



Centers for Medicare & Medicaid Services
Federally Facilitated Exchange

Contract HHSM-500-2016-00003I / 75FCMC21F0001

FFE Plan Management
Plan Preview Module
User Guide

Version 16.1

Plan Year 2023

June 2022

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1 Introduction

This user guide provides instructions for Centers for Medicare and Medicaid Services (CMS) users and issuers to use the Plan Preview module in the Health Information Oversight System (HIOS). Only users with appropriate permissions may access the Plan Preview module.

The Plan Management Plan Preview module allows issuers, states, and the Department of Health and Human Services (HHS) to view issuer and plan data that were submitted to CMS and validate that this information is accurate.

This User Guide applies to the 2023 Plan Preview module. The 2023 Plan Preview system can be used to view only Plan Year 2023 plans and cannot be used to view Plan Year 2022 plans. To view Plan Year 2022 plans, please use the 2022 version of Plan Preview.

2 Referenced Documents

The Center for Consumer Information and Insurance Oversight (CCIIO) provides additional information detailing policies for submitting and reviewing Qualified Health Plans (QHPs) on the CCIIO webpage. Further instructions and guidance are posted on the CMS portal and CCIIO webpage.

3 Overview

The Plan Management business area consists of processes for collecting Rates, Benefits, Service Areas, Provider Networks, and Prescription Drugs data from issuers planning to offer plans on the Exchange. The data is collected via:

- User interfaces and services for issuers to submit, review, and modify information.
- Data submission templates (MS Excel-based) that allow issuers to download, populate, validate, and upload data into the Plan Management system.

The Plan Management application design is built on a scalable, n-Tiered environment running on the CMS cloud environment and uses a Marklogic (XML) database. The user interface design is based on the CMS.gov web brand. It is Section 508 compliant.

3.1 Conventions

This document provides screenshots and corresponding narratives to describe how to use the Plan Preview module.

Fields or buttons to be acted upon are indicated in ***bold italics*** in the Action statement; links to be acted upon are indicated as links in [underlined blue text](#) in the Action statement.

NOTE: The term “user” is used throughout this document to refer to a person who requires or has acquired access to the Plan Preview module.

4 Getting Started

This section provides information about set-up and system access.

4.1 Set-Up Considerations

CMS screens are designed to be viewed at a minimum screen resolution of 1024 x 768 based on HHS standards. To optimize your access to the Plan Management (PM) system:

1. Please *disable pop-up blockers* prior to attempting access to the PM system.
2. Use one of the following browsers for optimum usability:
 - Edge 93.0
 - Firefox 92.0
3. Recommended Excel Versions include Excel 2013, Excel 2016 and Excel 2019.

4.2 User Access Considerations

Users of the Plan Preview module are assigned one of the following user roles:

- **Submitter or Validator Roles**

You may use the Plan Preview module if you were assigned the role of **Submitter** or **Validator** in any of the three HIOS QHP modules (Issuer, Rating, or Benefits and Service Area). You can use the module to view your associated issuers' QHP applications and review plans as they would appear to sample enrollment groups.

- **State Reviewer**

You may use the Plan Preview module if you were assigned the role of **State Reviewer** in the Federally Facilitated Exchange (FFE) State Evaluation Module. You can use the module to view issuers' QHP applications and review plans as they would appear to sample enrollment groups.

4.3 Accessing the System

All FFE users require a CMS Enterprise Portal ID and HIOS user role to access the system.

4.4 System Organization and Navigation

The Plan Preview Module allows issuers and state reviewers to enter sample rating scenarios and view details and rates for associated Individual Market and Small Group (SHOP) plans.

The web-based application displays plans that have Benefits & Service Area & Issuer Module validated and a Business Rules template submitted or plans that were cross-validated in the QHP Application modules. For plans submitted via System for Electronic Rate and Form Filing (SERFF), all templates except Rates need to be submitted. For those who have not submitted their Rates Table Template, "No Rates Available" will be displayed on the Plan Preview Module

under monthly premium. You can select the Market Type radio button to either view ***Individual Market*** or ***Small Group (SHOP)*** plans.

If you select the ***Individual*** radio button, you may enter the following demographic information (required fields denoted by asterisk):

- Effective date of coverage*
- Cost-sharing reduction (CSR) variant*
- Return Catastrophic Plans checkbox
- Primary subscriber birthdate*, gender, and tobacco use
- Primary subscriber Zip Code* and county combination*
- If applicable: Dependent birthdate*, gender, tobacco use, relationship*, and residence*

If you select the ***Small Group (SHOP)*** radio button, you may enter the following demographic information (required fields denoted by asterisk):

- Effective date of coverage*
- Primary subscriber birthdate*, gender, and tobacco use
- Employer Zip Code* and county combination*
- If applicable: Dependent birthdate*, gender, tobacco use, and relationship*

After you create a rating scenario, the system will display each available and unavailable plans for your enrollment group. You can preview lists of available and unavailable plans or click to select a specific plan and view its specific rates and benefits.

As of PY2022, Rates Table Templates no longer need to be submitted in order for plans to be viewed on Plan Preview.

4.5 Exiting the System

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

5 Using the System

5.1 Plan Preview Module

The Plan Preview module is divided into four main pages: the Summary page, the Rating Scenario page, the Plan Details page, and the Benefits Details page for both Individual and SHOP users.

- Summary page: This is the first page of the Plan Preview module, where you select the issuer whose plans you will view. If you are a State Reviewer with access to issuers in multiple states, you first select the state and then the issuer whose plans you will view.
- Rating Scenario page: On this page you create a sample enrollment group and view available and unavailable plans based on the consumer rating scenario you entered. You can create a scenario for either Individual Market plans or SHOP plans.
- Plan Details page: You can reach the Plan Details page by clicking on a plan and then clicking *View Plan*. The Plan Details page shows further details about each of the plans, including deductibles, out-of-pocket maximums, policies for specific benefits, limits and exclusions, and so on.
- Benefit Details page: You can reach the Benefit Details page by clicking on the *View All Limits and Exclusions* or the *View Limits and Exclusions* hyperlink on the Plan Details page. The Benefit Details page shows further details about the benefits included in the plan with their respective limits and exclusions.

5.2 Issuer Summary Page

The Issuer Summary page is where you can select an issuer ID to review. You will have access to all issuers associated with your user role.

You must be assigned a role of **Submitter** or **Validator** for at least one of the three QHP Application modules (Issuer Module, Benefits and Service Area Module, or Rating Module) or a role of **State Reviewer** in the FFE State Evaluation Module to access this page.

You can download the Plan Preview User Guide by clicking the *Instructions and Reference Materials (PDF)* link.

Figure below shows the Issuer Summary page.

PLAN MANAGEMENT

Text Size: [A](#) [A](#) [A](#)

PLAN YEAR : 2023
Welcome, FUNC02 | [Logout](#)

Plan Preview

[Instructions and Reference Material \(PDF\)](#)

This Plan Preview page provides information related to the plans that Issuers submitted in their QHP Application and allows Issuers to preview the information from this QHP Application that will be viewable on the Exchange portal. Utilize the following screens to review plan information and confirm that the display is correct.

Issuer Summary

Select the Issuer for each of your submitted QHP Application(s) below to preview its plans.

Show entries
Search:

Issuer ID	Issuer	Issuer State	Plan Preview
10055	Union Security Insurance Company	TX	Select
10333	TEST 14.0	TX	Select
11104	Federated Mutual Insurance Company	IN	Select
30613	Humana Insurance Company	MO	Select

Showing 1 to 4 of 4 entries

First Previous 1 Next Last

PLAN MANAGEMENT

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Figure 5-1: Issuer Summary Page

If you are a State Reviewer and have access to issuers from multiple states, you will see a drop-down menu in the “Select-State” section of the Issuer Summary page. To select a state, click on the drop-down list and select a state, and then click the **View Issuers** button. Otherwise, if you are not a State Reviewer with access to issuers from multiple states, you will directly proceed to the Issuer Summary section.

