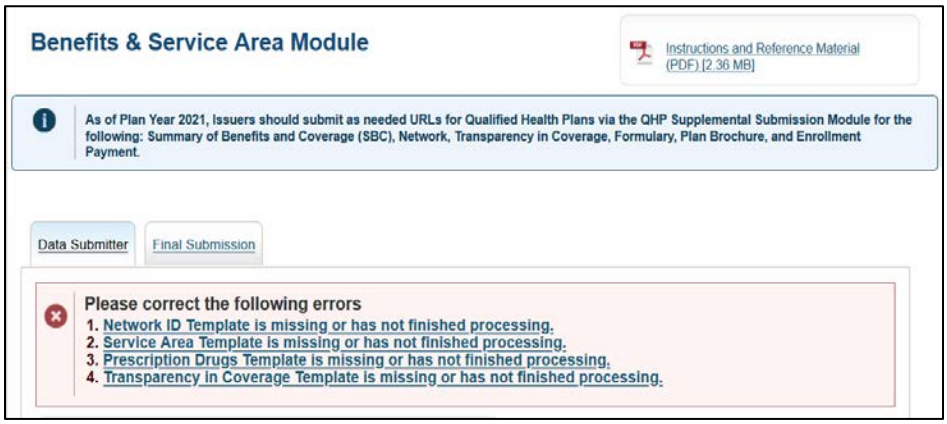


Figure 5: Benefits Submitter–Benefits & Service Area Page–Submission Failed

4.5 Benefits Submitter–Benefits & Service Area Page–Submission Successful

Once the user submits all required documents with no validation errors, a successful submission message will appear on screen. Once the Benefits Module has been submitted, it is available for validation. The Benefits Validator is responsible for validating the accuracy of the submitted data.

Figure 6 shows the Benefits Submitter Benefits & Service Area page after a successful submission.

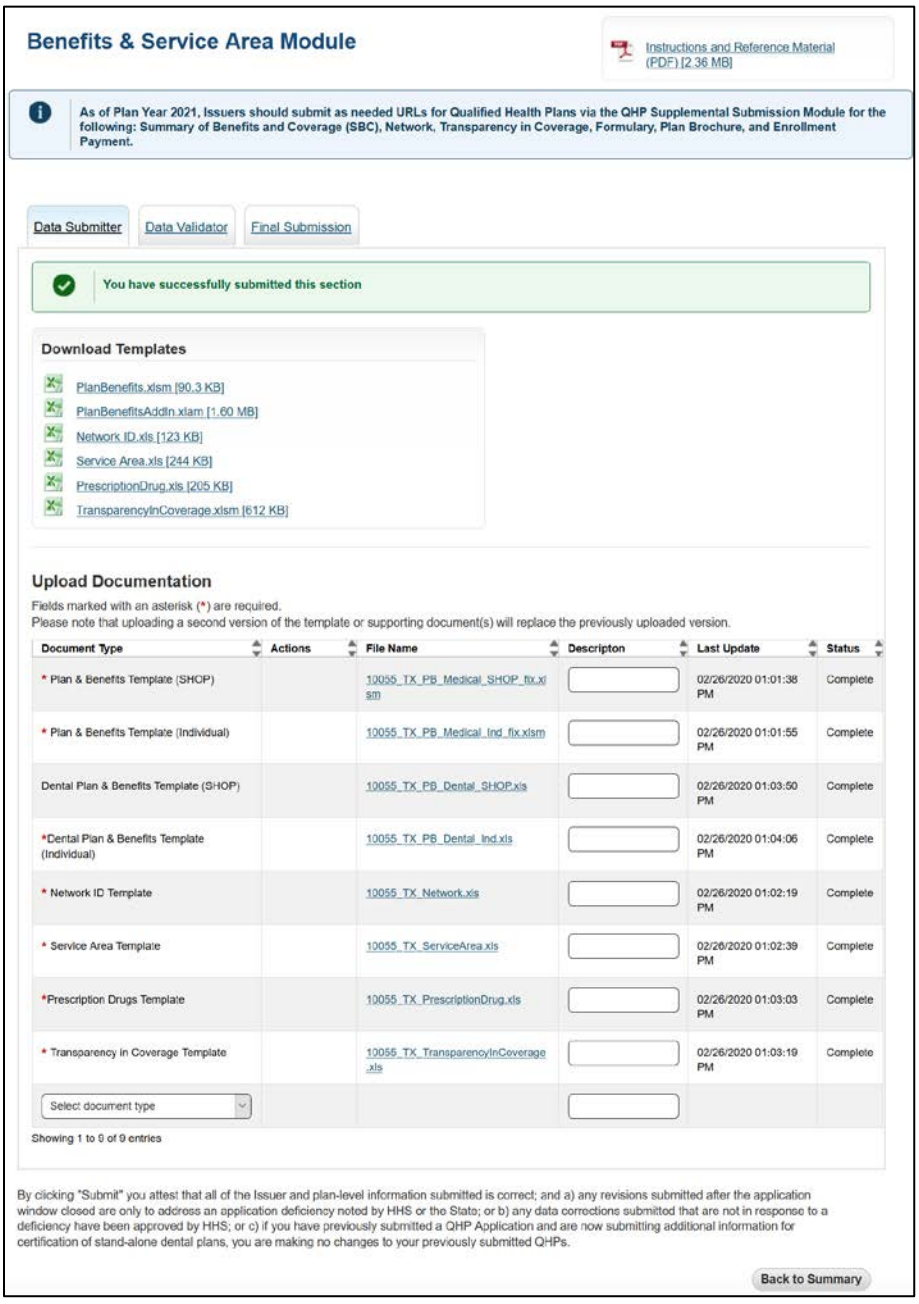


Figure 6: Benefits Submitter–Benefits & Service Area Page–Submission Successful

4.6 Benefits Validator–Summary Page

The Benefits Validator Summary page displays a list of all completed submissions and their statuses. The user can start or resume validation for a completed submission or edit the validation for a previously validated submission. The user must be assigned the role of Benefits Validator to access this page.

Figure 7 shows the Benefits Validator Summary page.

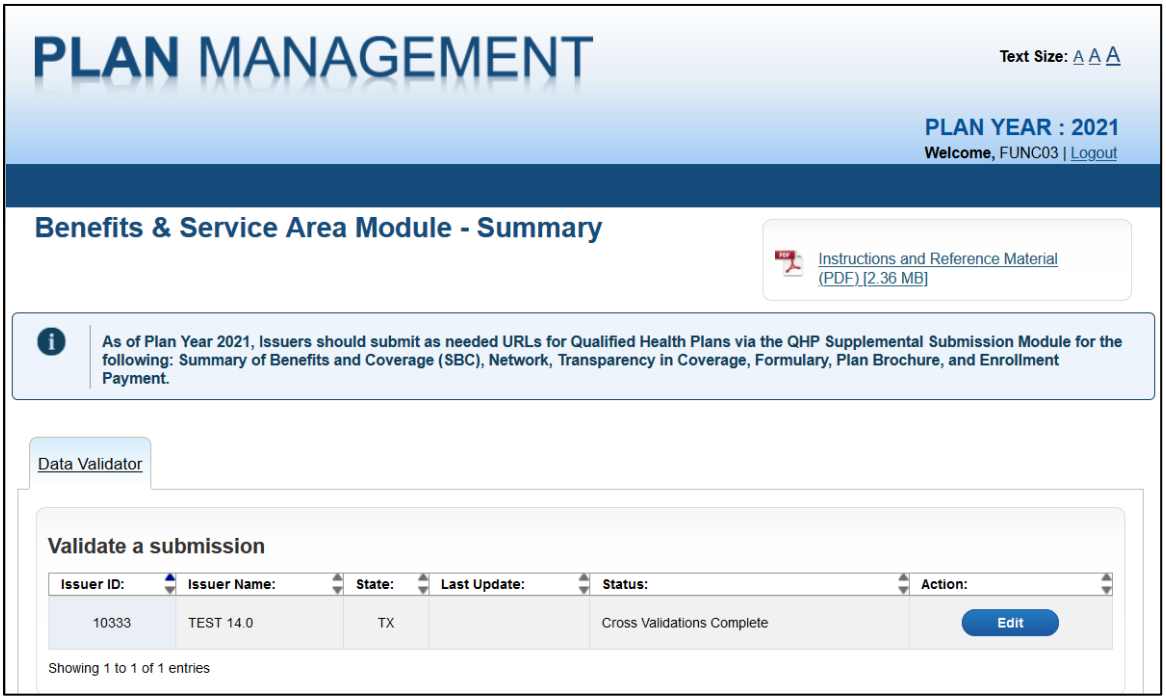


Figure 7: Benefits Validator–Summary Page

Table 4 describes the fields on the Benefits Validator Summary page and provides instructions about how to enter data in these fields.

Table 4: Benefits Validator–Summary Page Fields

Name	User Action	Description
Validate a Submission Table	N/A	Possible Statuses with appropriate action: Submission Completed–***Start Validation*** Pending Validation–***Resume*** Validation Completed–***Edit*** Cross Validation Completed–***Edit***
Start Validation	Select button	Navigates to the Validator Benefits & Service Area page. The ***Start Validation*** button should appear only when a submission has a status of “Submission Completed” or “Pending Validation.”
Edit	Select button	Navigates to the Validator Benefits & Service Area page. The ***Edit*** button should appear only when a submission has a status of “Validation Completed.”

4.7 Benefits Validator–Benefits & Service Area Page

The Benefits Validator Benefits & Service Area page is where Validators review and validate the data and information provided by the Benefits Submitter. The user may download the submitted templates and supplementary documents by selecting the hyperlink in the "File Name" column of the Uploaded Documents table (See Figure 8). The Benefits Validator should perform a review to ensure all the provided data and information is valid. Then, make the determination by selecting the "**Yes**" or "**No**" radio buttons in response to the question, "Do you validate that the information submitted for this section is correct?" and select ***Submit***. If the user selects ***Submit*** without answering the question, the system will return an error message (refer to Figure 9).

Figure 8 shows the Benefits Validator Benefits & Service Area page.

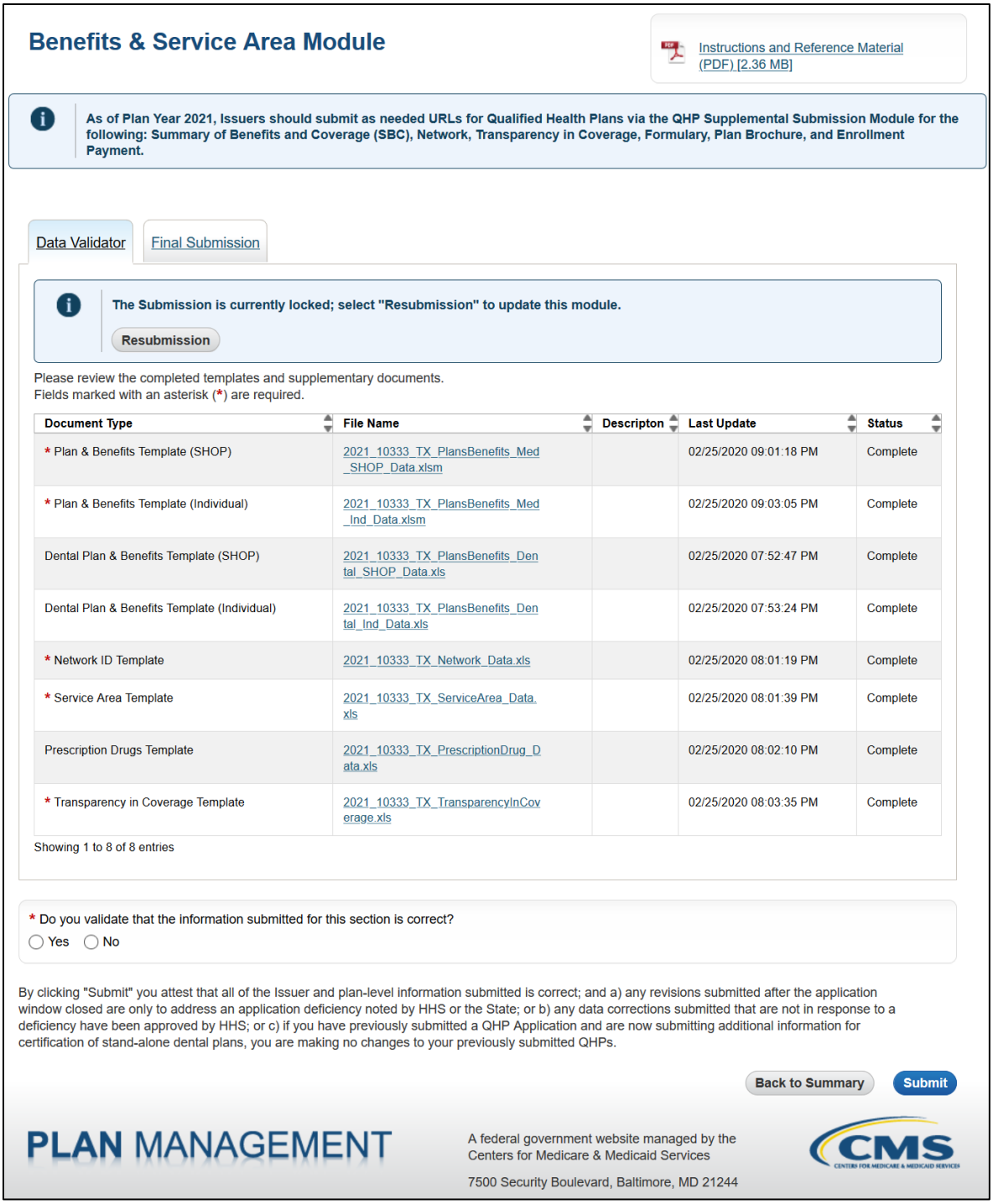


Figure 8: Validator Benefits & Service Area Page

Table 5 describes the fields on the Benefits Validator Benefits & Service Area page and provides instructions about how to enter data in these fields.

Table 5: Validator Benefits & Service Area Page Fields

Name	User Action	Description
Yes	Select button	Select ***Yes*** to confirm all submitted information is correct.
No	Select button	Select ***No*** to confirm the information submitted is not correct. The submission status will change to “Returned for Changes” and the Issuer Submitter will be allowed to resubmit.
Back to Summary	Select button	Navigates back to the Summary page. If changes are not saved, the following pop-up should appear: “There are unsaved changes. If you continue your changes will be lost. Would you like to continue?”
Submit	Select button	The page refreshes and a confirmation message will appear. If the user does not select “Yes” or “No” and selects ***Submit***, the system will return an on-screen error stating the question requires an answer. If Yes, upon selecting Submit, the submission status will change to “Validation Completed.” If No, upon selecting Submit, the submission status will change to “Returned For Changes.”

4.8 Benefits Validator Benefits & Service Area Page–Validation Failed

The user must answer the question, "Do you validate that the information submitted for this section is correct?" If the user submits the page without answering the "**Yes**" or "**No**" question, the system will return an error message (See Figure 9).

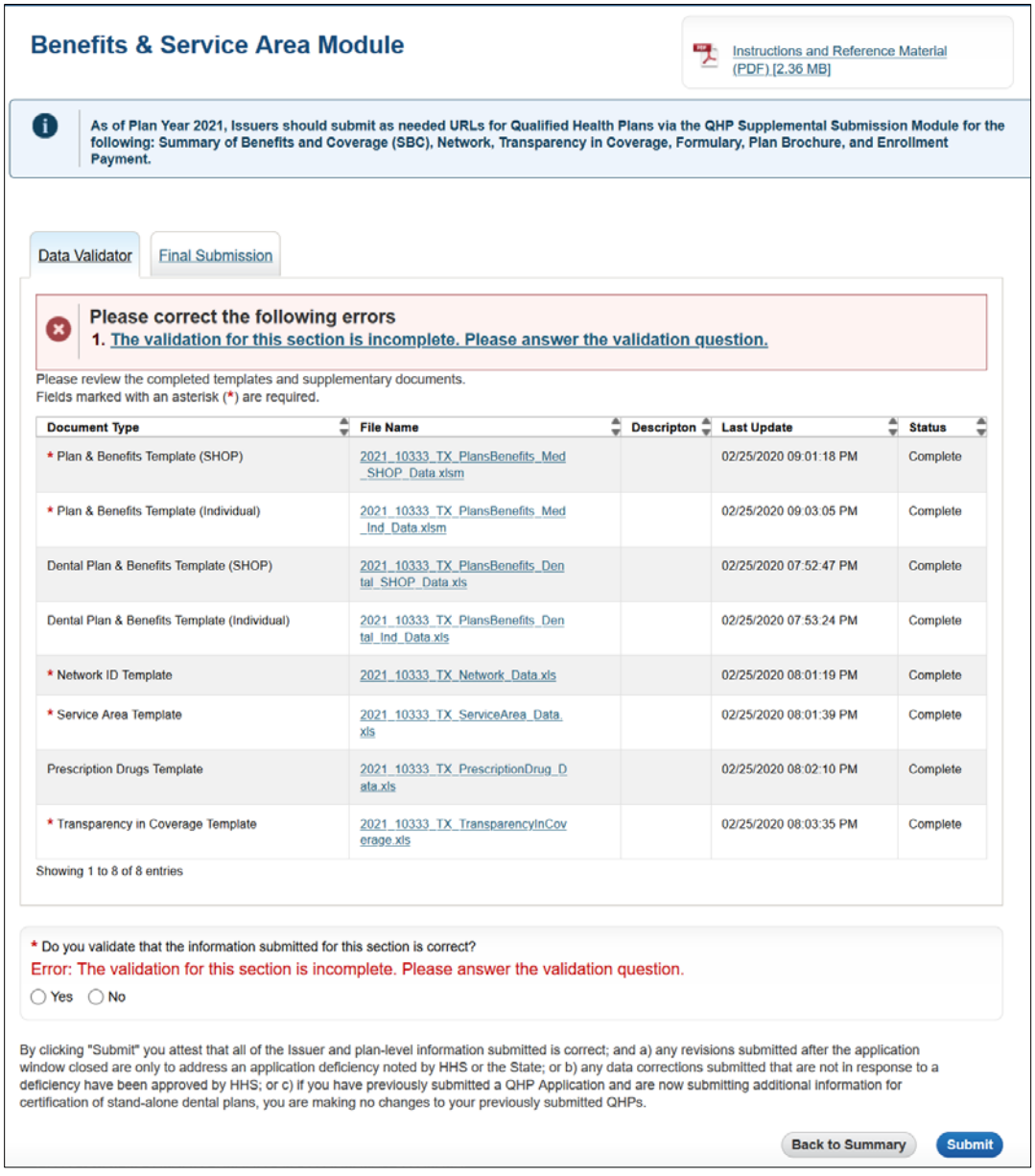


Figure 9: Validator Benefits & Service Area Page–Validation Failed

4.9 Benefits Validator Benefits & Service Area Page–Validation Question = Yes

The user must answer the question, "Do you validate that the information submitted for this section is correct?" If the user answers "**Yes**" and selects ***Submit***, the system will return a confirmation message the section has successfully validated (see Figure 10). The submission status will change to "**Validation Completed**".

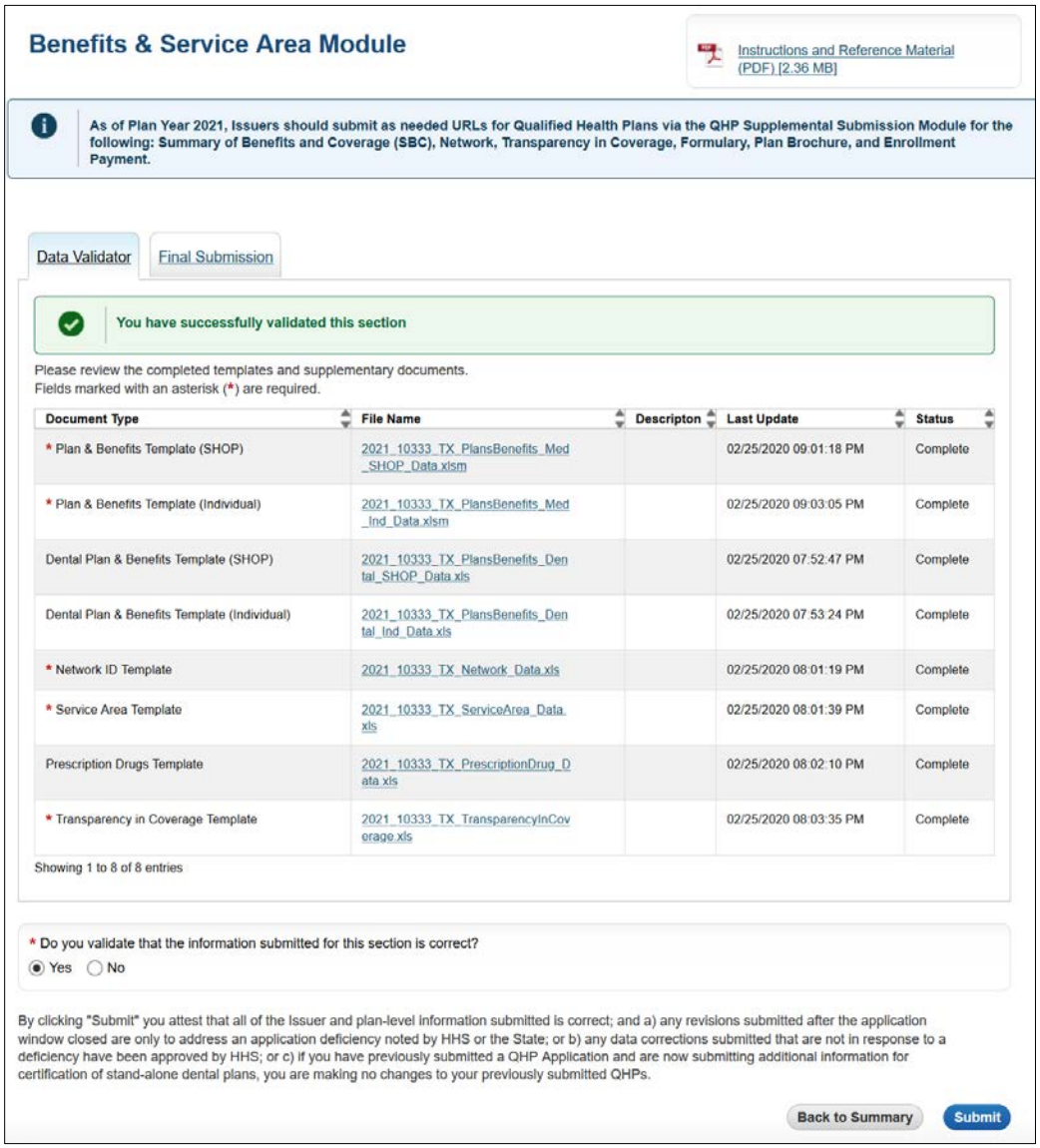


Figure 10: Validator Benefits & Service Area Page–Validation Question = Yes

4.10 Benefits Validator Benefits & Service Area Page–Validation Question = No

The user must answer the question, "Do you validate that the information submitted for this section is correct?" If the user answers "**No**" and selects ***Submit***, the system will return a

confirmation message (see Figure 11) that this submission has been "**Returned for Changes**". This submission will no longer be available in the Validator Summary page.

Please note that there is no way to send a notification within the system. The user must inform data submitters offline that the submission has been rejected and to correct the submission.

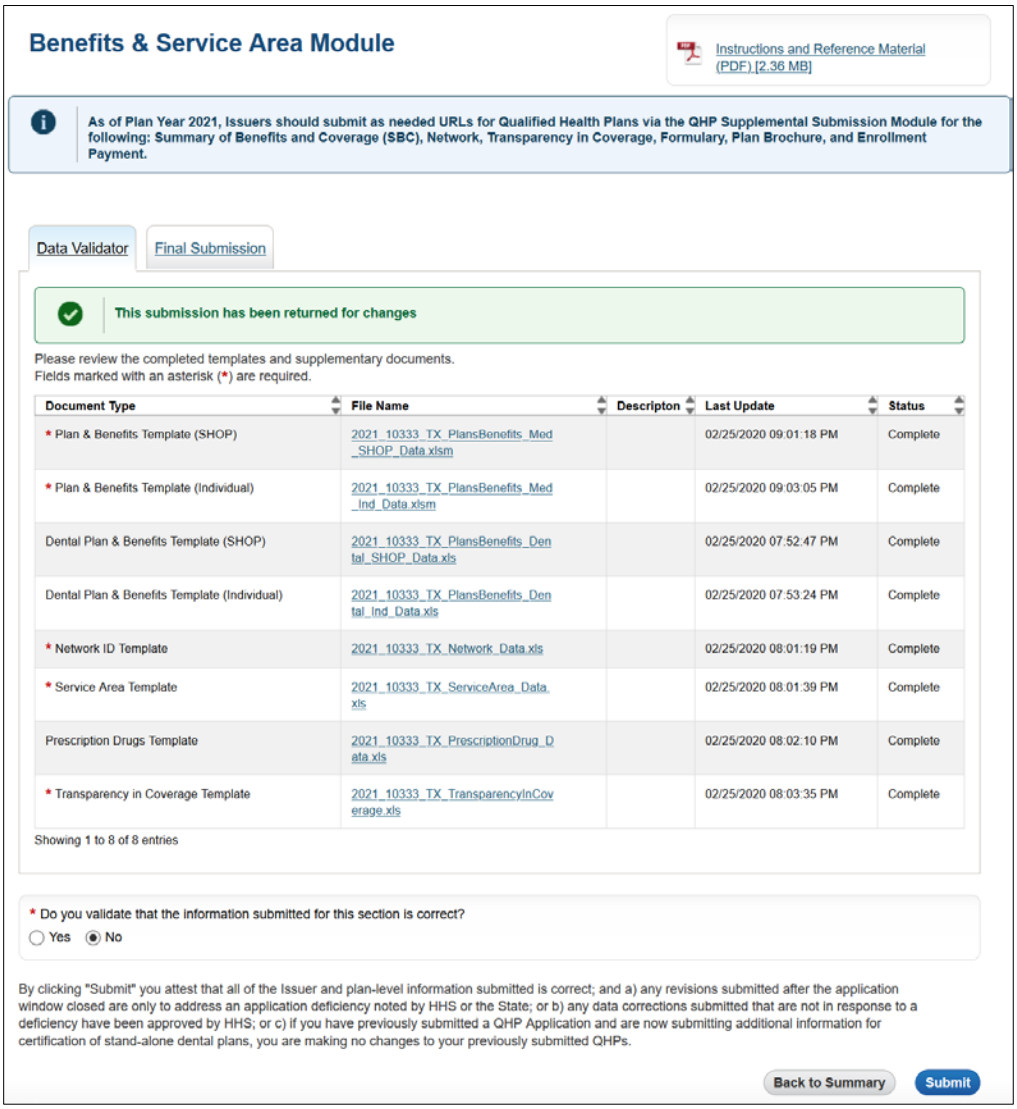


Figure 11: Validator Benefits & Service Area Page–Validation Question = No

4.11 Final Submission

This page allows users to cross validate data elements within a submission. The user can also submit an application to be evaluated for QHP certification.

4.11.1 Final Submission Access from the Modules

The Final Submission page can be accessed from the Final Submission tab that is integrated within the modules.

Example: From the Benefits & Service Area Module, shown in Figure 12, select the ***Final Submission*** tab to access the Final Submission page and view the statuses of modules throughout an application.

Figure 12: Example: Accessing the Final Submission Page from the Benefits Module

4.11.2 Final Submission Page

Depending on the user's access level, the Final Submission page can be used (see Figure 13) to perform two distinct functions. Submitters and Validators can cross validate data among modules by selecting the ***Cross Validate*** button. Validators can submit the application by selecting the ***Submit*** button.

The ***Back*** button returns to the last page accessed prior to navigating to the Final Submission page.

NOTE: Submission of Unified Rate Review is required to complete the QHP Application; however, the module status will not be displayed on the page.

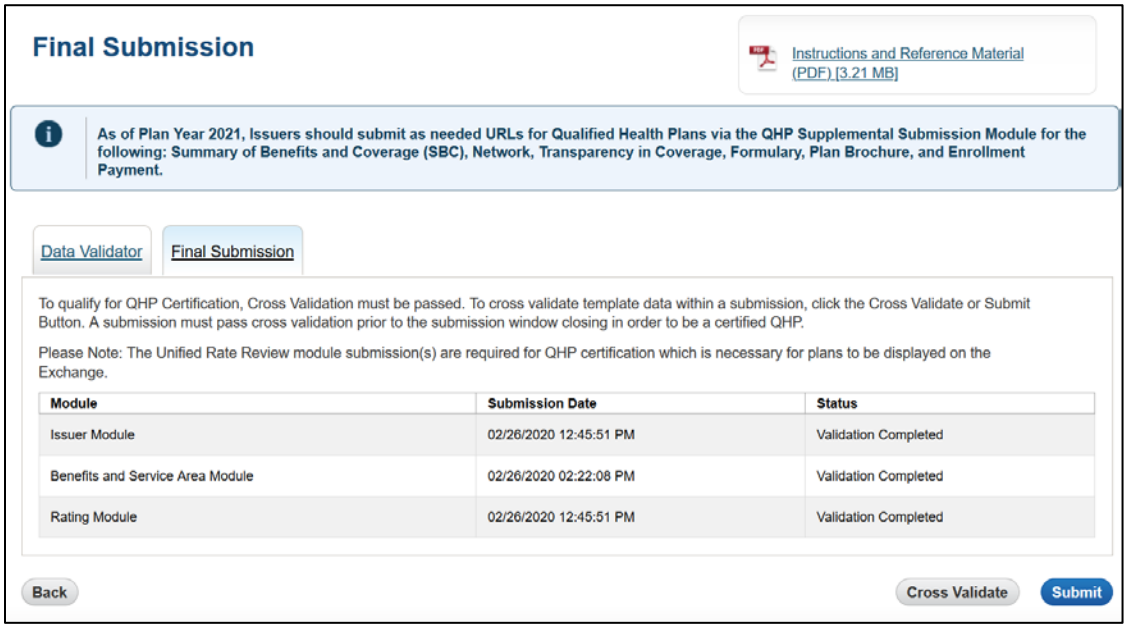


Figure 13: Final Submission Page

4.11.3 Final Submission Page–Errors

When inconsistencies are detected during cross validation, an error report will be generated, and an error message will appear on screen (see Figure 14). The error message instructs the user to download the Final Submission Error Report to view inconsistent data elements across the

modules. The user must download the Final Submission Error Report (see Figure 15) by selecting on the ErrorReport.csv link and correct the listed errors.

NOTE: Error report generation will not trigger a status change for any module. The user is responsible for coordinating with users from other modules to resolve discrepancies within the application. Once discrepancies are resolved, rerun cross validation to verify consistency across the Final Submission data elements.

NOTE: The Error Report is **deleted** once the user refreshes or leaves the page. It is strongly recommended to download this report.

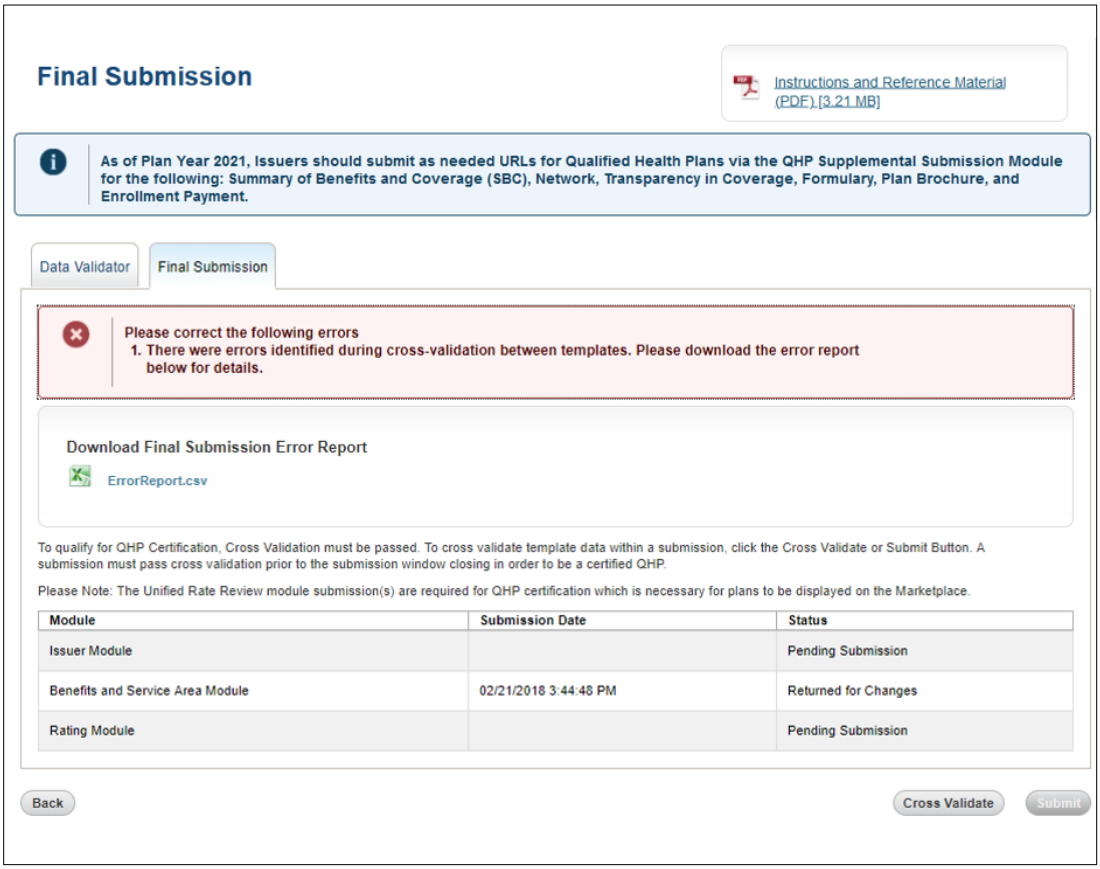


Figure 14: Final Submission Page–Errors

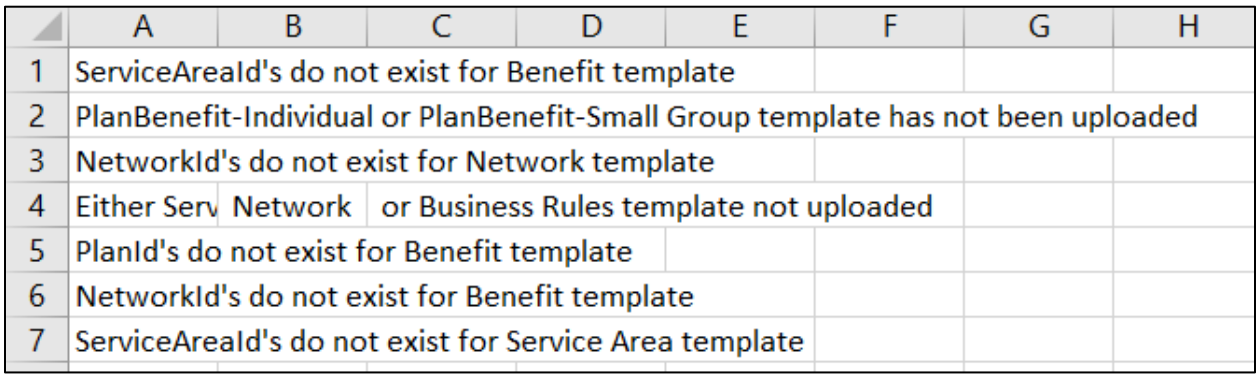


Figure 15: Final Submission Error Report

4.11.4 Final Submission Page–Cross Validations Successful

After cross validations have passed, a confirmation message will appear stating the chosen Issuer ID application has been successfully Cross Validated (see Figure 16). The Validator must still select ***Submit*** for the application to be flagged for Evaluation (Refer to 5.13.5 Final Submission Page–Submitted).