If you are a State Reviewer that has access to multiple issuers in the state you can use the buttons in the Issuer Summary Table to change the order or search the list of issuer IDs. Click the **Show Entries** dropdown list to select the number of entries you would like to view per page, and navigate through the table of issuers available using the **First**, **Previous**, **Next** and **Last** toggles.

Use the **Search** bar to search for specific issuer IDs or names. Click the **Select** button in the Plan Preview column to view an issuer.

Table below describes the fields on the Issuer Summary page.

Table 5-1: Issuer Summary Page Fields

Field Name	Description	Value
Issuer ID (pre-populated)	The 5-digit HIOS issuer ID.	Numeric
Issuer (pre-populated)	The HIOS Legal Name for this issuer.	Text
Issuer State (pre-populated)	The 2-letter abbreviation of the issuer's state.	Text
Plan Preview (pre-populated)	The actions available for the user for this issuer.	Select Button

5.3 Rating Scenario Page

The Rating Scenario page is where you enter an enrollment scenario and generate lists of plans that are available and unavailable to your enrollment group. You can also select any available plan to preview on the Plan Details Page. Use the Market Type radio buttons (shown in Figure 5-2) to choose to view **Individual** or **Small Group (SHOP)** plans for your enrollment groups.

5.3.1 Rating Scenario – Individual Market

Select the **Individual** Market Type radio button at the top of the Rating Scenario page (see Figure 5-2) to view available and unavailable Individual Market plans. Then enter your enrollment group information and click the **Update Plan Results** button. The system generates lists of available and unavailable Individual Market plans, mimicking the logic that Individual Market Plan Compare uses to return a list of plans available to an enrollment group. (For information on unavailable plans appearing on the Rating Scenario page, see Section 5.3.4.)

Figure 5-2: Rating Scenario – Apply Rating Scenario (Individual)

Enter your general plan criteria in the “Apply Rating Scenario” box and information about the primary subscriber in the “Primary Subscriber” box. Table below describes the fields in the Apply Rating Scenario box on the Rating Scenario page for Individual Market scenarios and provides instructions about how to enter data in these fields. (**NOTE:** The “Effective Date” field determines plan eligibility based on the Rate Effective Date from the Rates Table template.)

Table 5-2: Rating Scenario – Apply Rating Scenario Fields (Individual)

Field Name	Description	Value
Market Type	Allows the user to select the Market Type to view.	Radio buttons <ul style="list-style-type: none"> Individual Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY2023 plans can be viewed in 2023 Plan Preview.	Date (MM/DD/YYYY)

Field Name	Description	Value
Cost Sharing Reduction (CSR) Variant	Allows the user to select a CSR variation type to view.	Dropdown <ul style="list-style-type: none"> Exchange variant (no CSR) Zero Cost Sharing Plan Variation Limited Cost Sharing Plan Variation 73% AV Level Silver Plan CSR 87% AV Level Silver Plan CSR 94% AV Level Silver Plan CSR
Return Catastrophic Plans Checkbox	Checking this box returns catastrophic plans as available. If the box is unchecked, catastrophic plans will return as unavailable.	Checkbox

Table below describes the fields in the primary subscriber section of the Apply Rating Scenario box for Individual Market scenarios and provides instructions about how to enter data in these fields.

Table 5-3: Rating Scenario – Primary Subscriber Fields (Individual)

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the primary subscriber.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric <ul style="list-style-type: none"> 0 = current tobacco user > 0 = previous tobacco user Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown <ul style="list-style-type: none"> Male Female
Zip Code	Allows the user to enter a 5-digit zip code.	Numeric
County	Allows the user to select a county associated with the provided zip code.	Populated by system (Based on zip code entry)

5.3.2 Rating Scenario – Small Group/Small Business Health Options Program (SHOP)

Select the **Small Group (SHOP)** Market Type radio button at the top of the Rating Scenario page (see Figure 5-3) to view available and unavailable SHOP plans. Then enter your rating scenario and click the **Update Plan Results** button. The system generates lists of available and unavailable Small Group (SHOP) plans.

Figure 5-3: Rating Scenario – Apply Rating Scenario (SHOP)

When you enter a Small Group (SHOP) rating scenario, you will not see a place to input CSR information or subscriber residence information since they are not relevant to Small Group plans. Fields for “Employer Zip Code” and “Employer County” will appear as Small Group rating scenario fields.

Enter your general plan criteria in the Apply Rating Scenario box and information about the primary subscriber in the Primary Subscriber box. Table below describes the fields in the Apply Rating Scenario box on the Rating Scenario page for Small Group scenarios and provides instructions on how to enter data in these fields.

Table 5-4: Rating Scenario – Apply Rating Scenario Fields (SHOP)

Field Name	Description	Value
Market Type	Allows the user to select the Market Type to view.	Radio button <ul style="list-style-type: none"> Individual Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY2023 plans can be viewed in 2023 Plan Preview.	Date (MM/DD/YYYY)
Employer Zip Code	Allows the user to enter a 5-digit zip code.	Numeric
Employer County	Allows the user to select a county associated with the provided zip code.	Populated by system (Based on zip code entry)

Table below describes the fields in the primary subscriber section of the Apply Rating Scenario box for SHOP scenarios and provides instructions about how to enter data in these fields.

Table 5-5: Rating Scenario – Primary Subscriber Fields (SHOP)

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the primary subscriber.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric <ul style="list-style-type: none"> • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown <ul style="list-style-type: none"> • Male • Female

5.3.3 Rating Scenario – Add Dependents – Individual and SHOP

Along with your primary subscriber, you may add up to five dependents to your sample enrollment group. Your dependents may be identified as either a Spouse, Life Partner, Ex-Spouse, Child, Brother or Sister, Ward, Stepson or Stepdaughter, Grandson or Granddaughter, Nephew or Niece, Collateral Dependent, Foster Child, Sponsored Dependent, Other Relationship or Other Relative. Your enrollment group may contain at most one spouse or one life partner. If you add a spouse or life partner to your enrollment group, you may add up to four additional dependents, for a total of five dependents; if you do not add a spouse or life partner, you may add up to five dependents. (**NOTE:** The restriction on dependents only exists within Plan Preview and does not exist within Plan Compare.)

To add a spouse or life partner to your enrollment group, click the *Add Spouse/Life Partner* button beneath the Primary Subscriber box (see Figure 5-3 above), and you will see a new section for the Spouse/Life Partner. You may enter a gender for the scenario's spouse/life partner but this field is not required since gender does not impact eligibility or rate calculations. You can remove any dependent by clicking the *Remove Spouse/Life Partner* or *Remove Dependent* button.

Figure below shows the Spouse/Life Partner box on the Rating Scenario page.

Figure 5-4: Rating Scenario – Add Spouse/Life Partner

Table below describes the fields in the Spouse/Life Partner box on the Rating Scenario Page and provides instructions about how to enter data in these fields.

Table 5-6: Rating Scenario – Spouse/Life Partner Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the spouse/life partner.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric <ul style="list-style-type: none"> • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the spouse/life partner (not required).	Dropdown <ul style="list-style-type: none"> • Male • Female
Relationship	Allows the user to identify the relationship type.	Dropdown <ul style="list-style-type: none"> • Spouse • Life Partner • Ex-Spouse
Same address as Primary Subscriber	Allows the user to indicate whether or not the spouse/life partner’s address is the same as the primary subscriber’s address. (NOTE: Does not appear for SHOP.)	Radio button <ul style="list-style-type: none"> • Yes • No

To add a ‘child’, ‘brother or sister’, ‘ward’, ‘stepson or stepdaughter’, ‘grandson or granddaughter’, ‘nephew or niece’, ‘collateral dependent’, ‘foster child’, ‘sponsored dependent’, ‘other relationship’, or ‘other relative’ dependent to your enrollment group, click the **Add Dependent** button beneath the Primary Subscriber box (see Figure 4 above).