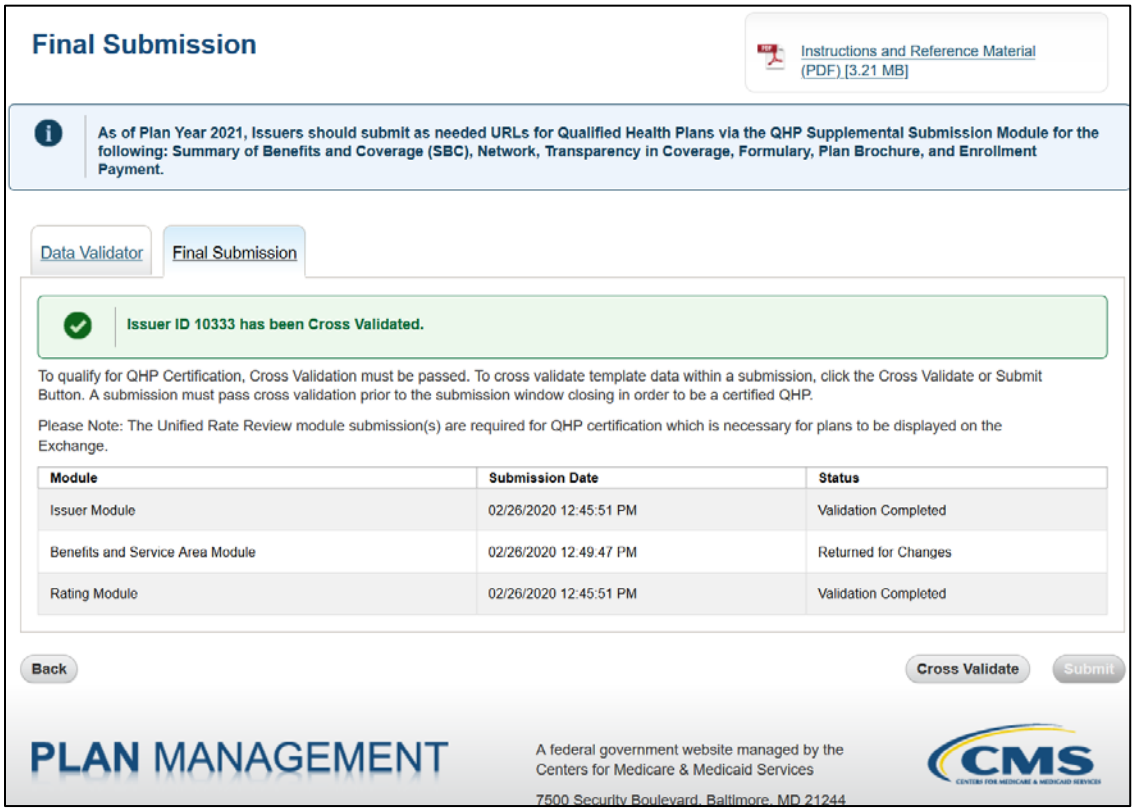


Figure 16: Final Submission Page–Cross Validations Successful

4.11.5 Final Submission Page–Submitted

Once all module statuses show as "**Validation Completed**," a **Validator** can submit the application by selecting the ***Submit*** button.

After successfully submitting the application, the Module statuses read "**Cross Validation Completed**" (see Figure 17), and the ***Submit*** button becomes disabled. If there are modifications to any Module, the user must repeat the Final Submission Cross Validation process. If changes are made, the Module statuses will no longer read "Cross Validation Completed."

NOTE: The user must complete the Final Submission prior to the close of the submission window for an application to qualify for QHP certification.

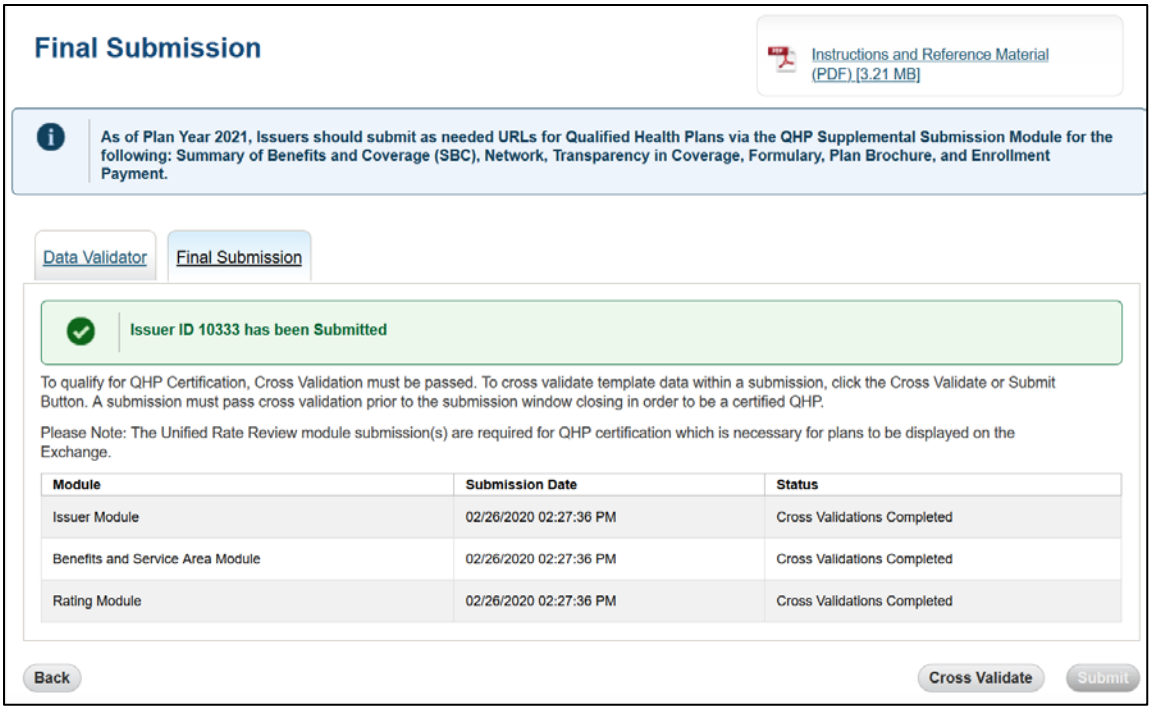


Figure 17: Final Submission Page–Submitted

4.12 Resubmission

The Resubmission (see Figure 19) functionality allows Validators to initiate the resubmission of the application to address a deficiency noted by CMS or the State and to submit a data correction during the plan preview period.

NOTE: Entering the resubmission process will invalidate the previously submitted QHP Application to allow information to be modified and resubmitted.

The user can initiate the resubmission process from any QHP Application module. Resubmission may impact data entries and validation previously completed in other QHP Application modules. Once beginning the resubmission process, the module status will change to "Returned for Changes" and all other modules to "Validation Completed." To modify a module with the status of "Validation Completed," follow the instructions provided in section 5.12.

Once the resubmission process has been successfully processed, follow the original submission process (Submission, Validation, Cross Validation) previously outlined within this guide.

4.12.1 Resubmission Benefits Validator: Summary Page

The Benefits Validator Summary (see Figure 18) is where the user can select an application to initiate the resubmission. The user can also select **Edit** for any submissions with the status of "Returned for Changes". The user must be assigned the role of **Benefits Validator** to access this page.

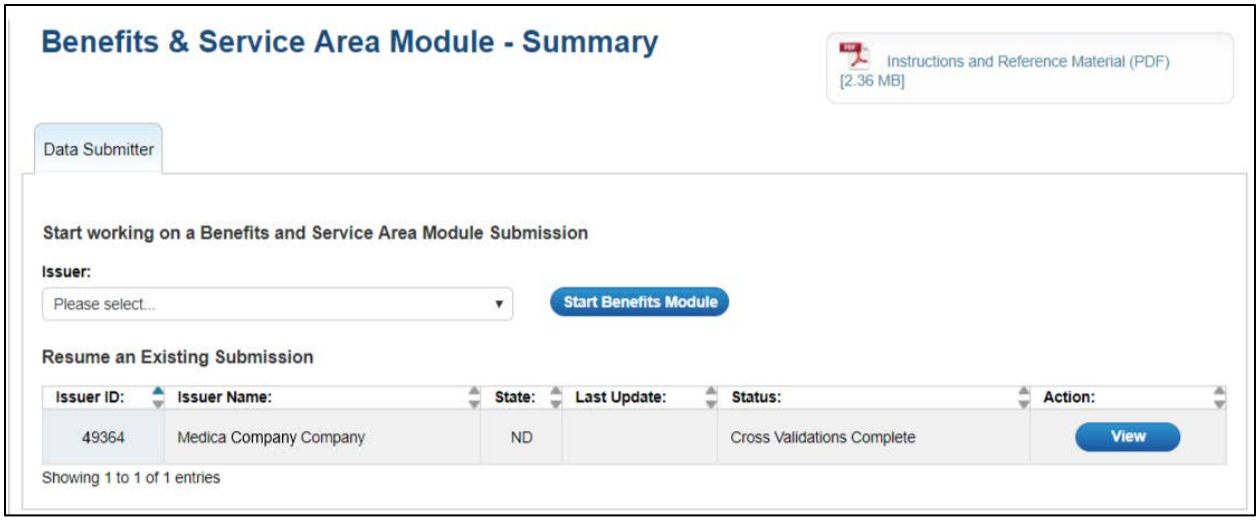


Figure 18: Benefits Validator–Summary Page

4.12.2 Resubmission Benefits Validator: Benefits & Service Area Page

The Benefits Validator page of the Benefits & Service Area module allows the user to review the validated data and information provided by the Benefits Submitter.

The user must select the ***Resubmission*** button from the alert box (see Figure 19). A confirmation pop-up will appear to ensure the resubmission is process is triggered to only address justifications outlined by CMS (see Figure 20). Selecting "**No**" will simply close the pop-up screen with no changes made to the module/application. If the user selects "**Yes,**" the pop-up screen will close, and a confirmation message will display stating that the module status has changed to "Returned to Submitter" and the module is now routed back to the submitter (see Figure 21).

Figure 19: Resubmission Alert Box

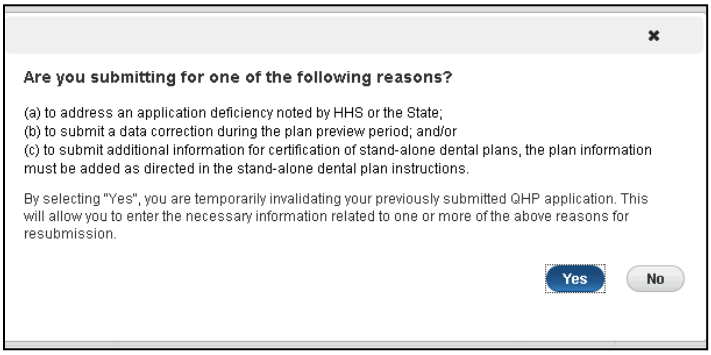


Figure 20: Confirmation Pop-Up

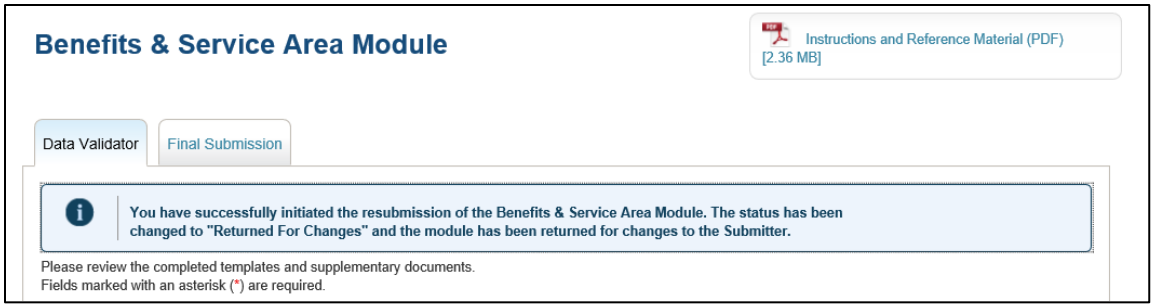


Figure 21: Resubmission Confirmation Message

5 Templates

The Benefits & Service Area module is where the user can complete the following templates and upload the template-generated .xml files:

- Transparency in Coverage Template
- Network Template
- Service Area Template
- Prescription Drug Template
- Plans & Benefits Template

This section provides background information and descriptions of the data elements contained within these templates.

NOTE: For Plan Year 2021, ALL templates except the Transparency in Coverage template should have a version of 10.0 The Transparency in Coverage template will be version 1.0. If the versions are not current, the user will not be able to complete the template upload and receive errors.

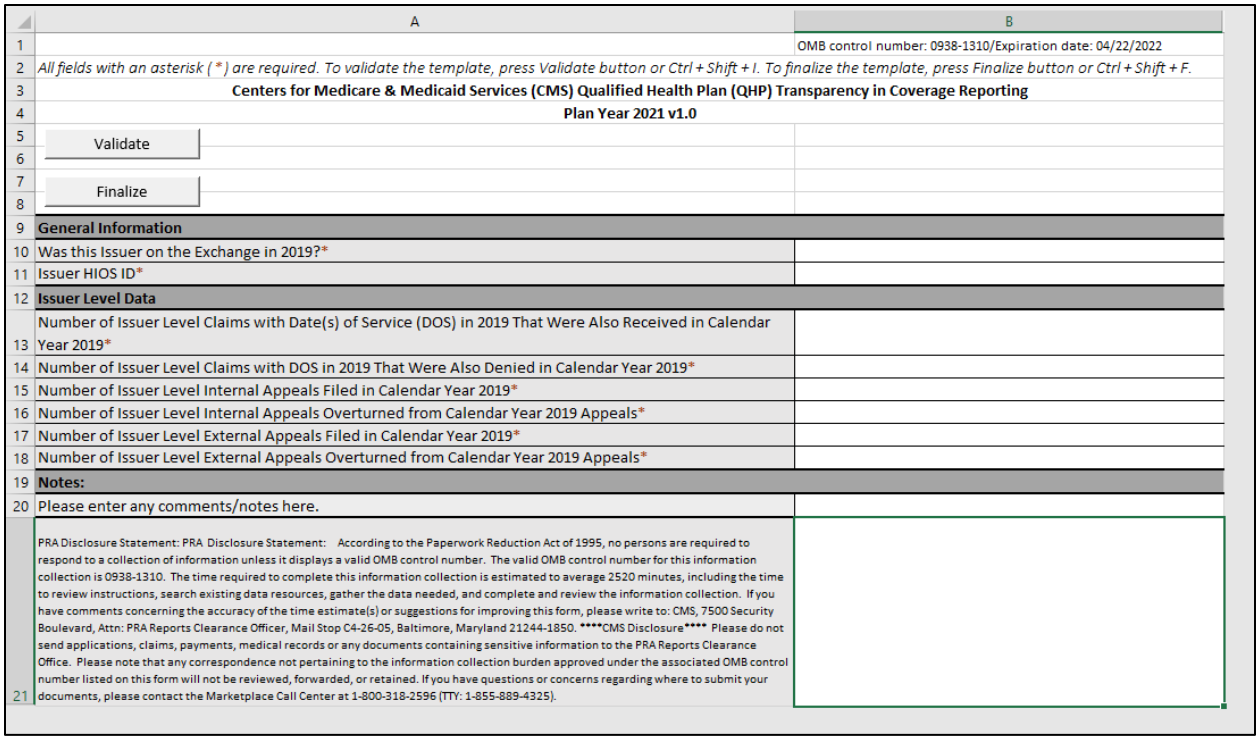
5.1 Transparency in Coverage Template

The user must enter information about claims and appeals, both issuer and plan level data reporting are required, for each plan offered on the exchange in the year specified on the template. Data is submitted for the plan year two years before the current plan year. For example, PY2019 data will be submitted for PY2021. For plans that were not offered on the exchange at that time, enter values of "N/A" for applicable fields.

The Transparency in Coverage template is cross-validated with the data from submitted Plans & Benefits Template(s). Each plan submitted in the Plans & Benefits Template(s) must be listed in the Plan Level Data tab of the Transparency in Coverage Template.

To populate this template, first enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

Figure 22 shows the Issuer Level Data tab of the Transparency in Coverage template.



	A	B
1		OMB control number: 0938-1310/Expiration date: 04/22/2022
2	*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*	
3	**Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting**	
4	**Plan Year 2021 v1.0**	
5	Validate	
6		
7	Finalize	
8		
9	**General Information**	
10	Was this Issuer on the Exchange in 2019?*	
11	Issuer HIOS ID*	
12	**Issuer Level Data**	
13	Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	
14	Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	
15	Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	
16	Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	
17	Number of Issuer Level External Appeals Filed in Calendar Year 2019*	
18	Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	
19	**Notes:**	
20	Please enter any comments/notes here.	
21	PRA Disclosure Statement: PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1310. The time required to complete this information collection is estimated to average 2520 minutes, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325).	

Figure 22: Transparency in Coverage Template – Issuer Level Data Tab

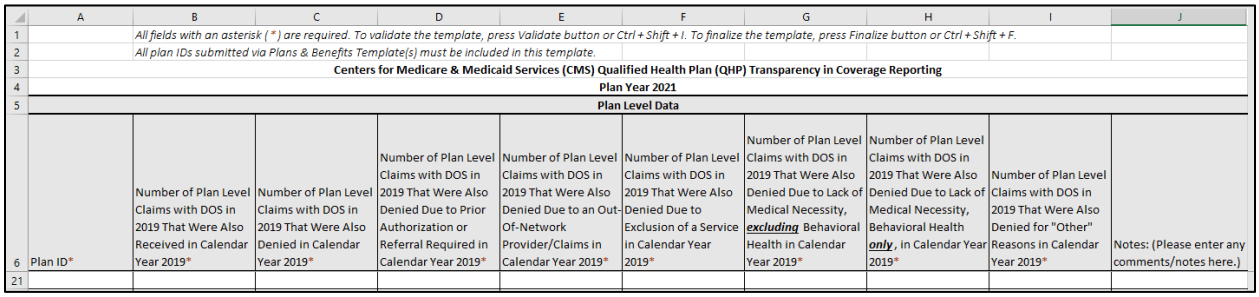
Table 6 describes the fields in the Issuer Level Data tab of the Transparency in Coverage template.

Table 6: Transparency in Coverage Template – Issuer Level Data Tab Fields

Field Name	Description	Field Values
Was this Issuer on the Exchange in [year specified in the template]?	Answer 'Yes' if the Issuer had offered plan(s) in the year specified in the template Answer 'No' if the Issuer had not offered plan(s) in the year specified in the template	Dropdown: Yes No
Issuer HIOS ID	Five-digit number that identifies the issuer.	Numeric
Number of Issuer Level Claims with Date(s) of Service (DOS) in [year specified in the template] That Were Also Received in Calendar Year [specified in the template]	Total amount of Issuer level claims with date(s) of service in the year specified in the template for all plans with this Issuer ID	Numeric or 'N/A'
Number of Issuer Level Claims with DOS in [year specified in the template] That Were Also Denied in Calendar Year [year specified in the template]	Total amount of Issuer level claims with date(s) of service in the year specified in the template for all plans with this Issuer ID	Numeric or 'N/A'
Number of Issuer Level Internal Appeals Filed in Calendar Year [year specified in the template]	Total amount of Issuer level internal appeals filed in the year specified in the template	Numeric or 'N/A'

Field Name	Description	Field Values
Number of Issuer Level Internal Appeals Overturned from Calendar Year [year specified in the template] Appeals	Total amount of Issuer level internal appeals overturned in the year specified in the template	Numeric or 'N/A'
Number of Issuer Level External Appeals Filed in Calendar Year [year specified in the template]	Total amount of Issuer level external appeals filed in the year specified in the template	Numeric or 'N/A'
Number of Issuer Level External Appeals Overturned from Calendar Year [year specified in the template] Appeals*	Total amount of Issuer level external appeals overturned in the year specified in the template	Numeric or 'N/A'
Please enter any comments/notes here.	Additional comments or notes regarding the information entered in the previous fields	Alphanumeric and the following symbols: • . • ,

Figure 23 shows the Plan Level Data tab of the Transparency in Coverage template.