A section will expand for you to input scenario information for dependents. The first dependent in the list will be called “Dependent 1,” and additional dependents will be numbered in order from “Dependent 2” through “Dependent 5.” The **Add Dependent** button will remain active until you reach the maximum of five dependents. You can remove any dependent by clicking the **Remove Dependent** button.

Figure below shows an enrollment group with a child, ward, brother or sister, grandson or granddaughter, and nephew or niece as dependents on the Rating Scenario page.

The screenshot displays a form titled "Rating Scenario – Add Dependent" with five sections, each for a dependent. Each section contains the following fields:

- Dependent 1:** Date of Birth: 01/01/2010; Relationship: Child; Same Address as Primary Subscriber: No.
- Dependent 2:** Date of Birth: 01/01/2010; Relationship: Ward; Same Address as Primary Subscriber: No.
- Dependent 3:** Date of Birth: 01/01/2010; Relationship: Brother or Sister; Same Address as Primary Subscriber: No.
- Dependent 4:** Date of Birth: 01/01/2010; Relationship: Grandson or Granddaughter; Same Address as Primary Subscriber: No.
- Dependent 5:** Date of Birth: 01/01/2010; Relationship: Nephew or Niece; Same Address as Primary Subscriber: No.

At the bottom of the form, there are three buttons: "Add Spouse/Life Partner", "Add Dependent", and "Update Plan Results".

Figure 5-5: Rating Scenario – Add Dependent

Table below describes the fields in the dependent box on the Rating Scenario page and provides instructions about how to enter data in these fields.

Table 5-7: Rating Scenario – Dependent Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the dependent.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3-digit number to indicate the number of months since last tobacco use or leave blank for no tobacco use.	Numeric <ul style="list-style-type: none"> • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Relationship	Allows the user to identify the relationship type.	Dropdown <ul style="list-style-type: none"> • Child • Brother or Sister • Ward • Stepson or Stepdaughter • Grandson or Granddaughter • Nephew or Niece • Collateral Dependent • Foster Child • Sponsored Dependent • Other Relationship • Other Relative
Same address as Primary Subscriber	Allows the user to indicate whether or not the dependent's address is the same as the primary subscriber's address. (NOTE: Does not appear for SHOP.)	Radio button <ul style="list-style-type: none"> • Yes • No

5.3.4 Rating Scenario – Plan Results

After you enter your rating scenario, click *Update Plan Results* to view lists of available and unavailable plans for your enrollment group. The plans will appear in the Plan Results table with the plans' IDs, names, metal levels, market types, plan types, product types, and links for additional information. Use the *Available* and *Unavailable* radio buttons to switch between available or unavailable plans. Click the *Available* radio button to view all of the plans that will be available to your sample enrollment group. The plan results page defaults to displaying the Available Plans table.

Figure below shows the Plan Results table with a list of available plans for the rating scenario.

Plan Results

Use this section to view plans based on the rating scenario above. Select "Available Plans" to view plans available for the enrollment group. Select "Unavailable Plans" to view plans for which this consumer group is ineligible. If this section is blank or no plans are displayed in the tables, enter a Rating Scenario above and click the "Update Plan Results" button.

***View available or unavailable plans?**
 Available Plans Unavailable Plans

Select the desired plan from the list below by locating all or part of a Plan ID, Plan Name, Market Type, Plan Type, Metal Level, or Product Type. Click on the plan's row in the table to select it. If no Plan IDs are shown, check the Unavailable Plans Table.

***Select a Plan**

Search:

Plan ID	Plan Name	Market Type	Plan Type	Metal Level	Product Type	Additional Info
13574NJ0050002	Pineapple	INDIVIDUAL	POS	GOLD	MEDICAL	View Info
13574NJ0050003	Raspberry	INDIVIDUAL	POS	SILVER	MEDICAL	View Info
13574NJ0050004	Grape	INDIVIDUAL	POS	BRONZE	MEDICAL	View Info
13574NJ0050007	Cherry	INDIVIDUAL	POS	GOLD	MEDICAL	View Info
13574NJ0050008	Mango	INDIVIDUAL	POS	PLATINUM	MEDICAL	View Info

Showing 1 to 7 of 7 entries

[View Plan](#)

Figure 5-6: Plan Results – Available Plans

To view additional information on a plan, click the *View Info* button in the Additional Info column. You will see a pop-up box with the Plan ID, Payment URL, Customer Service Phone Number, Customer Service URL, and Billing Address fields. Payment URL is populated via the Supplemental Submission Module. Customer Service Phone Number, Customer Service URL, and Billing Address fields are populated via data entered in HIOS in the "Marketplace" tab.

Figure below shows the Additional Info pop-up.

Additional Information

Plan ID:
12786DE0010001

Payment URL:
www.payment.com

Customer Service Phone Number:
1-800-555-5555

Customer Service URL:
https://www.insurancecompany.com/customerservice

Billing Address:
Thomas Insurance LTD
123 Main Drive
Springfield, VA 20212-4613

[Close](#)

Figure 5-7: Available Plans – Additional Information

If you click the *Unavailable* radio button, the system displays plans that are unavailable to your enrollment group.

NOTE: Individual Market plans will not appear as available or unavailable for the Small Group (SHOP) rating scenario groups, and vice-versa.

Plans will only display in Plan Preview if (1) the BSA and Issuer module are complete and validated, and a Business Rules template has been submitted in the rating module, and also (2) if the BSA, Issuer, and Rating module are complete and cross-validated. For your reference a complete list of unavailable reasons and codes is provided in Table below.

Table 5-8: Plan Results – Unavailable Plan Reason Codes

Reason Code	Unavailable Reason Text	Description	Click “View Info” to Display Reason
316	“Out of Service Area”	This reason code displays if the user-input Zip-Code/County is not in the plan’s service area	Yes
318	“Dependent X over max age” where X is the dependent number	This reason code displays if an included Child dependent is over the maximum age allowed by the plan’s business rules	No

Reason Code	Unavailable Reason Text	Description	Click "View Info" to Display Reason
321	"X Relationship not allowed" where X is the dependent's relationship type, e.g. "Dependent 1 Relationship not allowed"	This reason code displays if an included dependent relationship is not included in the allowed relationships, or if an included dependent is required to reside with the primary subscriber but does not.	No
322	"No rate for X" where X is the subscriber, e.g. "No rate for Dependent 1"	This reason code displays if a rate is not found for a subscriber, e.g. if the user-input county is included in a plan's Service Area but not in the plan's Rating Area.	No
600	"CSR Variant Mismatch"	This reason code displays if the user-input CSR Variant is not found for a plan, e.g. a user-input CSR Variant of 87% AV Level Silver Plan would not be found for a Gold plan.	No
602	"Ineligible for Child-only"	This reason code displays if the enrollment group is not eligible for child-only plans but the plan is child-only. <ul style="list-style-type: none"> All enrollees must be under 21 years of age, and any dependents must have the 'brother or sister' relationship type The group cannot include child, ward, spouse, life partner, stepson or stepdaughter, grandson or granddaughter, nephew or niece, collateral dependent, ex-spouse, foster child, sponsored dependent, other relationship, or other relative relationship types 	Yes
603	"Ineligible for Adult-only"	This reason code displays if the enrollment group is not eligible for adult-only plans but the plan is adult-only.	Yes
604	"Ineligible for Catastrophic"	This reason code displays if the enrollment group is not eligible for catastrophic plans but the plan has a metal level of catastrophic.	No
605	"Child-only plans are not available in the Small Group On Exchange Market"	This reason code displays if the enrollment scenario Market Type is Small Group (SHOP) but the plan is child-only.	Yes

Reason Code	Unavailable Reason Text	Description	Click "View Info" to Display Reason
606	"Catastrophic plans are not available in the Small Group On Exchange Market"	This reason code displays if the enrollment scenario Market Type is Small Group (SHOP) but the plan is catastrophic.	No
607	"Plan enrollment is closed"	Plan has a suppression status of closed	No
608	"Plan status invalid; plan will not display"	Plan needs updated suppression status	No

In the Unavailable Plans Table, the columns "Reason" and "Code," list the reason why the plan is unavailable for your rating scenario and the associated 'Reason Code.' If Reason Codes **318, 321, 322, 600, 606, 607, or 608** apply to a plan, then the *View Info* button will be inactive since an unavailable reason is already displayed. If the plan is unavailable for another reason, the *View Info* button will be activated. Reason Codes **316, 602, 603, and 605** require Issuers to click the *View Info* button to view the reason or reasons why a plan is unavailable.

Figure below shows the Plan Results table with a list of unavailable plans. Figure 5-9 shows the same table after clicking the *View Info* button for the plans shown.

Plan Results

Use this section to view plans based on the rating scenario above. Select "Available Plans" to view plans available for the enrollment group. Select "Unavailable Plans" to view plans for which this consumer group is ineligible. If this section is blank or no plans are displayed in the tables, enter a Rating Scenario above and click the "Update Plan Results" button.

View available or unavailable plans?
 Available Plans Unavailable Plans

The plans shown below are not available for the rating scenario entered above. The Reason column provides a reason that the enrollment group is ineligible for a plan. In some cases, more than one reason may be given.

***Select a Plan**

Search:

Plan ID	Plan Name	Plan Type	Metal Level	Product Type	Code	Reason	More Info
13574NJ0060001	Plan 1	PPO	BRONZE	MEDICAL		Click View Info Button for more information	View Info
13574NJ0070001	Plan 2	Indemnity	CATASTROPHIC	MEDICAL	606	Catastrophic plans are not available in the Small Group On Exchange Market	View Info
13574NJ0080002	Plan 3	HMO	GOLD	MEDICAL		Click View Info Button for more information	View Info
13574NJ0090001	Plan 4	EPO	PLATINUM	MEDICAL		Click View Info Button for more information	View Info
13574NJ0100001	Plan 5	POS	SILVER	MEDICAL		Click View Info Button for more information	View Info
13574NJ0100002	Plan 6	POS	SILVER	MEDICAL		Click View Info	View Info

Showing 1 to 9 of 9 entries

Figure 5-8: Plan Results – Unavailable Plans

Plan Results

Use this section to view plans based on the rating scenario above. Select "Available Plans" to view plans available for the enrollment group. Select "Unavailable Plans" to view plans for which this consumer group is ineligible. If this section is blank or no plans are displayed in the tables, enter a Rating Scenario above and click the "Update Plan Results" button.

View available or unavailable plans?
 Available Plans Unavailable Plans

The plans shown below are not available for the rating scenario entered above. The Reason column provides a reason that the enrollment group is ineligible for a plan. In some cases, more than one reason may be given.

*Select a Plan

Search:

Plan ID	Plan Name	Plan Type	Metal Level	Product Type	Code	Reason	More Info
13574NJ0060001	Plan 1	PPO	BRONZE	MEDICAL	316	Out of Service Area	View Info
13574NJ0070001	Plan 2	Indemnity	CATASTROPHIC	MEDICAL	606	Catastrophic plans are not available in the Small Group On Exchange Market	View Info
13574NJ0080002	Plan 3	HMO	GOLD	MEDICAL	316	Out of Service Area	View Info
13574NJ0090001	Plan 4	EPO	PLATINUM	MEDICAL	316	Out of Service Area	View Info
13574NJ0100001	Plan 5	POS	SILVER	MEDICAL	316	Out of Service Area	View Info
13574NJ0100002	Plan 6	POS	SILVER	MEDICAL	316	Out of Service Area	View Info
13574NJ0120001	Plan 7	EPO	HIGH	DENTAL	316	Out of Service Area	View Info

Showing 1 to 9 of 9 entries

Figure 5-9: Plan Results – Unavailable Plans after View Info Button is clicked

You can search the list of plans by Plan ID, Plan Name, Plan Type, Metal Level, or Product Type (see Table below).

For available plans, select the plan by clicking on it. After you select a plan, click the **View Plan** button to open the Plan Details Page. If no plans are found as available or unavailable for the entered criteria, the available plans table will be blank, and you will see a pop-up that says, “No Plans Available for Input Criteria.” For example, if you offer only Individual Market plans (and not Small Group plans) but select the ‘Small Group (SHOP)’ Market Type radio button, then there will be no plans to display, and the pop-up will display.

Table 5-9: Plan Results – Available Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text
Market Type (pre-populated)	Market Type.	<ul style="list-style-type: none"> • Individual • Small Group (SHOP)
Plan Type (pre-populated)	Network design for the plan.	<ul style="list-style-type: none"> • PPO • HMO • POS • EPO • Indemnity
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans: <ul style="list-style-type: none"> • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans: <ul style="list-style-type: none"> • High • Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	<ul style="list-style-type: none"> • Medical • Dental

Table below describes the fields for unavailable plans in the Select a Plan section on the Rating Scenario Page.

Table 5-10: Plan Results – Unavailable Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text
Plan Type (pre-populated)	Network design for the plan.	<ul style="list-style-type: none"> • PPO • HMO • POS • EPO • Indemnity

Field Name	Description	Value
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans: <ul style="list-style-type: none"> Platinum Gold Silver Bronze Catastrophic For dental plans: <ul style="list-style-type: none"> High Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	<ul style="list-style-type: none"> Medical Dental
Code	Numerical value referencing why a plan shows as unavailable	Numeric
Reason	Provides a description of the reason code for why plan is unavailable	Text

5.4 Plan Details Page

The Plan Details Page displays the details of the rating scenario used to generate the plan data and mimics Plan Compare. To access the Plan Details Page, click a plan within the Plan Results table to highlight the plan, and then click the **View Plan** button. The corresponding Plan Details page will load in a new tab in your browser.

5.4.1 Plan Details – Rating Scenario Section

Below the header in the Plan Details you will find the Ratings Scenario section. This section allows you to quickly view the variables entered in the Rating Scenario page to generate the plan being viewed.

Figure below shows the Rating Scenario section for a sample scenario used to generate an Individual Market plan.

Plan Preview - Rating Scenario and Plan Details				
Rating Scenario				
This section displays the rating scenario entered to generate the plan details shown below in the Plan Details Section.				
Plan ID: 13574NJ0010001 Exchange variant (no CSR)				
1/1/2021 Zip Code: 07675 County: Bergen				
Subscriber	Date of Birth	Age	Last Tobacco Use (months)	Resides with Primary Subscriber?
Primary Subscriber	1/1/1980	41	None	Not Applicable
Spouse	1/1/1980	41	None	Yes
Dependent 1 (Child)	1/1/2010	11	None	Yes

Figure 5-10: Plan Details Page – Rating Scenario Section

Table below describes the fields on the Ratings Scenario section of the Plan Details Page for Individual and Small Group (SHOP).