	A	B	C	D	E	F	G	H	I	J
1		*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*								
2		*All plan IDs submitted via Plans & Benefits Template(s) must be included in this template.*								
3		**Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting**								
4		**Plan Year 2021**								
5		**Plan Level Data**								
6	Plan ID*	Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019*	Notes: (Please enter any comments/notes here.)
21										

Figure 23: Transparency in Coverage Template – Plan Level Data Tab

Table 7 describes the fields in the Plan Level Data tab of the Transparency in Coverage template.

Table 7: Transparency in Coverage Template – Plan Level Data Tab Fields

Field Name	Description	Field Values
Plan ID	HIOS generated unique Standard Component ID that makes up the Plan ID.	Alphanumeric
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Received in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the year specified in the template that were also received in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'

Field Name	Description	Field Values
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the plan year specified in the template that were also denied in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the plan year specified in the template that were also denied due to not receiving prior authorization or not having a referral in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the plan year specified in the template that were also denied due to a provider/claim being out of the network in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied Due to Exclusion of a Service in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the plan year specified in the template that were also denied due to exclusion of service in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the plan year specified in the template that were also denied due to lack of medical necessity, **excluding** behavioral health reasons in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the year specified in the template that were also denied due to lack of medical necessity, for only behavioral health reasons in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Number of Plan Level Claims with DOS in [year specified in the template] That Were Also Denied for "Other" Reasons in Calendar Year [year specified in the template]	Total number of Plan level claims with day(s) of service in the year specified in the template that were also denied due to other reasons in that calendar year for the Plan ID in the corresponding row	Numeric or 'N/A'
Notes: (Please enter any comments/notes here.)	Additional comments or notes regarding the information entered in the previous fields for the Plan ID in the corresponding row	Alphanumeric and the following symbols: • . • ,

5.2 Network Template

The user must cross reference networks with Network IDs.

The Network Template links to the Plans & Benefits Template. Each plan in the Plans & Benefits Template must list the Network ID with which it is associated.

To populate this template, first enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

Figure 24 shows a blank Network Template.

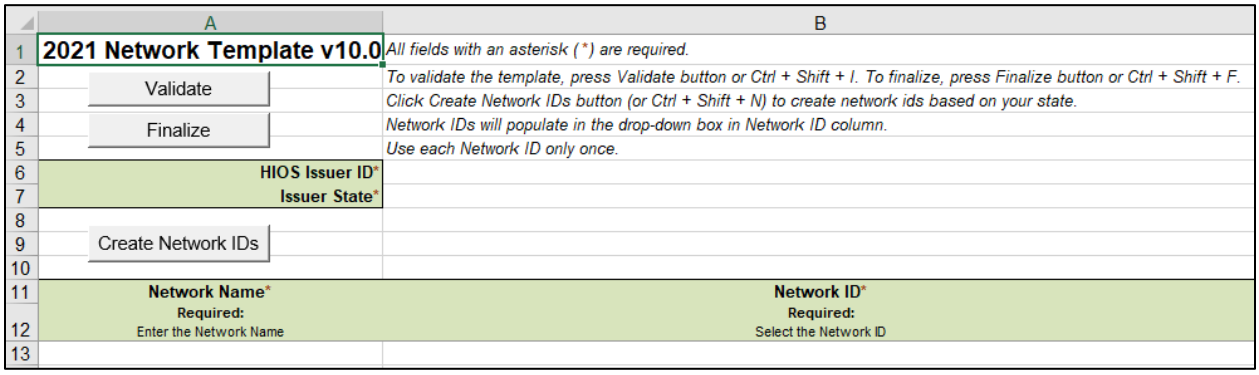


Figure 24: Network Template

Table 8 describes the fields on the Network Template.

Table 8: Network Template Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five-digit number that uniquely identifies the issuer.	Numeric
Issuer State	Select which state this template applies to.	Dropdown: State Abbreviations + Territories
Network Name	Enter the name of the specific network	Alphanumeric (including special characters)
Network ID	An ID generated by the template to identify each network provider directory.	Alphanumeric (including special characters)

5.3 Service Area Template

Plan coverage is defined by service area. Each service area is linked to a plan or multiple plans in the Plans & Benefits Template.

Issuers can define service areas by state name, county name, and ZIP code. If a service area covers part, but not all, of a state, the Issuer must define it by the covered counties. If a service area covers part, but not all, of a county, the Issuer must define it by the covered ZIP codes.

The Service Area Template links to the Plans & Benefits Template. Each plan in the Plans & Benefits Template must list the Service Area ID with which it is associated.

NOTE: ZIP Codes are subject to change and should be verified for validity.

To populate this template, first enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

The Service Area Template is shown in Figure 25.

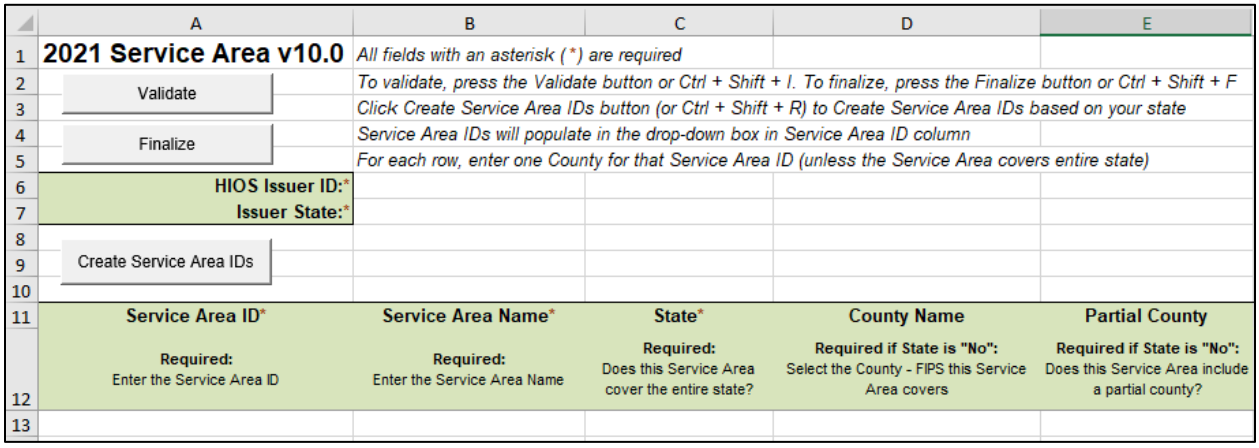


Figure 25: Service Area Template

Table 9 describes the fields in the Service Area Template.

Table 9: Service Area Template Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five-digit number that identifies the issuer.	Numeric
Issuer State	Select which state this template applies to.	Dropdown: State Abbreviations + Territories
Service Area ID	An ID generated by the template to identify each geographic service area.	Service Area IDs–this will vary based upon creation of IDs
Service Area Name	The name associated with a specific service area.	Alphanumeric (including special characters)
State	Flag to denote that the service area covers the entire state.	Dropdown: Yes No
County Name	The name of a county or counties that are included in a service area.	Dropdown: Counties–will vary depending on State Alphanumeric (including special characters)
Partial County	An indicator of whether a service area contains any partial counties.	Dropdown: Yes No
Service Area ZIP Code(s)	For any partial counties included in a service area, list each ZIP code from that county included in this service area.	Numeric separated by comma
Partial County Justification Filename	Space to provide the filename of the partial county justification for why all the ZIP codes are not included in this service area.	Alphanumeric (including special characters)

5.4 Prescription Drug Template

Use the Prescription Drug Template to provide cost sharing, tier placement, and specific drugs for each formulary.

The formulary is defined by the number of tiers and their cost sharing information. Each formulary links to one drug list, which includes the list of RxNorm Concept Unique Identifiers (RxCUIs) and the cost sharing tier they fall into.

The Prescription Drug Template links to the Plans & Benefits Template using the Formulary ID. Each plan in the Plans & Benefits Template must list the Formulary ID with which it is associated.

To populate this template, first enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

NOTE: It is recommended to complete the Drug Lists tab of the Prescription Drugs Template before completing the Formulary Tiers tab. Please see Figure 25 and Table 9.

Figure 26 shows the Formulary Tiers tab of the Prescription Drug Template.

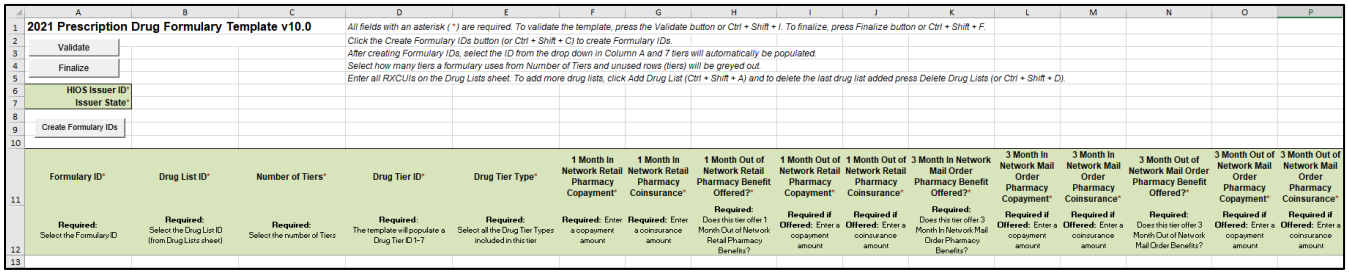


Figure 26: Prescription Drug Template–Formulary Tiers Tab

Table 10 describes the fields in the Formulary Tiers tab of the Prescription Drug Template. Note that if "$X" is selected as a value for any of the fields, a pop-up window will appear to enter a dollar value up to the second decimal point ($X.XX). Also note that if "X%" is selected as a value for any of the fields, a pop-up window will appear to enter a percentage value up to the second decimal point (X.XX %).

Table 10: Prescription Drug Template–Formulary Tiers Tab Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five-digit number that identifies the issuer.	Numeric
Issuer State	Select which state this template applies to.	Dropdown: State Abbreviations + Territories
Formulary ID	An ID generated by the template to identify each formulary.	Dropdown: Varies based on State and Number of Formularies entered
Drug List ID	Template generated identifier for Drug List in template.	Dropdown: Varies based on number of Drug Lists
Number of Tiers	The number of cost share tiers included in the formulary.	1-7
Drug Tier ID	Template populated field according to the selection in *Number of Tiers*.	Numeric
Drug Tier Type	List of drug types included in this tier.	Pop-up Window: Generic Preferred Generic Non-Preferred Generic Brand Preferred Brand Non-Preferred Brand Specialty Drugs Zero Cost Share Preventative Drugs Medical Service Drugs

Field Name	Description	Field Values
1 Month in Network Retail Pharmacy Copayment	Indicate copayment for Up to 1 Month In-Network Retail Pharmacy.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable
1 Month in Network Retail Pharmacy Coinsurance	Indicate coinsurance for Up to 1 Month In-Network Retail Pharmacy.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable
1 Month Out of Network Retail Pharmacy Benefit Offered?	Indicate whether 1 Month Out-of-Network Retail Pharmacy is offered.	Dropdown: Yes No
1 Month Out of Network Retail Pharmacy Copayment	Indicate copayment for Up to 1 Month Out-of-Network Retail Pharmacy.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable
1 Month Out of Network Retail Pharmacy Coinsurance	Indicate coinsurance for Up to 1 Month Out-of-Network Retail Pharmacy.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable
3 Month In Network Mail Order Pharmacy Benefit Offered?	Indicate whether 3 Month In-Network Mail Order Pharmacy Benefit is offered.	Dropdown: Yes No
3 Month In Network Mail Order Pharmacy Copayment	Indicates copayment amount for mail order pharmacy 3-month supply In-Network.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable

Field Name	Description	Field Values
3 Month In Network Mail Order Pharmacy Coinsurance	Indicate cost-sharing type for 3 Month out-of-network Mail Order Pharmacy.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable
3 Month Out-of-Network Mail Order Pharmacy Benefit Offered?	Indicate whether 3 Month Out-of-Network Mail Order Pharmacy Benefit is offered.	Dropdown: Yes No
3 Month Out-of-Network Mail Order Pharmacy Copayment	Indicate copayment amount for mail order pharmacy 3-month supply Out-of-Network.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable
3 Month Out-of-Network Mail Order Pharmacy Coinsurance	Indicate coinsurance amount for mail order pharmacy 3-month supply Out-of-Network.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable

Figure 27 shows the Drug Lists tab of the Prescription Drug Template.

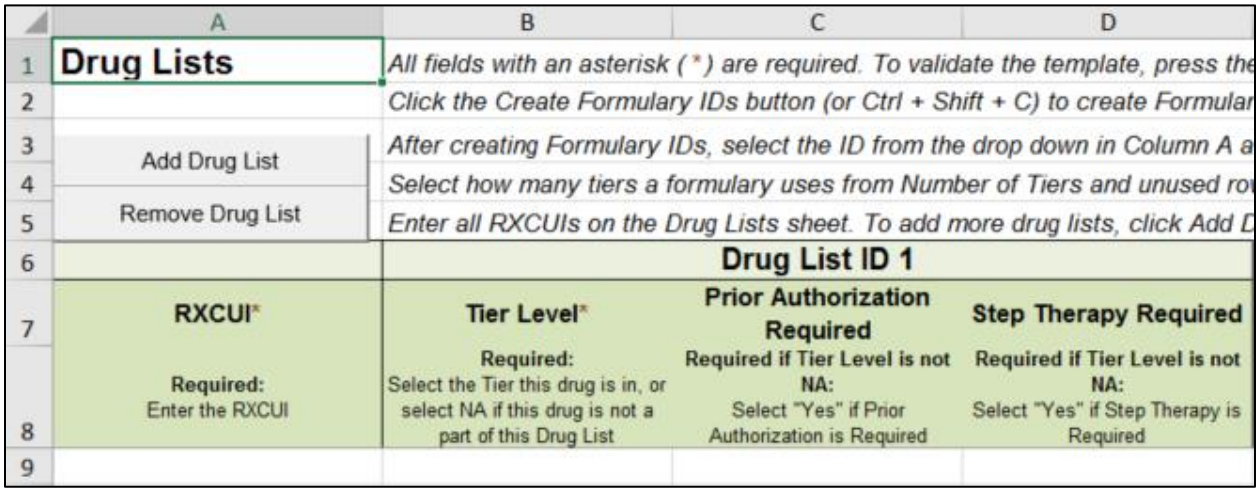


Figure 27: Prescription Drug Template–Drug Lists Tab Field

Table 11 describes the fields in the Drug Lists tab of the Prescription Drug Template.

Table 11: Prescription Drug Template–Drug Lists Tab Fields

Field Name	Description	Field Values
RxCUI	1-8-digit RxNorm Count Unique Identifier	Numeric
Tier Level	Cost-sharing tier level.	Dropdown: N/A 1-7
Prior Authorization Required	Indicate whether prior authorization is required.	Dropdown: Yes No
Step Therapy Required	Indicate whether step therapy is required.	Dropdown: Yes No

5.5 Plan & Benefits Template Add-In File

The Add-In File is the key for proper functionality of the Plans & Benefits Template. This file contains all the macros, code, and logic required to calculate cost share variances (CSV) and populate EHB data within the Plans & Benefits Template. The Add-In File also creates a new tab called "Plans & Benefits" on the Excel ribbon within the template, with different buttons available to assist in creating plans.

For certain circumstances for working with multi-year templates, please refer to Appendix E.

To complete the Plans & Benefits Template, the user must do the following, or the template will not function properly:

- Delete all prior versions of the Add-In File from the computer, unless explicitly following Appendix E guidelines for working with multi-year template versions.
- Download the most current Add-In File and save it in the same folder as the Plans & Benefits Template.

Once the Plan & Benefits Template is opened, macros from the Add-In File will be automatically integrated.

For any problems encountered while creating Plans & Benefits due to the Add-In File, refer to Appendix D and Appendix E for further guidance.

5.6 Plans & Benefits Template

This template captures the following four levels of data:

- General plan information
- Plan cost-sharing information
- General benefit information
- Benefit cost-sharing information

The Plans & Benefits Template contains two sections (tabs). The first section is the "**Benefits Package**," which includes high-level information regarding the plans, as well as a list of benefits with any quantitative limits or exclusions (refer to Tables 11-21 for Health and Tables 32-40 for Stand-alone Dental Plan (SADP). All plans defined within a Benefits Package will share the same set of benefits and limits but differ in cost-sharing variations.

The second section is the "**Cost Share Variances.**" The CSV tab is where the user provide Deductibles and Maximum Out-Of-Pocket (MOOP) information for In/Out/Combined Networks, for both Individual and Family, as well as In/Out/Combined Network Copays and Coinsurances (refer to Tables 22-30 for Health and Tables 40-44 for SADP). The user must provide this information for each plan variance.

Before using this template, enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

NOTE: There must be one CSV tab for each Benefits Package tab. Corresponding tabs will be labeled with the same number.

Figure 28 shows the first half of the Benefits Package tab of the Plans & Benefits Template.

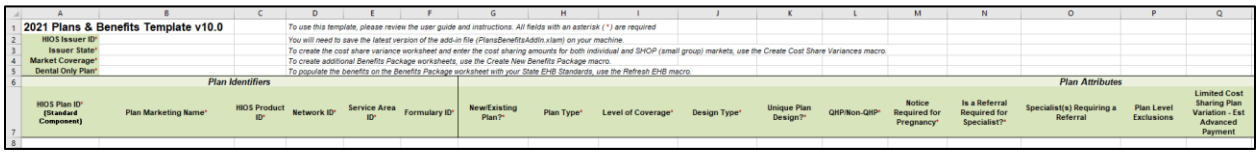


Figure 28: First Half Plans & Benefits Template–Health Benefits Package Tab

Figure 29 shows the second half of the Benefits Package tab of the Plans & Benefits Template.

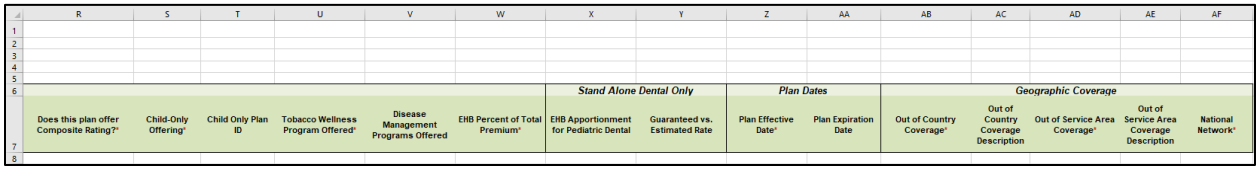


Figure 29: Second Half of the Plans & Benefits Template – Health Benefits Package Tab

Table 12 describes the fields in the Benefits Package tab of the Plans & Benefits Template.