Table 5-11: Plan Details Page – Ratings Scenarios

Field Name	Description
Plan ID and CSR Variant	Displays the 14-digit HIOS Plan ID (Standard Component) and CSR Plan Variant: <ul style="list-style-type: none"> • Exchange variant (no CSR) • Zero Cost Sharing Plan Variation • Limited Cost Sharing Plan Variation • 73% AV Level Silver Plan CSR • 87% AV Level Silver Plan CSR • 94% AV Level Silver Plan CSR CSR Variant does not display for Small Group (SHOP) plans
Effective Date	The effective date of coverage for the rating scenario in a MM/DD/YYYY format.
Zip code	The 5-digit selected zip code.
County name	The name of the selected US county.
Subscriber name and relationship for each subscriber	The type of subscriber and dependent relationship for the subscriber/dependent: <ul style="list-style-type: none"> • Primary Subscriber • Spouse • Life partner • Child • Brother or Sister • Ward • Stepson or Stepdaughter • Grandson or Granddaughter • Nephew or Niece • Collateral Dependent • Ex-Spouse • Foster Child • Sponsored Dependent • Other Relationship • Other Relative
Date of birth for each subscriber and/or dependent	The date of birth in DD/MM/YYYY format for each subscriber and/or dependent.
Age for each subscriber and/or dependent	The age in years for each subscriber and/or dependent based on the age rating method in the Business Rules template, Effective Date entered in the Ratings Scenario, and Date of birth entered in the Ratings Scenario.
Number of months since last tobacco use for each subscriber	The number of months since last tobacco use: <ul style="list-style-type: none"> • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use

Field Name	Description
Indicator for residence with the primary subscriber for each dependent	Indicates if a dependent resides with the primary subscriber: <ul style="list-style-type: none"> • Yes • No • Not Applicable <p>NOTE: Does not display for SHOP</p>

5.4.2 Plan Details – Plan Overview

Subsequent to the Ratings Scenario section is the Plan Overview section. This section provides basic information about the plan you've chosen to view. Table 5-12 describes the fields on the overview section of the Plan Details Page for Individual and Small Group (SHOP). Please note that the CSR Variant field will not display for Small Group (SHOP) plans. The ***Print*** button allows you to print the page with your browser's standard print feature. The arrows on the side of each section within Plan Details allows the section to be expanded to show more information.

Figure below shows the Plan Overview section for a sample plan in the Individual Exchange.

Plan Card

This is the initial view of the plan that will be displayed in the Plan Search Results on the Exchange portal.

Quick tips
[Think about all costs, not just the premium](#)

Estimated monthly premium

\$233.00

REL 16.08 Mrktpl Marketing Name

ND Medical 2

Silver | Indemnity | National Provider Network | Plan ID: 39364ND0010002

Not rated ?

[Compare](#)

Deductible ?

\$1,100

Individual Total

Out-of-pocket maximum ?

\$2,403

Individual Total

Estimated total yearly costs ?

[Add](#)

Copayments / Coinsurance ?

Emergency room care	Generic drugs	Primary doctor	Specialist doctor
\$583 Copay with deductible/10%	Not Applicable	\$503 Copay with deductible/10%	\$513 Copay with deductible/10%
Coinsurance after deductible		Coinsurance after deductible	Coinsurance after deductible

Plan features

- ✖ Adult Dental
- ✔ Child Dental

[Add Your Medical Providers](#)

Add your medical providers and we'll show you which plans cover them

[Add Your Prescription Drugs](#)

Add your prescription drugs and we'll show you which plans cover them

[Plan Details](#)

[Like This Plan](#)

Plan Details

[View all limits and exclusions](#)

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

- [Highlights](#) ▼
- [Star Rating](#) ▼
- [Plan documents](#) ▼
- [Costs for medical care](#) ▼
- [Prescription drug coverage](#) ▼
- [Access to doctors and hospitals](#) ▼
- [Hospital services](#) ▼
- [Cost & Coverage Examples](#) ▼
- [Adult dental coverage](#) ▼
- [Child dental coverage](#) ▼
- [Medical management programs](#) ▼
- [Other services](#) ▼

Figure 5-11: Plan Details Page – Overview Fields

Table 5-12: Plan Details Page – Overview Fields

Field Name	Description
Plan Name	Displays the Issuer Marketing Name (pulled from HIOS “Marketplace” tab), plus the Plan Variant Marketing Name (pulled from the Cost Share Variances tab of the Plans and Benefits template). If the Issuer Marketing name is blank, displays the Issuer Legal Name (pulled from HIOS), plus the Plan Variant Marketing Name.
Plan Attributes	<p>Displays the following details of the selected plan, in this order (if applicable):</p> <ol style="list-style-type: none"> 1) Level of Coverage 2) Plan Type 3) “National Provider Network” displays if the “National Network” field in the Plans and Benefits template is equal to “Yes.” No text displays if the “National Network” field is equal to “No” 4) Plan ID
Compare	<p>This field is included to mimic what will display in Plan Compare, however, the “Compare” button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not perform any action.</p>
Overall Rating (Quality Measures)	<p>Displays the overall quality rating as 1-5 stars for the selected plan.</p> <p>NOTE: If no quality data is available for the plan, the Rating will display ‘Not rated.’ If the plan is ineligible for scoring because it is a new plan, then ‘New Plan – Quality Ratings unavailable’ will display.</p>
Other Rating (Other Quality Measures)	<p>Displays the Member Experience, Medical Care, and Plan Administration rating as 1-5 stars for the selected plan.</p> <p>NOTE: If no quality data is available for the plan, or if the plan is ineligible for scoring because it is a new plan, then ‘Not rated’ will display.</p>
Monthly Premium	<p>Displays the monthly premium amount that the rating engine calculates based on the individuals in the enrollment group and the plan effective date.</p> <p>For Stand Alone Dental Plans, displays “Estimated Rate” along with the premium amount.</p> <p>If the rate is guaranteed, then displays a checkmark and “Guaranteed Rate” based on the “Guaranteed vs. Estimated Rates” field in the Plans and Benefits template.</p> <p>NOTE: If Rates Table template has not been submitted then “No Rates Available” will be displayed.</p>
Health Savings Account Eligibility	This banner indicates whether the plan is eligible for a Health Savings Account.
Plan Details	<p>This field is included to mimic what will display in Plan Compare, however, the “Plan Details” button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not perform any action.</p>

Field Name	Description
Like This Plan	<p>This field is included to mimic what will display in Plan Compare, however, the “Like This Plan” button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not perform any action.</p>
Deductible	<p>The deductible field will show data for both one person and multiple people enrollment groups:</p> <ol style="list-style-type: none"> 1. If the enrollment group size is one (no dependents) <ol style="list-style-type: none"> a) If Individual In-Network value is \$X, display “\$X Individual Total”; else, if this value is “Not Applicable”, b) If Individual Combined In/Out-Network value is \$X, display “\$X Individual Total”; else, if this value is “Not Applicable”, c) Display “Not Applicable”. 2. If the enrollment group size is greater than one (at least one dependent) <ol style="list-style-type: none"> a) If both Family Per Group and Family Per Person are \$X (including \$0), then display both as “\$X Family Total” and “\$X individual Total” <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. b) If Family Per Group is \$X (including \$0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display “\$X Family Total” and do not display a per person value. <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. c) If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is \$X (including \$0), then display “\$X Individual Total” and do not display a per group value. <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. <p>If medical and drug deductibles are integrated, then the combined medical and drug deductible displays in the overview section. “Included in plan’s deductible” displays in the prescription drug coverage details section.</p> <p>If medical and drug deductibles are not integrated, only the medical deductible displays in the overview section. The drug deductible displays in the prescription drug coverage details section.</p> <p>In-Network Tier 2 and Out-of-Network deductibles do not display in Plan Preview or Plan Compare.</p>