Table 12: Plans & Benefits Template–Health Benefits Package Tab Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five-digit number that identifies the issuer.	Numeric
Issuer State	Select which state this template applies to.	Dropdown: State Abbreviations + Territories
Market Coverage Type	Market coverage, Individual or SHOP, for the entire benefit package/template.	Dropdown: SHOP Individual

Field Name	Description	Field Values
Dental Only Plan Indicator	Indicator if the plans offered in this benefit package are for stand-alone dental only (not medical).	Dropdown: Yes No

Table 13 describes the fields in the Plan Identifiers section of the Benefits Package tab.

Table 13: Health Benefits Package Tab–Plan Identifiers Section Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component)	HIOS generated unique Standard Component ID that makes up the Plan ID.	Alphanumeric
Plan Marketing Name	Name of each plan.	Alphanumeric (including special characters)
HIOS Product ID	The HIOS Product ID associated with each proposed Exchange plan.	Alphanumeric
Network ID	The Network ID for this plan which identifies the Network Provider Directory this plan uses.	Dropdown: List of values will be imported in from the Network Template by user
Service Area ID	The Service Area ID for this plan which identifies the Service Area the plan covers.	Dropdown: List of values will be imported in from the Service Area Template by user
Formulary ID	The Formulary ID for this plan which identifies which prescription drug formulary this plan uses.	Dropdown: List of values will be imported in from the Prescription Drug Template by user

Table 14 describes the fields in the Plan Attributes section of the Benefits Package tab.

Table 14: Health Benefits Package Tab–Plan Attributes Section Fields

Field Name	Description	Field Values
New/Existing Plan	Indicate if the plan is new or existing.	Dropdown: New Plan Existing Plan
Plan Type	Network design for the product: indemnity, preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO).	Dropdown: Indemnity PPO HMO POS EPO

Field Name	Description	Field Values
Level of Coverage	Coverage level for a specific proposed plan.	Dropdown: Platinum Gold Silver Expanded Bronze Bronze Catastrophic
Design Type	Indicates the Standardized Plan Design of a plan *This field should be 'Not Applicable' if the user is not located in an SBE state.	Dropdown: Not Applicable Design 1 Design 2 Design 3 Design 4 Design 5
Unique Plan Design	Indicates if this is a unique plan design for AV Calculator purposes. These are health plans that are not compatible with the AV Calculator.	Dropdown: Yes No
QHP/Non QHP	Indicator if the plan is offered on exchange, off exchange or on both.	Dropdown: On Exchange Off Exchange Both
Notice Required for Pregnancy	Indicator if notice is required for pregnancy.	Dropdown: Yes No
Is a Referral Required for Specialist?	Indicator if a referral is required for specialist visit.	Dropdown: Yes No
Specialist Requiring a Referral	Specialist types for which referrals are required for this plan.	Alphanumeric (including special characters)
Plan Level Exclusions	All plan level exclusions.	Alphanumeric (including special characters)
Limited Cost Sharing Plan Variation - Est Advance Payment	Estimate of the per-member per- month dollar value of the cost-sharing reductions to be provided over the benefit year under limited cost sharing plan variation.	Whole Dollar Amount
Does this plan offer Composite Rating?	Indicates whether plans will be available based on the average enrollee premium amounts of enrollees at the time of enrollment.	Dropdown: Yes No

Field Name	Description	Field Values
Child-Only Offering	Indicator of whether a specific plan will also be offered at a child-only rate or have a corresponding child-only plan. *This field should be 'Allows Adult and Child-Only' if the Level of Coverage is Catastrophic.	Dropdown: Allows Adult and Child-Only Allows Adult-Only Allows Child-Only
Child Only Plan ID	Identifies the associated child-only equivalent Plan ID.	Alphanumeric
Tobacco Wellness Program Offered	Indicates whether the plan offers wellness programs according to Section 2705 of the Public Health Service Act.	Dropdown: Yes No
Disease Management Programs Offered	Indicates whether disease management programs are offered with this plan.	Dropdown: Asthma Heart disease Depression Diabetes High blood pressure & high cholesterol Low back pain Pain management Pregnancy Weight Loss Programs
EHB Percent of Total Premium	Indicates the percentage of the total plan premium that is comprised of EHBs.	Percentage between 0 and up to and including 100%

Table 15 describes the fields in the Stand-Alone Dental Only section of the Benefits Package tab.

Table 15: Health Benefits Package Tab–Stand-Alone Dental Only Section Fields

Field Name	Description	Field Values
EHB Apportionment for Pediatric Dental	Identifies the dollar amount of the expected monthly premium allocated for the Pediatric Dental EHB.	Percentage
Guaranteed vs. Estimated Rate	Indicates if the rate for this SADP is a guaranteed rate or an estimated rate.	Dropdown: Guaranteed Rate Estimated Rate

Table 16 describes the fields in the Plan Dates section of the Benefits Package tab.

Table 16: Health Benefits Package Tab–Plan Dates Section Fields

Field Name	Description	Field Values
Plan Effective Date	Effective date of the plan.	Date
Plan Expiration Date	Date that a plan becomes closed and no longer accepts new enrollments.	Date

Table 17 describes the fields in the Geographic Coverage section of the Benefits Package tab.

Table 17: Health Benefits Package Tab–Geographic Coverage Section Fields

Field Name	Description	Field Values
Out of Country Coverage	Indicates whether care obtained outside the country is covered under the plan.	Dropdown: Yes No
Out of Country Coverage Description	A short description of whether care obtained outside the country is covered under the plan.	Alphanumeric (including special characters)
Out of Service Area Coverage	Indicates whether care obtained outside the service area is covered under the plan.	Dropdown: Yes No
Out of Service Area Coverage Description	A short description of whether care obtained outside the service area is covered under the plan.	Alphanumeric (including special characters)
National Network	Indicates whether a national network is available.	Dropdown: Yes No

Table 18 describes the fields in the Benefit Information section of the Benefits Package tab.

Table 18: Health Benefits Package Tab–Benefit Information Section Fields

Field Name	Description	Field Values
Benefits	Name of the benefit.	N/A
EHB	Indicates if this benefit is an EHB benefit.	N/A

Table 19 describes the fields in the General Information section of the Benefits Package tab.

Table 19: Health Benefits Package Tab–General Information Section Fields

Field Name	Description	Field Values
Is this Benefit Covered?	Indicates if this benefit is covered or not covered.	Dropdown: Covered Not Covered (or blank)

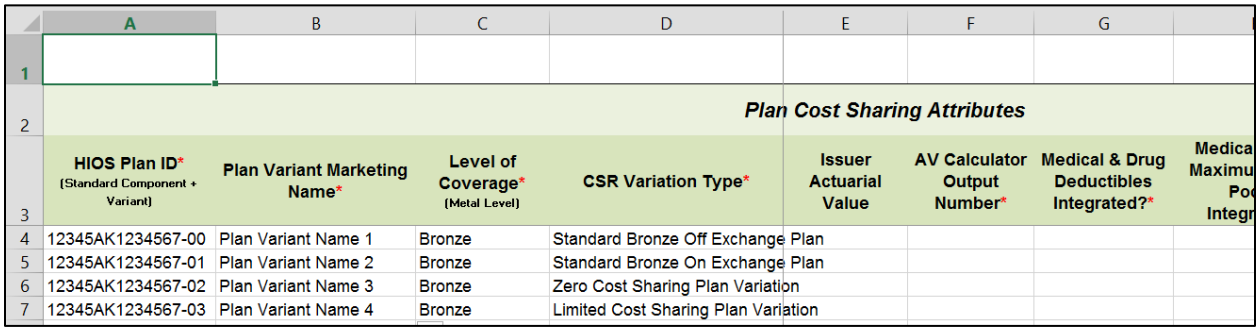
Field Name	Description	Field Values
Quantitative Limit on Service	Indicates if there are quantitative limits on this benefit.	Dropdown: Yes No (or blank)
Limit Quantity	Indicates any quantitative limits on this benefit (e.g., number of days or visit limits).	Whole Number
Limit Unit	Indicates unit of those limits.	Popup: First Category Visit(s) Dollars Exam(s) Days Item(s) Months Treatment(s) Procedure(s) Hours Admission(s) Second Category Year Benefit Period Lifetime Month Episode Stay Transplant 6 Months 2 Years 3 Years Procedure Week Admission
Exclusions	List of exclusions if services or diagnoses are excluded from this plan.	Alphanumeric (including special characters)
Benefit Explanation (text field)	Free text field to list any notes on the Benefit	Alphanumeric (including special characters)
EHB Variance Reason	Reason that this benefit varies from EHB.	Dropdown: Not EHB Substituted Substantially Equal Using Alternate Benchmark Other Law/Regulation Additional EHB Benefit Dental Only Plan Available

Table 20 describes the fields in the Deductibles and Out of Pocket Exceptions section of the Benefits Package tab.

Table 20: Health Benefits Package Tab–Deductibles and Out of Pocket Exceptions Section Fields

Field Name	Description	Field Values
Excluded from In Network MOOP	Indicates if this benefit is excluded from the in network MOOP	Dropdown: Yes No
Excluded from Out of Network MOOP	Indicates if this benefit is excluded from the out of network MOOP	Dropdown: Yes No

Figure 30 shows the CSV tab of the Plans & Benefits Template.



	A	B	C	D	E	F	G
1							
2					*Plan Cost Sharing Attributes*		
3	**HIOS Plan ID*** (Standard Component + Variant)	**Plan Variant Marketing Name***	**Level of Coverage*** (Metal Level)	**CSR Variation Type***	**Issuer Actuarial Value**	**AV Calculator Output Number***	**Medical & Drug Deductibles Integrated?***
4	12345AK1234567-00	Plan Variant Name 1	Bronze	Standard Bronze Off Exchange Plan			
5	12345AK1234567-01	Plan Variant Name 2	Bronze	Standard Bronze On Exchange Plan			
6	12345AK1234567-02	Plan Variant Name 3	Bronze	Zero Cost Sharing Plan Variation			
7	12345AK1234567-03	Plan Variant Name 4	Bronze	Limited Cost Sharing Plan Variation			

Figure 30: Health Plans & Benefits Template–CSV Tab

Table 21 describes the fields in the CSV tab of the Plans & Benefits Template.

Table 21: Health Plans & Benefits Template–CSV Tab Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component + Variant)	HIOS generated unique Standard Component ID with suffixes automatically added depending on the plan variation.	Copied over from the Benefits Package sheet, with suffixes added.
Plan Variant Marketing Name	Name of each plan.	Alphanumeric (copied over from the Benefits Package sheet)
Level of Coverage (Metal Level)	Pre-populated with metal level from designated plan.	Copied over from the Benefits Package sheet.

Field Name	Description	Field Values
CSR Variation Type	The Cost Share Reduction (CSR) Variance level of the plan.	Auto-Populated (varies by proposed metal level): 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 Standard Bronze On Exchange Standard Bronze Off Exchange Standard Silver On Exchange Standard Silver Off Exchange Standard Gold On Exchange Standard Gold Off Exchange Standard Platinum On Exchange Standard Platinum Off Exchange
Issuer Actuarial Value	Issuer calculated AV.	Percentage
AV Calculator Output Number	The AV of this plan as calculated by the AV Calculator.	Percentage
Medical & Drug Deductibles Integrated?	Indicates if this plan design has an integrated medical and drug deductible. Based on the selection, certain fields will be disabled.	Dropdown: Yes No
Medical & Drug Maximum Out-Of-Pocket Integrated?	Indicates if this plan design has an integrated medical and drug out of pocket maximum. Based on the selection, certain fields will be disabled.	Dropdown: Yes No
Multiple In Network Tiers?	Indicates if this plan uses multiple in-network provider tiers.	Dropdown: Yes No
1st Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 1 for plans with multiple in network tiers.	Percentage
2nd Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 2 for plans with multiple in network tiers.	Percentage

Table 22 describes the fields in the SBC Scenario section of the CSV tab.

Table 22: Health CSV Tab–SBC Scenario Section Fields

Field Name	Description	Field Values
Having a Baby - Deductible	Estimated deductible for the SBC scenario “Having a baby”.	Whole Dollar Amount
Having a Baby - Copayment	Estimated copayment for the SBC scenario “Having a baby”.	Whole Dollar Amount

Field Name	Description	Field Values
Having a Baby - Coinsurance	Estimated coinsurance for the SBC scenario "Having a baby."	Whole Dollar Amount
Having a Baby - Limit	Estimated Limit dollar amount for the SBC scenario "Having a baby."	Whole Dollar Amount
Having Diabetes - Deductible	Estimated deductible for the SBC scenario "Having Diabetes."	Whole Dollar Amount
Having Diabetes - Copayment	Estimated copayment for the SBC scenario "Having Diabetes."	Whole Dollar Amount
Having Diabetes - Coinsurance	Estimated coinsurance for the SBC scenario "Having Diabetes."	Whole Dollar Amount
Having Diabetes - Limit	Estimated Limit dollar amount for the SBC scenario "Having Diabetes."	Whole Dollar Amount
Treatment of a Simple Fracture - Deductible	Estimated deductible for the SBC scenario "Treatment of a Simple Fracture."	Whole Dollar Amount
Treatment of a Simple Fracture - Copayment	Estimated copayment for the SBC scenario "Treatment of a Simple Fracture."	Whole Dollar Amount
Treatment of a Simple Fracture - Coinsurance	Estimated coinsurance for the SBC scenario "Treatment of a Simple Fracture."	Whole Dollar Amount
Treatment of a Simple Fracture - Limit	Estimated Limit dollar amount for the SBC scenario "Treatment of a Simple Fracture."	Whole Dollar Amount

Table 23 describes the fields in the MOOP for Medical EHB Benefits section of the CSV tab.

Table 23: Health CSV Tab–MOOP for Medical EHB Benefits Section Fields

Field Name	Description	Field Values
In Network - Individual	The Maximum Out-Of-Pocket for Medical EHB Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The MOOP for Medical EHB Benefits In Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	The MOOP for Medical EHB Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The MOOP for Medical EHB Benefits In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Field Name	Description	Field Values
Out of Network - Individual	The MOOP for Medical EHB Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The MOOP for Medical EHB Benefits Out of Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The MOOP for Medical EHB Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The MOOP for Medical EHB Benefits Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 24 describes the fields in the MOOP for Drug EHB section of the CSV tab.

Table 24: Health CSV Tab–MOOP for Drug EHB Section Fields

Field Name	Description	Field Values
In Network - Individual	The MOOP for Drug EHB Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The MOOP for Drug EHB Benefits In Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	The MOOP for Drug EHB Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The MOOP for Drug EHB Benefits In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The MOOP for Drug EHB Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The MOOP for Drug EHB Benefits Out of Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Field Name	Description	Field Values
Combined In/Out of Network - Individual	The MOOP for Drug EHB Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The MOOP for Drug EHB Benefits Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 25 describes the fields in the MOOP for Medical and Drug EHB Benefits (Total) section of the CSV tab.

Table 25: Health CSV Tab–MOOP for Medical and Drug EHB Benefits (Total) Section Fields

Field Name	Description	Field Values
In Network - Individual	The MOOP for Medical and Drug EHB Benefits (Total) In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The MOOP for Medical and Drug EHB Benefits (Total) In Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	The MOOP for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The MOOP for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The MOOP for Medical and Drug EHB Benefits (Total) Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The MOOP for Medical and Drug EHB Benefits (Total) Out of Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The MOOP for Medical and Drug EHB Benefits (Total) Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The MOOP for Medical and Drug EHB Benefits (Total) Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 26 describes the fields in the Medical EHB Deductible section of the CSV tab.

Table 26: Health CSV Tab–Medical EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Medical EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Medical EHB Deductible - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Medical EHB Default Coinsurance In Network (Tier 1)	The Medical EHB default Coinsurance for In Network Tier 1.	Percentage
In Network Tier 2 - Individual	The Medical EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Medical EHB Deductible - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Medical EHB Default Coinsurance In Network (Tier 2)	The Medical EHB Default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Medical EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Medical EHB Deductible - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The Medical EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Medical EHB Deductible - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 27 describes the fields in the Drug EHB Deductible section of the CSV tab.

Table 27: Health CSV Tab–Drug EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Drug EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Drug EHB Deductible - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Drug EHB Default Coinsurance In Network (Tier 1)	The Drug EHB default Coinsurance for In Network Tier 1.	Percentage
In Network Tier 2 - Individual	The Drug EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Drug EHB Deductible - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Drug EHB Default Coinsurance In Network (Tier 2)	The Drug EHB default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Drug EHB Deductible - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 28 describes the fields in the Combined Medical and Drug EHB Deductible section of the CSV tab.

Table 28: Health CSV Tab–Combined Medical and Drug EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Combined Medical and Drug EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Combined Medical and Drug EHB Deductible - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined Medical and Drug EHB Default Coinsurance In Network (Tier 1)	The Combined Medical and Drug EHB default Coinsurance for In Network.	Percentage
In Network Tier 2 - Individual	The Combined Medical and Drug EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Combined Medical and Drug EHB Deductible - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined Medical and Drug EHB Default Coinsurance In Network (Tier 2)	The Combined Medical Drug EHB Default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Combined Medical Drug EHB Deductible - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The Combined Medical Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 29 describes the fields in the Health Savings Account (HSA)/Health Reimbursement Account (HRA) Detail section of the CSV tab.

Table 29: Health CSV Tab–HSA/HRA Details

Field Name	Description	Field Values
HSA - Eligible	Indicates if this plan meets all the requirements to be a HSA-qualified high deductible health plan.	Dropdown: Yes No (default)
HSA/HRA Employer Contribution	Indicates if this plan has a HSA/HRA employer contribution. Applies to SHOP only.	Dropdown: Yes No
HSA/HRA Employer Contribution Amount	Dollar amount of HSA/HRA employer contribution. Applies to SHOP only.	Whole Dollar Amount

Table 30 describes the fields in the AV Calculator section of the Benefits Package tab.

Table 30: Health Benefits Package Tab–AV Calculator Section Fields

Field Name	Description	Field Values
Maximum Coinsurance for Specialty Drugs	Indicates if there is a limit on the amount of coinsurance on specialty prescription drugs by capping the maximum coinsurance payment on specialty drugs at a set amount.	Whole Dollar Amount
Maximum Number of Days for Charging Inpatient Copay?	Indicates if there is a limit on the number of days on which a patient can be charged copay for an inpatient stay, if inpatient copays are charged per day.	Whole Number
Begin Primary Care Cost-Sharing After a Set Number of Visits?	Indicates if primary care cost sharing begins after a certain number of (fully covered) visits have occurred.	Whole Number
Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?	Indicates when to begin subjecting primary care visits to the deductible or coinsurance rates only after a certain number of primary care visits with copay have occurred.	Whole Number

Table 31 describes the fields in the Other Deductible (User Defined) section of the CSV tab.

Table 31: Health CSV Tab–Other Deductible (User Defined) Section Fields

Field Name	Description	Field Values
In Network - Individual	Other Deductible (user defined) - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	Other Deductible (user defined) - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	Other Deductible (user defined) - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	Other Deductible (user defined) - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	Other Deductible (user defined) - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	Other Deductible (user defined) - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	Other Deductible (user defined) - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 32 describes the fields in the Each Covered Benefit section of the CSV tab.

Table 32: Health CSV Tab–Each Covered Benefit Section Fields

Field Name	Description	Field Values
Copay - In Network (Tier 1)	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Stay $X Copay per Stay with deductible $X Copay per Stay after deductible $X Copay per Day $X Copay per Day with deductible $X Copay per Day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** the options in both lists above will be available.

Field Name	Description	Field Values
Copay - In Network (Tier 2)	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Stay $X Copay per Stay with deductible $X Copay per Stay after deductible $X Copay per Day $X Copay per Day with deductible $X Copay per Day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** the options in both lists above will be available.

Field Name	Description	Field Values
Copay - Out of Network	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay with deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Stay $X Copay per Stay with deductible $X Copay per Stay after deductible $X Copay per Day $X Copay per Day with deductible $X Copay per Day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** the options in both lists above will be available.
Coinsurance - In Network (Tier 1)	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable
Coinsurance - In Network (Tier 2)	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable
Coinsurance - Out of Network	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% X% Coinsurance after deductible Not Applicable

Figure 31 shows the SADP Benefits Package tab of the Plans & Benefits Template.

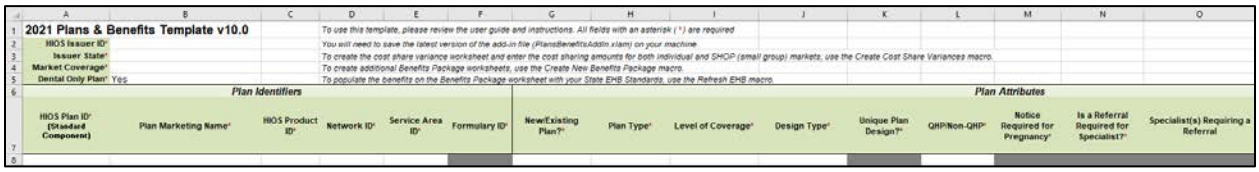


Figure 31: Plans & Benefits Template–SADP Benefits Package Tab

Table 33 describes the fields in the SADP Benefits Package tab of the Plans & Benefits Template.

Table 33: Plans & Benefits Template–SADP Benefits Package Tab Fields

Field Name	Description	Field Values
HIOS Issuer ID	HIOS Issuer ID	Numeric
Issuer State	State Abbreviation	Dropdown: State Abbreviations + Territories
Market Coverage Type	Market coverage, individual or SHOP, for the entire benefit package/template.	Dropdown: SHOP Individual
Dental Only Plan	Indicator if the plans offered in this benefit package are for stand-alone dental only (not medical).	Dropdown: Yes No

Table 34 describes the fields in the Plan Identifiers section of the SADP Benefits Package tab.

Table 34: SADP Benefits Package Tab–Plan Identifiers Section Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component)	HIOS generated number assigned to a specific proposed QHP.	Alphanumeric
Plan Marketing Name	Name of each plan.	Alphanumeric (including special characters)
HIOS Product ID	The HIOS Product ID associated with each proposed Exchange plan.	Alphanumeric
Network ID	The Network ID for this plan from the Network ID template.	Dropdown: List of values will be imported in from the Network Template by user
Service Area ID	The Service Area ID for this plan from the Service Area template.	Dropdown: List of values will be imported in from the Service Area Template by user

Table 35 describes the fields in the Plan Attributes section of the SADP Benefits Package tab.

Table 35: SADP Benefits Package Tab–Plan Attributes Section Fields

Field Name	Description	Field Values
New/Existing Plan	Indicates whether the plan is new or existing.	Dropdown: New Plan Existing Plan
Plan Type	Network design for the product: indemnity, preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO).	Dropdown: Indemnity PPO HMO POS EPO
Level of Coverage	Coverage level for a specific proposed plan (High, Low)	Dropdown: High Low
QHP/Non QHP	Indicator if the plan is offered on exchange, off exchange or on both.	Dropdown: On Exchange Off Exchange Both
Plan Level Exclusions	List all plan level exclusions.	Alphanumeric (including special characters)
Child-Only Offering	Indicates whether the plan is child-only.	Dropdown: Allows Adult and Child-Only Allows Adult-Only Allows Child-Only
EHB Apportionment for Pediatric Dental	Dollar amount of monthly premium that is for EHB benefits only.	Percentage
Guaranteed vs. Estimated Rate	Indicates whether rate for this SADP is guaranteed or estimated.	Dropdown: Guaranteed Rate Estimated Rate

Table 36 describes the fields in the Plan Dates section of the SADP Benefits Package tab.

Table 36: SADP Benefits Package Tab–Plan Dates Section Fields

Field Name	Description	Field Values
Plan Effective Date	Effective date of the plan.	Date
Plan Expiration Date	Date that a plan becomes closed and no longer accepts new enrollments.	Date

Table 37 describes the fields in the Geographic Coverage section of the SADP Benefits Package tab.

Table 37: SADP Benefits Package Tab–Geographic Coverage Section Fields

Field Name	Description	Field Values
Out of Country Coverage	Indicates whether care obtained outside the country is covered under the plan.	Dropdown: Yes No
Out of Country Coverage Description	A short description of whether care obtained outside the country is covered under the plan.	Alphanumeric (including special characters)
Out of Service Area Coverage	Indicates whether care obtained outside the service area is covered under the plan.	Dropdown: Yes No
Out of Service Area Coverage Description	A short description of whether care obtained outside the service area is covered under the plan.	Alphanumeric (including special characters)
National Network	Indicates whether a national network is available.	Dropdown: Yes No

Table 38 describes the fields in the Benefit Information section of the Benefits Package tab.

Table 38: SADP Benefits Package Tab–Benefit Information Section Fields

Field Name	Description	Field Values
Benefits	Name of the benefit.	N/A
EHB	Indicates if this benefit is an EHB benefit.	N/A

Table 39 describes the fields in the General Information section of the Benefits Package tab.

Table 39: SADP Benefits Package Tab–General Information Section Fields

Field Name	Description	Field Values
Is this Benefit Covered?	Indicates if this benefit is covered or not covered.	Dropdown: Covered Not Covered (or blank)
Quantitative Limit on Service	Indicates if there are quantitative limits on this benefit.	Dropdown: Yes No (or blank)
Limit Quantity	Indicates any quantitative limits on the benefit (e.g., number of days or visit limits).	Whole Number

Field Name	Description	Field Values
Limit Unit	Indicates unit of those limits.	Popup: First Category Visit(s) Dollars Exam(s) Days Item(s) Months Treatment(s) Procedure(s) Hours Admission(s) Second Category Year Benefit Period Lifetime Month Episode Stay Transplant 6 Months 2 Years 3 Years Procedure Week Admission
Exclusions	Lists the exclusions if services or diagnoses are excluded from this plan.	Alphanumeric (including special characters)
Benefit Explanation (text field)	Free text field to list any notes explaining this.	Alphanumeric (including special characters)
EHB Variance Reason	Reason that this benefit varies from EHB.	Dropdown: Not EHB Substituted Substantially Equal Using Alternate Benchmark Other Law/Regulation Additional EHB Benefit Dental Only Plan Available

Table 40 describes the fields in the Deductibles and Out of Pocket Exceptions section of the Benefits Package tab.

Table 40: SADP Benefits Package Tab–Deductibles and Out of Pocket Exceptions Section Fields

Field Name	Description	Field Values
Subject to Deductible (Tier 1)	Indicates if this benefit is subject to deductible for Tier 1.	Dropdown: Yes No
Subject to Deductible (Tier 2)	Indicates if this benefit is subject to deductible for Tier 2.	Dropdown: Yes No
Excluded from In Network MOOP	Indicates if this benefit is excluded from the in network Maximum Out-Of-Pocket.	Dropdown: Yes No
Excluded from Out of Network MOOP	Indicates if this benefit is excluded from the out of network Maximum Out-Of-Pocket?	Dropdown: Yes No

Figure 32 shows the CSV tab of the SADP Plans & Benefits Template.

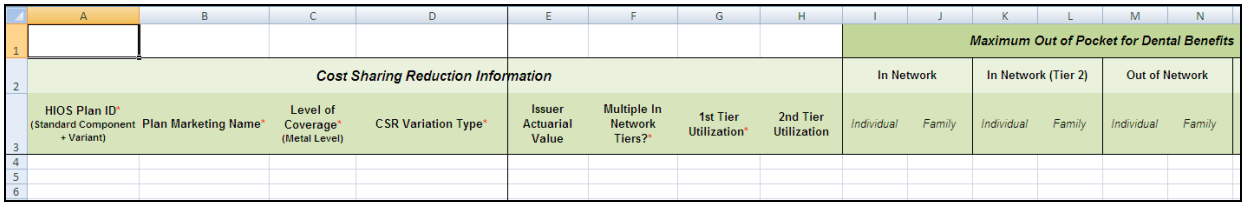


Figure 32: SADP Plan & Benefits Template–CSV Tab

Table 41 describes the fields in the CSV tab of the Plans & Benefits Template.

Table 41: SADP Plans & Benefits Template–CSV Tab Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component + Variant)	HIOS generated unique Standard Component ID with suffixes automatically added depending on the plan variation.	Copied over from the Benefits Package sheet, with suffixes added.
Plan Variant Marketing Name	Name of each plan.	Alphanumeric (copied over from the Benefits Package sheet)
Level of Coverage (Metal Level)	Pre-populated with metal level from designated plan.	Copied over from the Benefits Package sheet.
CSR Variation Type	The Cost Share Reduction Variance level of the plan.	Auto-Populated (varies by proposed metal level): Standard On Exchange Standard Off Exchange
Issuer Actuarial Value	Issuer calculated AV, optional for SADPs. NOTE: If an AV is provided for SADPs, it must be within the range for the applicable Level of Coverage.	Percentage
Multiple In Network Tiers?	Indicates if this plan uses multiple in-network provider tiers.	Dropdown: Yes No
1st Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 1 for plans with multiple in network tiers.	Percentage
2nd Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 2 for plans with multiple in network tiers.	Percentage

Table 42 describes the fields in the MOOP for Dental Benefits section of the CSV tab.

Table 42: SADP CSV Tab–MOOP for Dental Benefits Section Fields

Field Name	Description	Field Values
In Network - Individual	The MOOP for Dental Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The MOOP for Dental Benefits In Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	The MOOP for Dental Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
In Network Tier 2 - Family	The MOOP for Dental Benefits In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The MOOP for Dental Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The MOOP for Dental Benefits Out of Network Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The MOOP for Dental Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The MOOP for Dental Benefits Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 43 describes the fields in the Dental Deductible for Dental Benefits section of the CSV tab.

Table 43: SADP CSV Tab–Dental Benefit Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Dental Benefit Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Dental Benefit Deductible - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	The Dental Benefit Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Dental Benefit Deductible - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The Dental Benefit - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
Out of Network - Family	The Combined Medical Drug EHB Deductible - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	The Combined Medical Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

Table 44 describes the fields in the Other Deductible section of the CSV tab.

Table 44: SADP CSV Tab–Other Deductible (User Defined) Section Fields

Field Name	Description	Field Values
In Network - Individual	Other Deductible (user defined) - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	Other Deductible (user defined) - In Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
In Network Tier 2 - Individual	Other Deductible (user defined) - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	Other Deductible (user defined) - In Network Tier 2 - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Out of Network - Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	Other Deductible (user defined) - Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group
Combined In/Out of Network - Individual	Other Deductible (user defined) - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
Combined In/Out of Network - Family	Other Deductible (user defined) - Combined In/Out of Network - Family dollar amount.	Pop-up: $X per person Not Applicable per person $X per group Not Applicable per group

6 Template Error Reports

The Benefits & Service Area module may produce "Failed" reports for any of the five templates, if the templates do not pass back-end validation. The user must download the report(s) and correct the errors listed in the report(s) before successfully re-submitting the template.

NOTE: The error reports displayed below are samples. It is not a comprehensive list of all the possible errors.

6.1 Network Template Failed Report

Figure 33 shows a sample Network Template Failed Report.

	A
1	HIOS Issuer ID 1234 - Invalid HIOS Issuer ID (Networks - B6)
2	Issuer State MD - Invalid Issuer State (Networks - B7)

Figure 33: Network Template Failed Report

6.2 Service Area Template Failed Report

Figure 34 shows a sample Service Area Template Failed Report.

	A
1	HIOS Issuer ID 1234 - Invalid HIOS Issuer ID (Service Areas - B6)
2	Issuer State MD - Invalid Issuer State (Service Areas - B7)

Figure 34: Service Area Template Failed Report

6.3 Prescription Drug Template Failed Report

Figure 35 shows a sample Prescription Drug Template Failed Report.

	A
1	HIOS Issuer ID 1234 - Invalid HIOS Issuer ID (Formulary Tiers - B6)
2	Issuer State VA - Invalid Issuer State (Formulary Tiers - B7)

Figure 35: Prescription Drug Template Failed Report

6.4 Plans & Benefits Template Failed Report

Figure 36 shows a sample Plans & Benefits Template Failed Report.

	A	B	C	D	E
1	Field Name	Field Value	Error Message	Field Location	
2	Plan Effective Date	TESTING	Plan Effective Date is Invalid.	(Benefits Package 1-AA9)	
3					

Figure 36: Plans & Benefits Template Failed Report

7 Troubleshooting and Support

7.1 Error Messages

Table 45 provides a list of error messages in the Benefits Module of the Plan Management system.

Table 45: Plan Management System Error Messages

Error Message	Corrective Action
The selected Issuer is located in a state that performs plan management functions.	The user should submit QHP data through SERFF, after which the state will transfer the application data to HIOS.
Error: An application currently exists for this Issuer.	Select the Issuer from the Resume Existing Submission table on the Submitter Summary page.
Please correct the following errors.	Upload the required templates listed out in the error message on the Submitter Benefits & Service Area page.
The validation for this section is incomplete. Please answer the validation question.	The user should answer the validation question by selecting Yes or No and then selecting ***Submit***, on the Validator Benefits & Service Area page.
There were errors identified during cross-validation between the templates. Please download the error report below for details.	The user should download/review the error report and coordinate with users from other modules to resolve discrepancies within the application.
Invalid Template version uploaded. Please upload the current template version. Check with the CMS helpdesk for directions on how to access the correct versions of the templates.	The user will receive this error message when uploading an invalid template year version. The user should verify the uploaded template is from the current plan year.
Save Failed, please retry in a few minutes. If the error persists, please contact the CMS Helpdesk	The user will receive this error message if a system issue occurred. The user should retry uploading their document.

7.2 Support

Table 46 provides details to contact the Help Desk should users require further assistance

Table 46: Points of Contact

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

Appendix A: Acronyms and Abbreviations

Table 47 provides a list of acronyms used in this document.

Table 47: Acronyms and Abbreviations

Acronym / Abbreviation	Definition
AV	Actuarial Value
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CSR	Cost Sharing Reduction
EHB	Essential Health Benefit
EPO	Exclusive Provider Organization
FFE	Federally-facilitated Exchange
HHS	Health & Human Services
HIOS	Health Insurance Oversight System
HMO	Health Maintenance Organization
HRA	Health Reimbursement Account
HSA	Health Savings Account
PM	Plan Management
POS	Point-of-Service Plan
PPO	Preferred Provider Organization
MOOP	Maximum Out-Of-Pocket
MSD	Marketplace Service Desk
QHP	Qualified Health Plan
RxCUI	RxNorm Concept Unique Identifier (US NIH; drug standardization)
SADP	Stand-Alone Dental Plan
SHOP	Small Business Health Options Program
TIN	Tax Identification Number
UI	User Interface
URL	Uniform Resource Locator
XML	Extensible Markup Language

Appendix B: Glossary

Table 48 provides a list of terms/phrases used in this document.

Table 48: Glossary

Term/Phrase	Definition
Issuer	A participating insurance organization that provides insurance for an individual or family.
User	An individual who accesses the application. A user of the Benefits & Service Area Module will be a Submitter or Validator. A user's access is controlled by assigned roles and entitlements (responsibilities).

Appendix C: Enabling Macros in Microsoft Excel

To properly view and use the Excel templates for the QHP Application macros need to be enabled. It is recommended that the user enable macros before downloading any template.