Field Name	Description
<p>Out-of-Pocket Maximum</p>	<p>The Out-of-Pocket Maximum field will show data for both one person and multiple people enrollment groups:</p> <ol style="list-style-type: none"> 1. If the enrollment group size is one (no dependents) <ol style="list-style-type: none"> a) If Individual In-Network value is \$X, display “\$X Individual Total”; else, if this value is “Not Applicable”, b) If Individual Combined In/Out-Network value is \$X, display “\$X Individual Total”; else, if this value is “Not Applicable”, c) Display “Not Applicable”. 2. If the enrollment group size is greater than one (at least one dependent) <ol style="list-style-type: none"> a) If both Family Per Group and Family Per Person are \$X (including \$0), then display both as “\$X Family Total” and “\$X Individual Total” <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. b) If Family Per Group is \$X (including \$0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display “\$X Family Total” and do not display a per person value. <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. c) If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is \$X (including \$0), then display “\$X Individual Total” and do not display a per group value. <ol style="list-style-type: none"> i) Use In-Network value if it is \$X ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value. <p>If medical and drug maximum out-of-pocket (MOOP) amounts are integrated, then the combined medical and drug maximum displays in the overview section. “Included in plan’s out-of-pocket maximum” displays in the prescription drug coverage details section.</p> <p>If medical and drug maximums are not integrated, only the medical amount displays on this part of the page. The drug MOOP displays in the prescription drug coverage details section.</p> <p>In-Network Tier 2 and Out-of-Network MOOP values do not display in Plan Preview or Plan Compare.</p>

Field Name	Description
Copayments /Coinsurance	<p>For Emergency room care, Primary doctor, Specialist doctor, or Generic drugs, displays cost-sharing information according to the Copay/Coinsurance mapping logic in section 5.4.1.</p> <p>Displays information from the following fields in the Plans and Benefits template:</p> <ul style="list-style-type: none"> • Emergency room care • Generic drugs • Primary doctor • Specialist doctor
Estimated total yearly costs	<p>This field is included to mimic what will display in Plan Compare, however, the "Add" button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not display values for the costs.</p>
Medical Providers	<p>This field is included to mimic what will display in Plan Compare, however, the "Add Your Medical Providers" button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not display covered providers.</p>
Prescription Drugs	<p>This field is included to mimic what will display in Plan Compare, however, the "Add Your Prescription Drugs" button will be inactive in Plan Preview.</p> <p>NOTE: In Plan Preview this is a placeholder and will not display covered drugs.</p>

Field Name	Description
Dental Plan Features	<p>Indicates whether the plan includes dental coverage.</p> <p>If the plan offers Child Dental by covering all three child dental benefits, displays "Child dental" with a green checkmark.</p> <p>If the plan offers one or two of the child dental benefits, displays "Child dental" with a yellow checkmark.</p> <p>If the plan does not offer Child Dental, displays "Child dental" with a red X-mark.</p> <p>If the plan offers Adult Dental by covering all three adult dental benefits, displays "Adult dental" with a green checkmark.</p> <p>If the plan offers one or two of the adult dental benefits, displays "Adult dental" with a yellow checkmark.</p> <p>If the plan does not offer Adult Dental, displays "Adult dental" with a red X-mark.</p> <p>A plan is considered to cover adult dental benefits if it covers all three of the following benefits:</p> <ul style="list-style-type: none"> • Routine Dental Services (Adult) • Basic Dental Care (Adult) • Major Dental Care (Adult) <p>A plan is considered to cover child dental benefits if it covers all three of the following benefits:</p> <ul style="list-style-type: none"> • Dental Check-Up for Children • Basic Dental Care (Child) • Major Dental Care (Child)

5.4.3 Plan Details – Benefits Sections

The Plan Details page contains eleven benefits sections that display coverage information for specific benefits in the same way as Individual Market Exchange Plan Compare. Copay, coinsurance, deductible, and maximum out-of-pocket amounts display according to the same logic found in sections 5.4.1 and 5.4.2.

Stand-alone dental plans will display only the Highlights, Plan Documents, Adult Dental Coverage and Child Dental Coverage fields.

Figure below shows the Highlights section of the Plan Details page.

Highlights	
Estimated monthly premium	\$229
Deductible	\$2,202 Individual Total
Out-of-pocket maximum	\$3,202 Individual Total
Estimated total yearly costs	<input type="button" value="Add"/>
Medical Providers In-network	<input type="button" value="Add Your Medical Providers"/>
Drugs covered/Not covered	<input type="button" value="Add Your Prescription Drugs"/>

Figure 5-12: Plan Details – Highlights

The Highlights section replicates information from the Plan Card section to mimic the user experience in Plan Compare. The fields in this section include Estimated monthly premium, Deductible, Out-of-pocket maximum, Estimated total yearly costs (non-functional placeholder), Medical Providers In-network (non-functional placeholder), and Drugs covered/Not covered (non-functional placeholder).

Figure below shows the Star Rating section of the Plan Details page.

Star Rating	
Overall Rating	Not rated
Overall star rating is based on the categories below.	
Member Experience	Not rated
Based on member satisfaction surveys about their health care, doctors, and ease of getting appointments and services.	
Medical Care	Not rated
Based on providers improving or maintaining the health of their patients with regular screenings, tests, vaccines, and condition monitoring.	
Plan Administration	Not rated
Based on how well a plan is run, including customer service, access to needed information, and providers ordering appropriate tests and treatment.	

Figure 5-13: Plan Details – Star Rating

Displays the overall quality rating as 1-5 stars for the selected plan.

NOTE: If no quality data is available for the plan, the Rating will display ‘Not rated.’

Figure below shows the Documents section of the Plan Details page.



Figure 5-14: Plan Details – Plan Documents

This section displays the URLs submitted from the Supplemental Submission Module. The Summary of Benefits link utilizes the Summary of Benefits & Coverage URL. The Plan Brochure link utilizes the Plan Brochure URL. The Provider Directory link utilizes the Network URL. The List of covered drugs link utilizes the Formulary URL.

Figure below shows the Costs for medical section of the Plan Details page.

Costs for medical care	
Deductible	\$2,202 Individual Total
Out-of-pocket maximum	\$3,202 Individual Total
Primary care doctor visit	In Network Tier 1: \$102/22% In Network Tier 2: No Charge After Deductible Out of Network: No Charge After Deductible
Specialist visit	In Network Tier 1: \$112 In Network Tier 2: No Charge Out of Network: No Charge After Deductible
X-rays and diagnostic imaging	In Network Tier 1: \$3,422 Copay after deductible/32% Coinsurance after deductible In Network Tier 2: \$1,652 Copay after deductible/22% Coinsurance after deductible Out of Network: Not Applicable
Laboratory outpatient and professional services	In Network Tier 1: Benefit Not Covered In Network Tier 2: Not Applicable Out of Network: Not Applicable
Outpatient facility	In Network Tier 1: 32% In Network Tier 2: No Charge Out of Network: Not Applicable
Outpatient professional services	In Network Tier 1: No Charge After Deductible In Network Tier 2: No Charge Out of Network: Not Applicable
Hearing aids	In Network Tier 1: 21% In Network Tier 2: \$71 Copay after deductible/21% Coinsurance after deductible Out of Network: Not Applicable View limits and exclusions
Routine eye exam for adults	In Network: Benefit Not Covered
Routine eye exam for children	In Network Tier 1: Not Applicable In Network Tier 2: Benefit Not Covered Out of Network: Not Applicable
Eyeglasses for children	In Network Tier 1: \$21 Copay with deductible In Network Tier 2: 81% Out of Network: Not Applicable
Eligible for Health Savings Account (HSA)	Yes

Figure 5-15: Plan Details – Costs for Medical Care Section

Table below describes the fields in the Medical Care Coverage section of the Plan Details Page.