1. From the File button in the top left corner, choose ***Options***

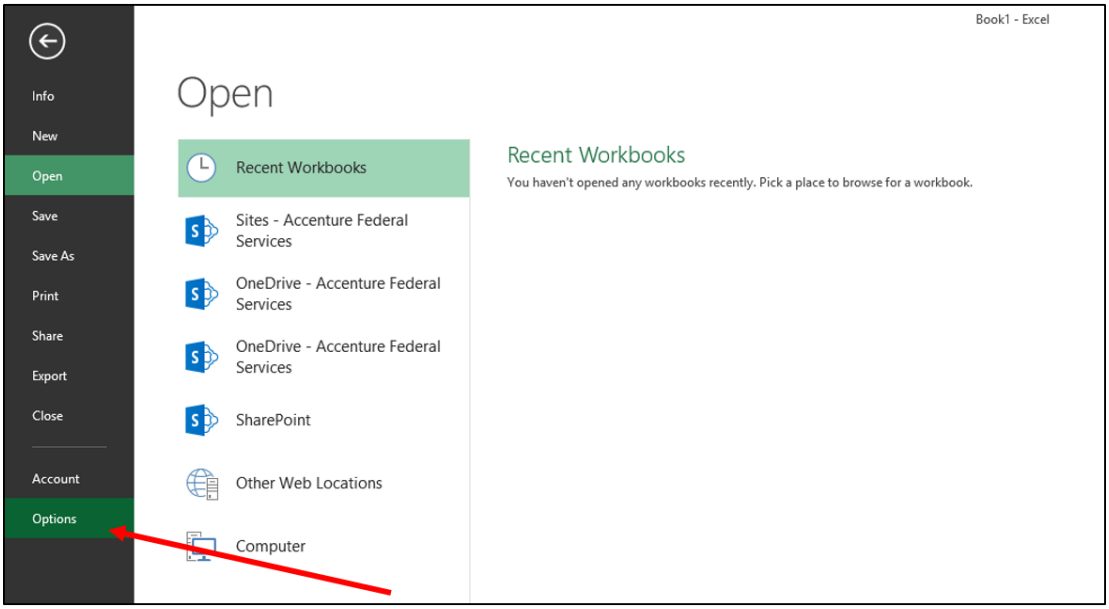


Figure 37: Choosing Excel Options

2. Select ***Trust Center***

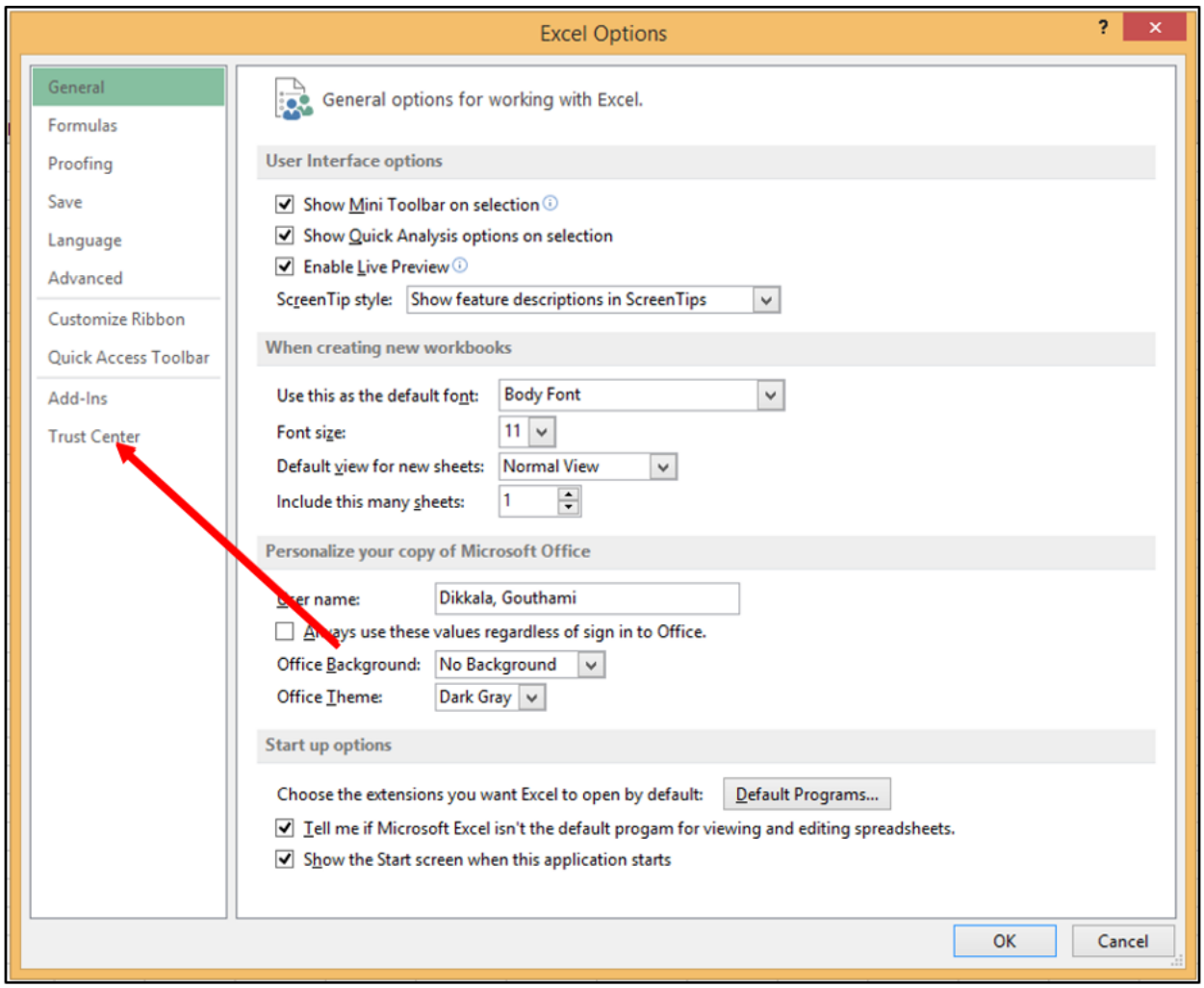


Figure 38: Choosing Excel Options

3. Choose ***Trust Center Settings***

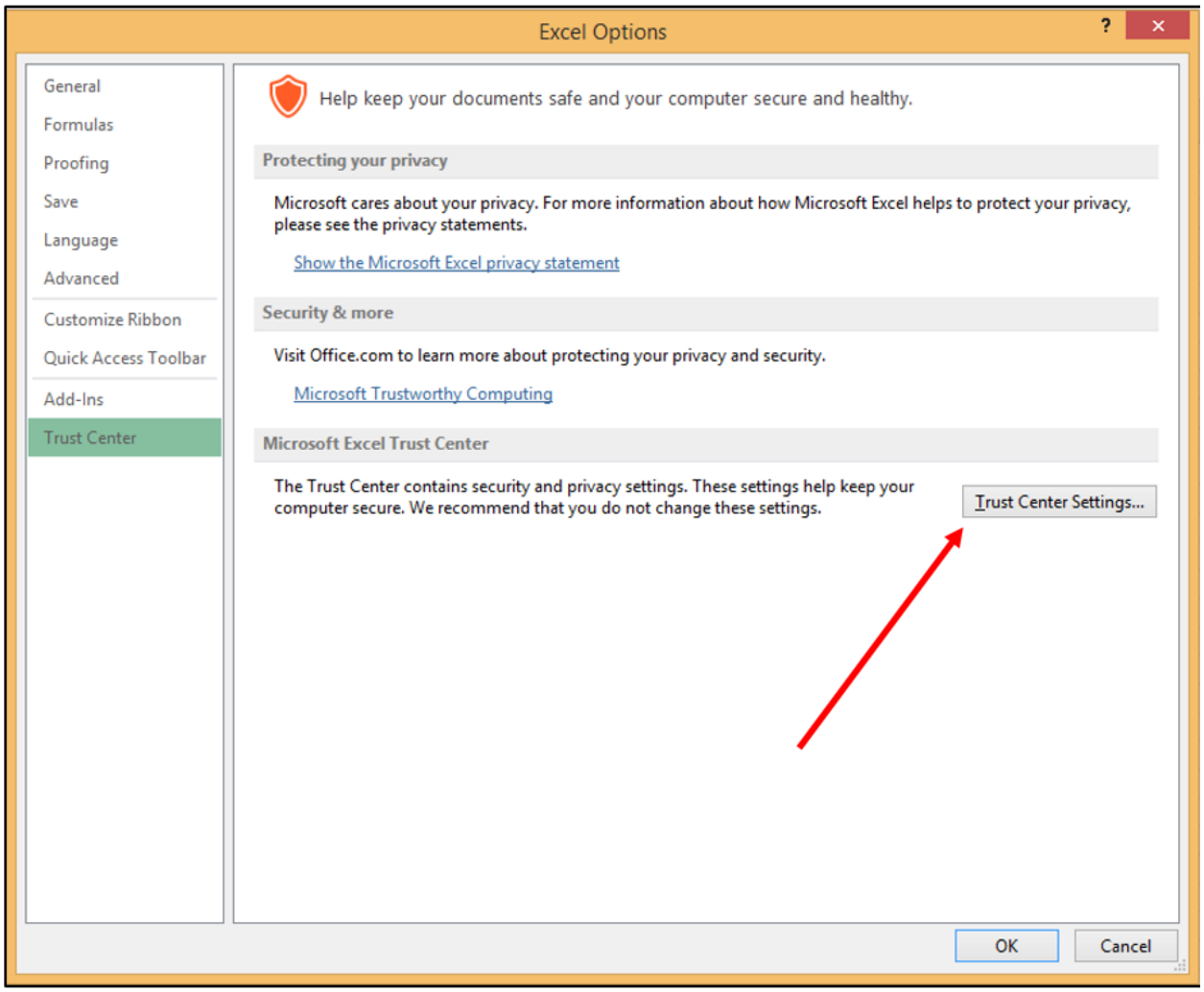


Figure 39: Choosing Trust Center Settings

4. Choose ***Macro Settings***

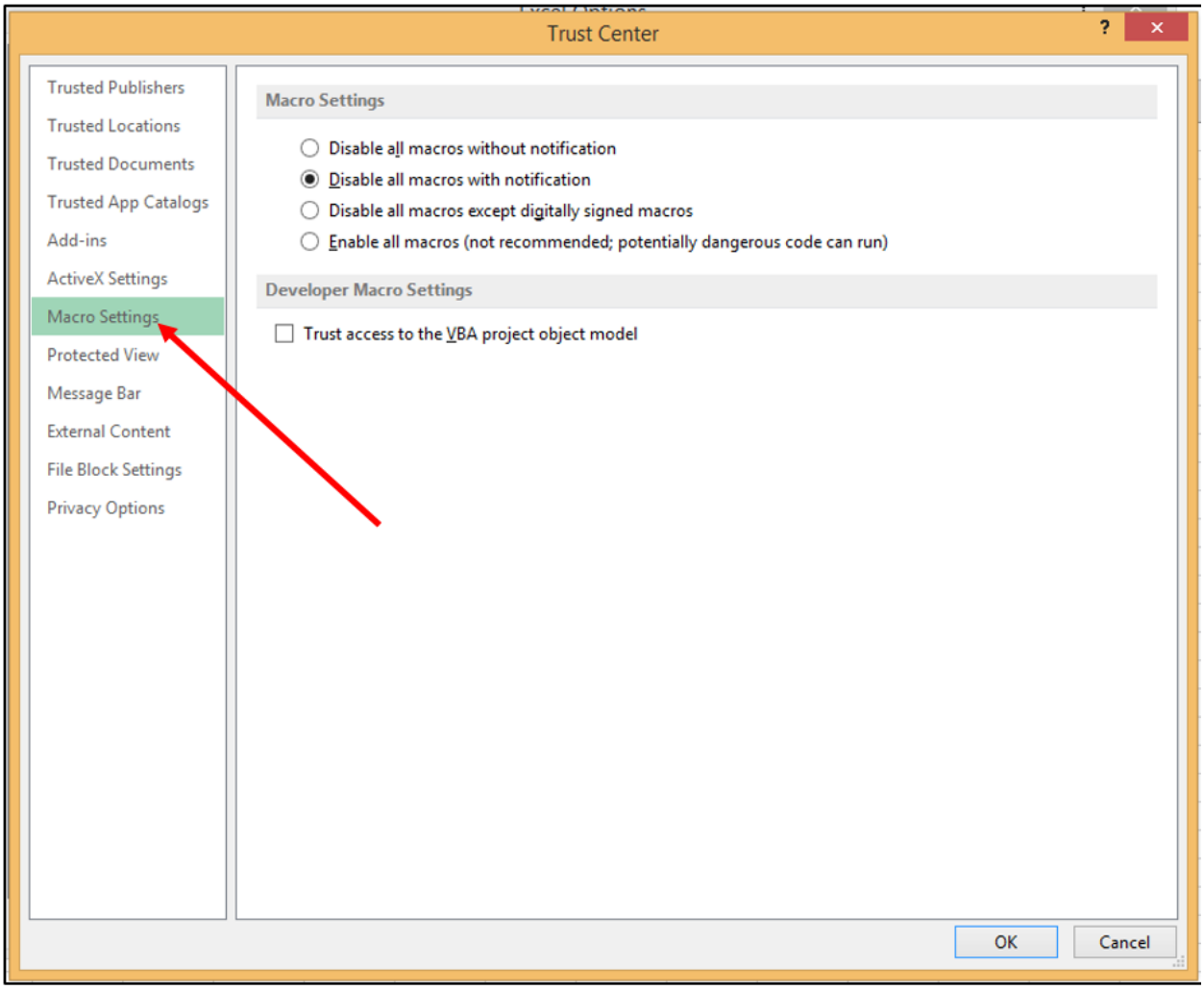


Figure 40: Choosing Macro Settings

5. Choose ***Disable all macros with notification***

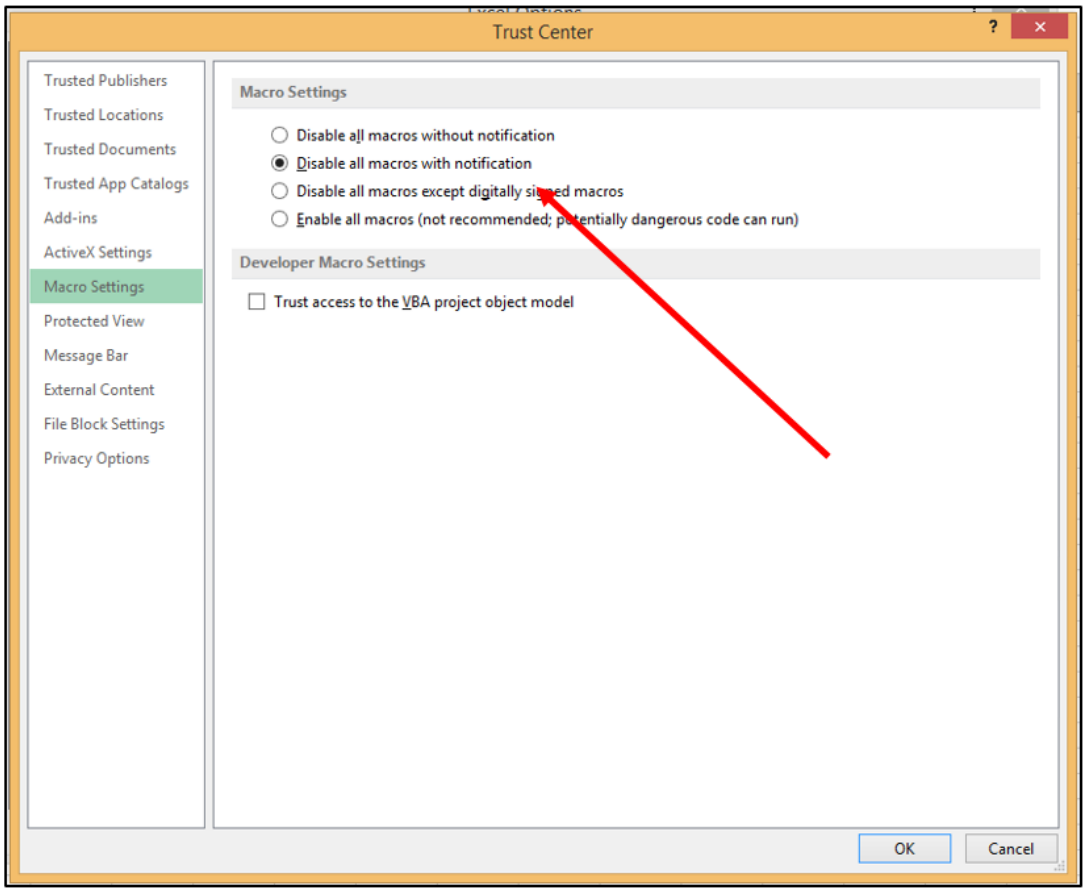


Figure 41: Choosing Disable all macros with notification

6. When opening any of the templates downloaded from the site, the following prompt appears at the top of the spreadsheet. Select ***Enable Content…***

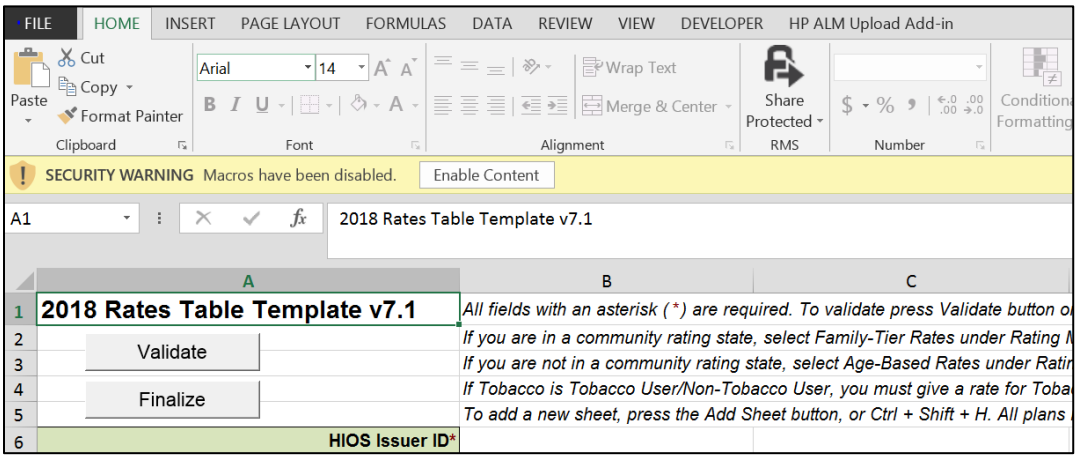


Figure 42: Security Warning on Downloaded Template

7. Macros are now enabled for the open workbook. Repeat step 6 every time a new template is downloaded.

Appendix D: Enabling the Plans & Benefits Add-In File in Excel

To properly view and use the Plans & Benefits Template for the Benefits & Service Area Module, the Plans & Benefits Add-In File needs to be enabled. It is critical that the user delete any previous versions of the Add-In File from their computer (unless explicitly following the guidelines in Appendix C for multi-year template versions) and download and save the most recent version of the Add-In File in the same folder as the Plans & Benefits Template.

Once all prior versions of the Add-In File have been deleted from the user's computer and the most current version of the Add-In File has been saved, open the Plans & Benefits Template.