Table 5-13: Plan Details – Costs for Medical Care Section Fields

Field Name	Description
Deductible	<p>For one-person enrollment groups (no dependents):</p> <ul style="list-style-type: none"> • If the Individual In-Network value equals a dollar amount, then the Individual In-Network value displays (as '\$X Individual Total'). • If the Individual In-Network value equals "Not Applicable" and the Individual Combined In/Out-Network value equals a dollar amount, then the Individual Combined In/Out Network value displays (as '\$X Individual Total'). • If the Individual In-Network and Combined In/Out-Network values both equal "Not Applicable," then "Not Applicable" displays. <p>For enrollment groups with more than one person (one or more dependents), displays both "Individual Total" and "Family Total" amount.</p> <p>Per Person Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as "\$X Individual Total"). • If the Family In-Network Per Person value equals "Not Applicable," and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as "\$X Individual Total"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal "Not Applicable," then "Not Applicable" displays. <p>Per Group Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as "\$X Family Total"). • If the Family In-Network Per Group value equals "Not Applicable" and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as "\$X Family Total"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal "Not Applicable," then "Not Applicable" displays. <p>In-Network Tier 2 and out-of-network deductibles do not display in Plan Preview or Plan Compare.</p>

Field Name	Description
Out-of-pocket maximum	<p>For one-person enrollment groups (no dependents):</p> <ul style="list-style-type: none"> • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as "\$X Individual Total"). • If the Individual In-Network maximum equals "Not Applicable" and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as "\$X Individual Total"). • If Individual In-Network and Combined In/Out-Network maximums both equal "Not Applicable," "Not Applicable" displays. <p>For enrollment groups with more than one person (one or more dependents), displays both "Individual Total" and "Family Total" amount.</p> <p>Per Person Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as "\$X Individual Total"). • If the Family In-Network Per Person maximum equals "Not Applicable", and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as "\$X Individual Total"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal "Not Applicable", then "Not Applicable" displays. <p>Per Group Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as "\$X Family Total"). • If the Family In-Network Per Group maximum equals "Not Applicable" and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as "\$X Family Total"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal "Not Applicable," then "Not Applicable" displays. <p>In-Network Tier 2 and out-of-network maximums do not display in Plan Preview or Plan Compare.</p>
Primary care doctor visit	Provides cost sharing information for the benefit "Primary Care Visit to Treat an Injury or Illness", found in the Plans and Benefits template.
Specialist visit	Provides cost sharing information for the benefit "Specialist Visit", found in the Plans and Benefits template.
X-Rays and diagnostic imaging	Provides cost sharing information for the benefit "X-rays and Diagnostic Imaging", found in the Plans and Benefits template.
Laboratory outpatient and professional services	Provides cost sharing information for the benefit "Laboratory Outpatient and Professional Services", found in the Plans and Benefits template.

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

Figure below shows the Prescription Drug Coverage section of the Plan Details Page.

Prescription drug coverage ^

Generic drugs	In Network Tier 1: 24% In Network Tier 2: 14% Coinsurance after deductible Out of Network: 34%
Preferred brand drugs	In Network Tier 1: 24% In Network Tier 2: 14% Coinsurance after deductible Out of Network: 34%
Non-preferred brand drugs	In Network Tier 1: 24% In Network Tier 2: 14% Coinsurance after deductible Out of Network: 34%
Specialty drugs	In Network Tier 1: 24% In Network Tier 2: 14% Coinsurance after deductible Out of Network: 34%
List of covered drugs	View
Three month in-network mail order pharmacy benefit	No
Prescription drug deductible	Included in plan deductible
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

Figure 5-16: Plan Details – Prescription Drug Coverage Section

Table below describes the fields in the Prescription Drug Coverage section of the Plan Details page.

Table 5-14: Plan Details – Prescription Drug Coverage Section Fields

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

Field Name	Description
<p>Prescription drug deductible</p>	<p>If medical and drug deductibles are integrated, displays “Included in plan deductible.” Otherwise, the logic below applies.</p> <p>If medical and drug deductibles are not integrated, display depends on the enrollment group size.</p> <p>If the enrollment group size is one (no dependents):</p> <ul style="list-style-type: none"> • If the Individual In-Network prescription drug deductible equals a dollar amount, then the Individual In-Network deductible displays (as “\$X Individual Total”). • If the Individual In-Network prescription drug deductible equals “Not Applicable” and the Individual Combined In/Out-Network prescription drug deductible equals a dollar amount, then the Individual Combined In/Out Network deductible displays (as “\$X Individual Total”). • If the Individual In-Network and Combined In/Out-Network prescription drug deductibles both equal “Not Applicable,” then “Not Applicable” displays. <p>If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” amount.</p> <p>Per Person Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as “\$X Individual Total”). • If the Family In-Network Per Person value equals “Not Applicable,” and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as “\$X Individual Total”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal “Not Applicable,” then “Not Applicable” displays. <p>Per Group Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as “\$X Family Total”). • If the Family In-Network Per Group value equals “Not Applicable” and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as “\$X Family Total”). <p>If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal “Not Applicable,” then “Not Applicable” displays.</p>

Field Name	Description
<p>Prescription drug out-of-pocket maximum</p>	<p>If medical and drug maximums are integrated, displays “Included in plan’s out-of-pocket maximum” Otherwise, the logic below applies.</p> <p>If medical and drug maximums are not integrated, display depends on the enrollment group size.</p> <p>If the enrollment group size is one (no dependents):</p> <ul style="list-style-type: none"> • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as “\$X Individual Total”). • If the Individual In-Network maximum equals “Not Applicable” and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as “\$X Individual Total”). • If Individual In-Network and Combined In/Out-Network maximums both equal “Not Applicable,” “Not Applicable” displays. <p>If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” maximum.</p> <p>Per Person Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as “\$X Individual Total”). • If the Family In-Network Per Person maximum equals “Not Applicable,” and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as “\$X Individual Total”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal “Not Applicable,” then “Not Applicable” displays. <p>Per Group Logic:</p> <ul style="list-style-type: none"> • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as “\$X Family Total”). • If the Family In-Network Per Group maximum equals “Not Applicable” and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as “\$X Family Total”). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal “Not Applicable,” then “Not Applicable” displays.

Figure below shows the Access to Doctors and Hospitals section of the Plan Details page.

Access to doctors and hospitals ^	
Provider directory	View
National Provider Network ⓘ	Yes
Need referral to see a specialist	Yes
Size of provider network, compared to other plans: ⓘ	
Hospitals	Not Available
Primary Care Doctors	Not Available
Pediatricians	Not Available

Figure 5-17: Plan Details – Access to Doctors and Hospitals Section

Table below describes the fields in the Access to Doctors and Hospitals section of the Plan Details page.

Table 5-15: Plan Details – Access to Doctors and Hospitals Section Fields

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

Figure below shows the Hospital Services section of the Plan Details page.

Hospital services	
Emergency room care	In Network Tier 1: No Charge In Network Tier 2: No Charge After Deductible Out of Network: Not Applicable
Inpatient doctor and surgical services	In Network Tier 1: Benefit Not Covered In Network Tier 2: Benefit Not Covered Out of Network: Not Applicable
Inpatient hospital services (like a hospital stay)	In Network Tier 1: \$102 Copay per Stay/32% In Network Tier 2: \$202 Copay per day with deductible Out of Network: \$302 Copay per day after deductible View limits and exclusions

Figure 5-18: Plan Details – Hospital Services Section

Table below describes the fields in the Hospital Services section of the Plan Details page.

Table 5-16: Plan Details – Hospital Services Section Fields

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

Figure 5-19 shows the Cost & Coverage Examples section of the Plan Details page.

Cost & Coverage Examples	
Typical cost for a healthy pregnancy and normal delivery.	\$1,808
Typical yearly cost for managing type 2 diabetes for one person.	\$3,508
Typical cost for treatment of a simple fracture.	\$5,708

Figure 5-19: Plan Details – Cost & Coverage Examples Section

Table below describes the fields in the Cost & Coverage Examples section of the Plan Details page.