1. From the File menu shown, select ***Options***.

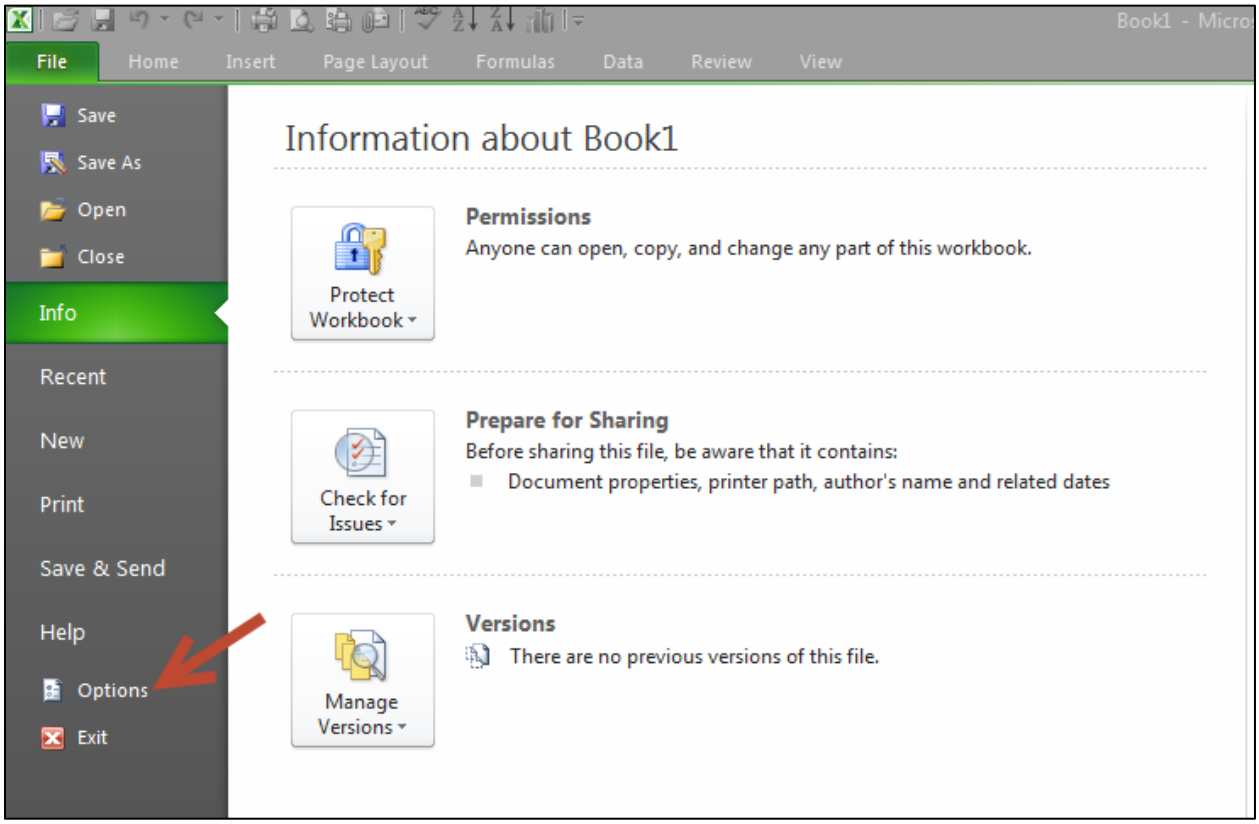


Figure 43: Selecting Excel Options

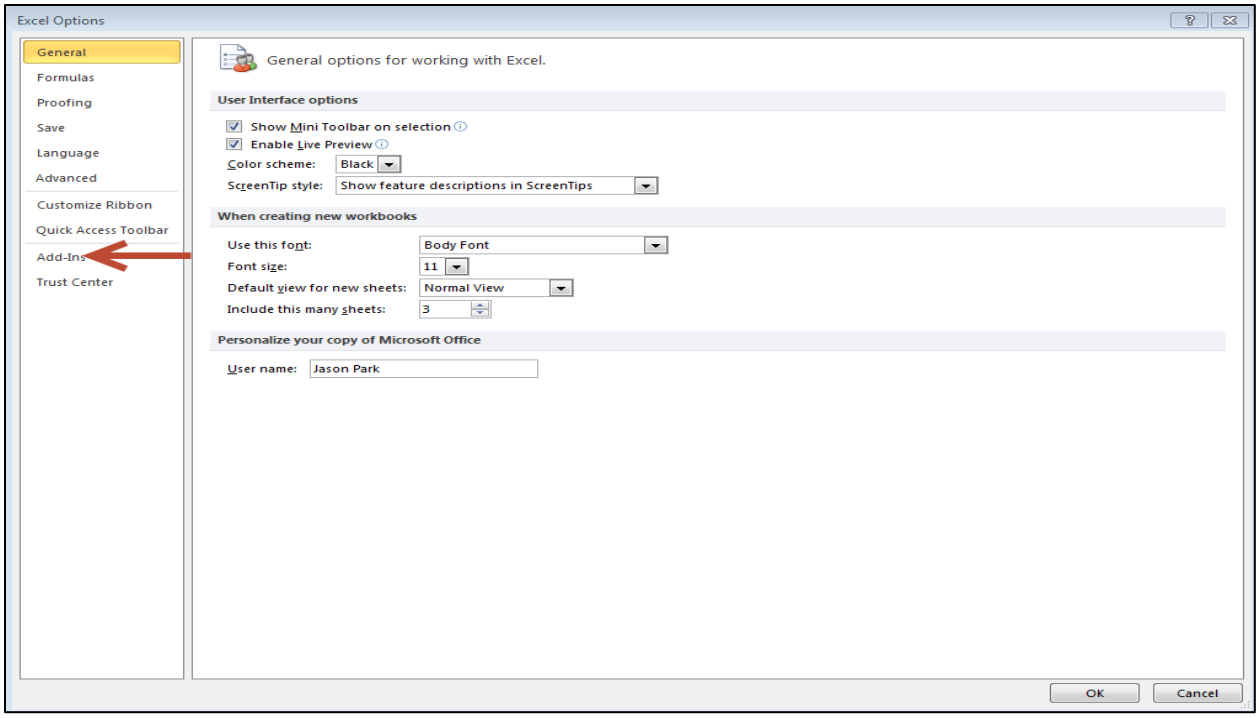


Figure 44: Selecting Add-Ins

2. Select Excel Add-ins and select ***Go***

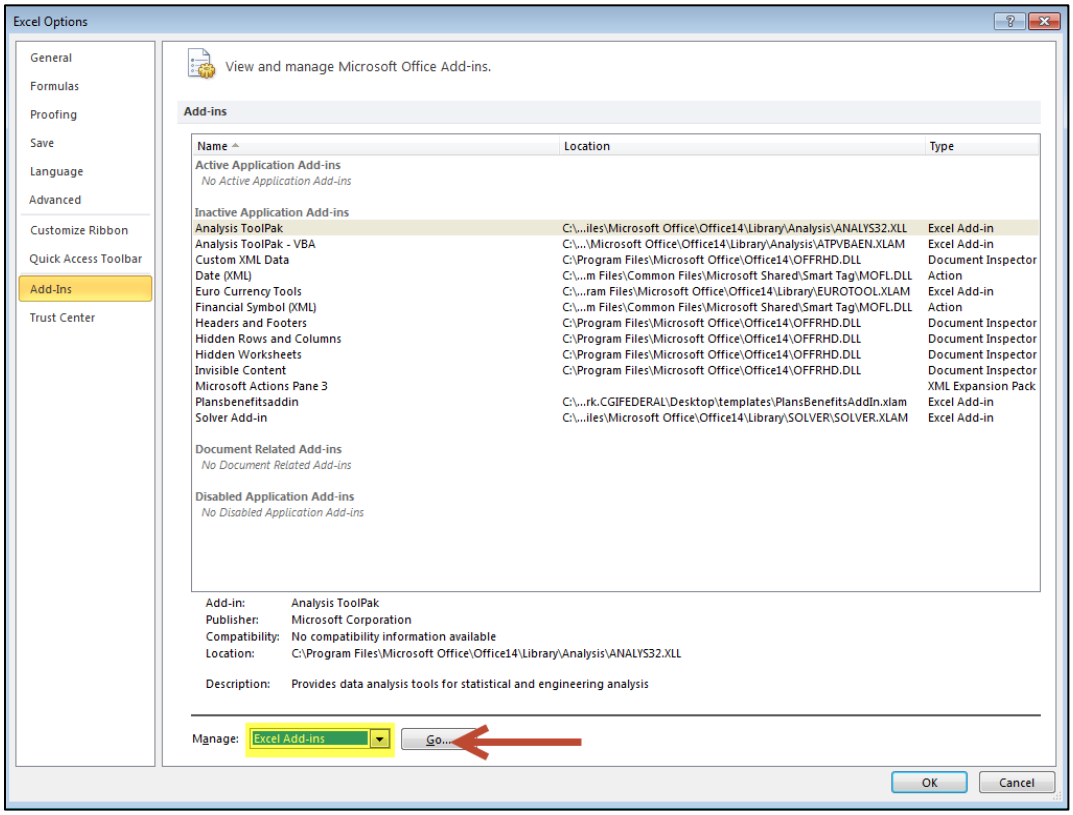


Figure 45: Manage Excel Add-Ins

3. From the Add-Ins pop-up, select ***Browse***

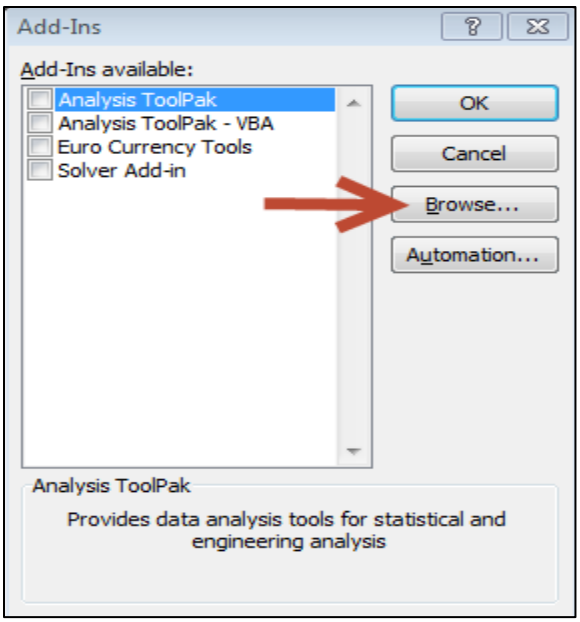


Figure 46: Browse for Add-In File

4. From the file dialog box, find the Add-In File and select ***OK***

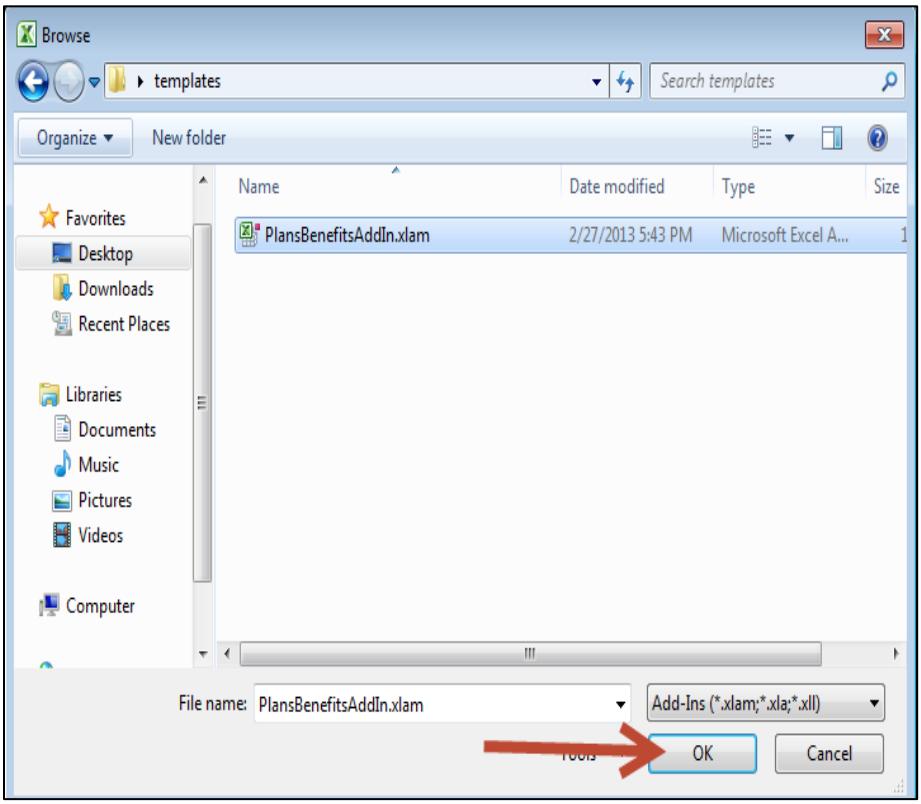


Figure 47: Select Add-In File

5. The Add-In File is now available. Select ***OK***

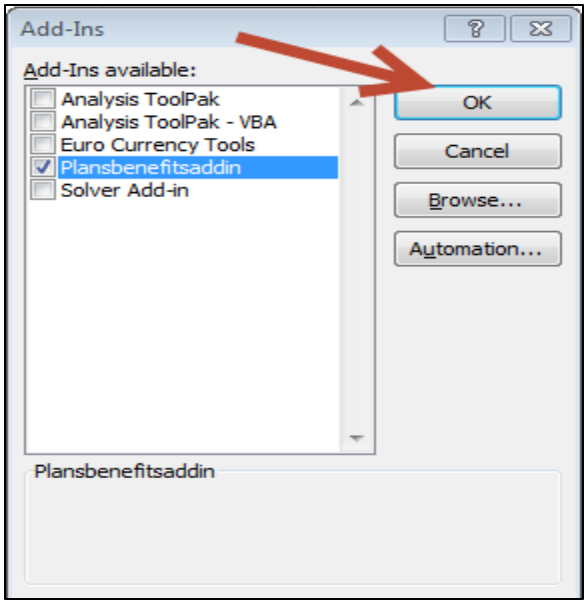


Figure 48: Add-In File Now Available

Appendix E: Working With Dual Template Versions

Issuers may need to work with multiple Plans & Benefits Template versions to complete filing requirements. For example:

- Issuers submitting on-Exchange insurance plans must be submitted through the FFE. The FFE will only accept the Plans & Benefits V10 Template, which is only compatible with the V10 Plans & Benefits Add-In.

The steps here describe submission of both data sets with minimal complications for issuers.

General Guidelines:

- **Add-In File:** It is vitally important to **NOT** rename the PlansBenefitsAddIn File. The Add-In File will not work if it is renamed.
- **Location:** Save the PlansBenefitsAddIn File in the same folder as the Plans & Benefits Template for the macros to run properly. To ensure proper functionality, please download the latest Plans & Benefits Add-In File and AV Calculator into a **separate** folder than any other versions of these tools.
- When working with the Plans & Benefits Template and associated Add-In file, it is very important to close ALL open Excel documents. If ANY Excel documents are left open, the last used PlansBenefitsAddIn will be incorrectly loaded.
- Furthermore, Excel caches the last Add-In File selected, so the correct Add-In File needs to be reloaded whenever the user switches back and forth between the two templates, instructions found in Appendix D.

Detailed Steps:

1. Create two folders on local machine:
    - Plan Year 2020
    - Plan Year 2021
2. Move all downloaded tools related to older Plan Years into the appropriate folder.
    - Plans & Benefits Template V9.0
    - PlansBenefitsAddIn File V9.0
    - Once validated, these versions can be uploaded to RBIS.
3. Download all Plan Year 2021 tools into the appropriate folder.
    - Plans & Benefits Template V10.0
    - PlansBenefitsAddIn File V10.0
    - Once validated, these versions can be uploaded to HIOS.

Once appropriately linked, the corresponding Add-In file version will display on the associated template. See screenshots below.

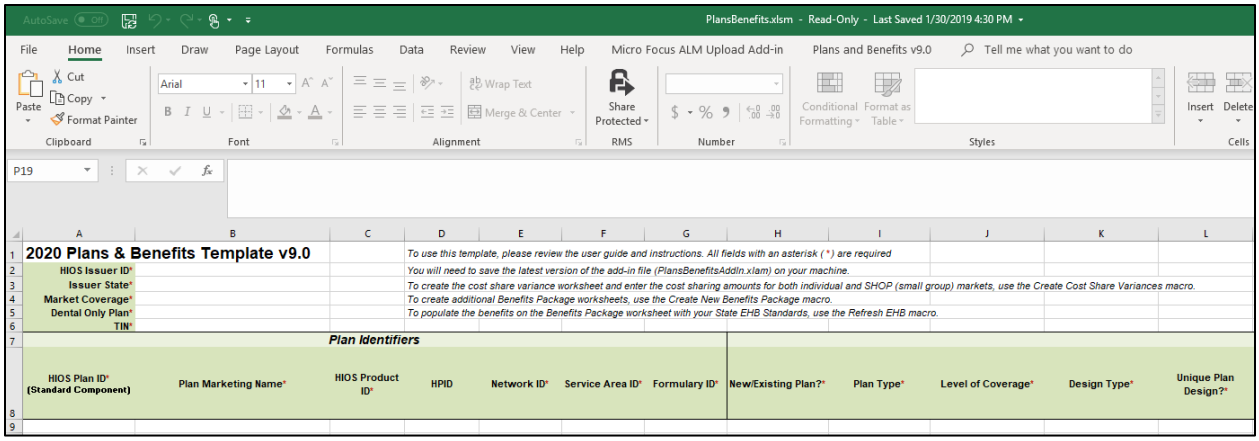


Figure 49: Plans & Benefits 2020 v9.0 Template & Add-In Correctly Associated

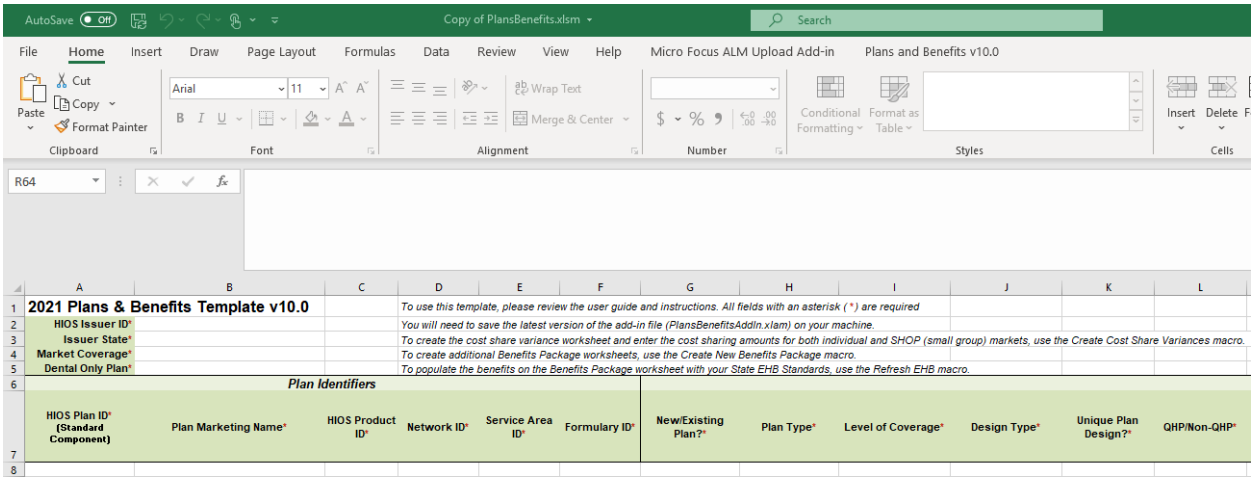


Figure 50: Plans & Benefits 2021 v10.0 Template & Add-In Correctly Associated