Table 5-17: Plan Details – Cost & Coverage Examples Section Fields

Field Name	Description
Typical cost for a healthy pregnancy and normal delivery	Displays the sum of the following four values from the Plans and Benefits template: <ul style="list-style-type: none"> • Having a Baby – Deductible • Having a Baby – Copayment • Having a Baby – Coinsurance • Having a Baby – Limit
Typical yearly cost of managing type 2 diabetes for one person	Displays the sum of the following four values from the Plans and Benefits template: <ul style="list-style-type: none"> • Having Diabetes – Deductible • Having Diabetes – Copayment • Having Diabetes – Coinsurance • Having Diabetes – Limit

Field Name	Description
Typical cost of treatment of a simple fracture	Displays the sum of the following four values from the Plans and Benefits template: <ul style="list-style-type: none"> • Treatment of a Simple Fracture – Deductible • Treatment of a Simple Fracture – Copayment • Treatment of a Simple Fracture – Coinsurance • Treatment of a Simple Fracture – Limit

Figure below shows the Adult Dental Coverage section of the Plan Details page.

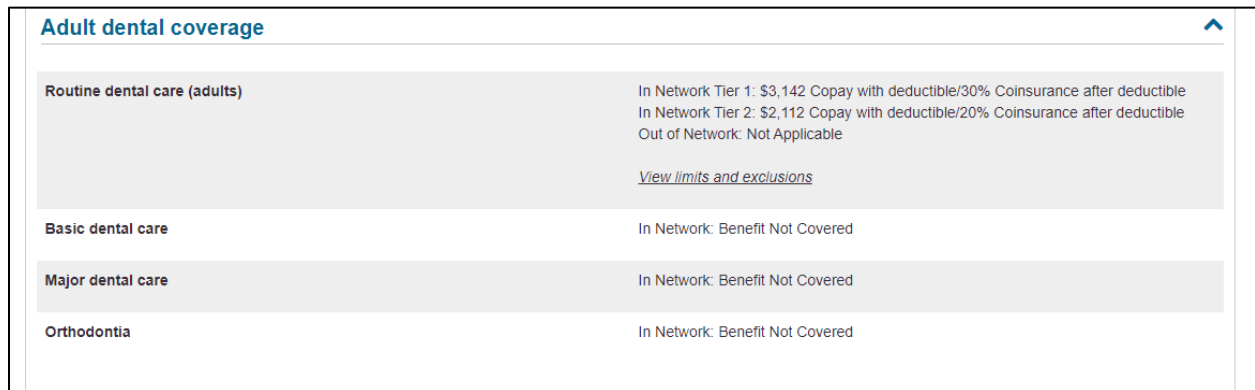


Figure 5-20: Plan Details – Adult Dental Coverage Section

Table below describes the fields in the Adult Dental Coverage section of the Plan Details page.

Table 5-18: Plan Details – Adult Dental Coverage Section Fields

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

Figure below shows the Child Dental Coverage section of the Plan Details page.


Child dental coverage 	
Check-up	In Network Tier 1: \$3,002 Copay with deductible/30% Coinsurance after deductible In Network Tier 2: \$1,502 Copay with deductible/15% Coinsurance after deductible Out of Network: Not Applicable
Major dental care	In Network Tier 1: \$2,782/30% Coinsurance after deductible In Network Tier 2: \$2,112/20% Coinsurance after deductible Out of Network: Not Applicable
Basic dental care	In Network Tier 1: \$1,662 Copay with deductible/30% Coinsurance after deductible In Network Tier 2: \$1,232 Copay with deductible/22% Coinsurance after deductible Out of Network: Not Applicable
Medically necessary orthodontia (Orthodontic treatment may require pre-approval and must meet the plan's 'medical necessity' criteria)	In Network Tier 1: \$1,872 Copay after deductible/31% Coinsurance after deductible In Network Tier 2: \$1,652 Copay with deductible/22% Coinsurance after deductible Out of Network: Not Applicable

Figure 5-21: Plan Details – Child Dental Coverage Section

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

Table 5-19: Plan Details – Child Dental Coverage Section Fields

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

Figure below shows the Medical Management Programs section of the Plan Details page.

Medical management programs	
Asthma	Not Available
Heart disease	Available
Depression	Available
Diabetes	Not Available
High blood pressure and high cholesterol	Not Available
Low back pain	Not Available
Pain management	Not Available
Pregnancy	Not Available
Weight loss programs	Not Available

Figure 5-22: Plan Details – Medical Management Programs Section

Table below describes the fields in the Medical Management Programs section of the Plan Details page. All of the information in this section comes from the “Disease Management Program Offered” field in the Plans and Benefits template. If no Medical management programs are available for the selected plan, this section will be hidden from view.

Table 5-20: Plan Details – Medical Management Programs Section Fields

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

Figure below shows the Other Benefits section of the Plan Details page.

Other services ▲	
Acupuncture	In Network: Benefit Not Covered
Chiropractic care	In Network Tier 1: Not Applicable In Network Tier 2: Not Applicable Out of Network: Not Applicable View limits and exclusions
Infertility treatment	In Network: Benefit Not Covered
Mental/behavioral health outpatient services	In Network Tier 1: No Charge After Deductible In Network Tier 2: No Charge Out of Network: Not Applicable View limits and exclusions
Mental/behavioral health inpatient services	In Network Tier 1: \$172 Copay per stay after deductible In Network Tier 2: \$132 Copay per day after deductible/52% Out of Network: \$402 Copay per Day View limits and exclusions
Habilitative services	In Network Tier 1: Not Applicable In Network Tier 2: Not Applicable Out of Network: Not Applicable
Bariatric services	In Network: Benefit Not Covered
Outpatient rehabilitation services	In Network Tier 1: Not Applicable In Network Tier 2: Not Applicable Out of Network: Not Applicable View limits and exclusions
Skilled Nursing Facility care	In Network Tier 1: \$152 Copay per day with deductible/42% In Network Tier 2: \$252 Copay per stay after deductible/22% Out of Network: \$112 Copay per stay after deductible View limits and exclusions
Private-duty nursing	In Network: Benefit Not Covered

Figure 5-23: Plan Details – Other Benefits Section

Table below describes the fields in the Other Benefits section of the Plan Details page.

Table 5-21: Plan Details – Other Benefits Section Fields

Field Name	Description
Acupuncture	Provides cost sharing information for the benefit “Acupuncture,” found in the Plans and Benefits template.
Chiropractic care	Provides cost sharing information for the benefit “Chiropractic Care,” found in the Plans and Benefits template.
Infertility treatment	Provides cost sharing information for the benefit “Infertility Treatment,” found in the Plans and Benefits template.
Mental/behavioral health outpatient services	Provides cost sharing information for the benefit “Mental/Behavioral Health Outpatient Services,” found in the Plans and Benefits template.

Field Name	Description
Mental/behavioral health inpatient services	Provides cost sharing information for the benefit “Mental/Behavioral Health Inpatient Services,” found in the Plans and Benefits template.
Habilitative services	Provides cost sharing information for the benefit “Habilitative Services,” found in the Plans and Benefits template.
Bariatric services	Provides cost sharing information for the benefit “Bariatric Surgery,” found in the Plans and Benefits template.
Outpatient rehabilitation services	Provides cost sharing information for the benefit “Outpatient rehabilitation services,” found in the Plans and Benefits template.
Skilled Nursing Facility care	Provides cost sharing information for the benefit “Skilled Nursing Facility,” found in the Plans and Benefits template.
Private-duty nursing	Provides cost sharing information for the benefit “Private-Duty Nursing,” found in the Plans and Benefits template.

5.4.4 Plan Details – Benefit Cost Sharing Logic

In the detailed benefit rows, Tier 1 In-Network, Tier 2 In-Network, and Out-of-Network cost sharing for each benefit display. There is also a link that provides explanatory text for limits and exclusions; if you click the link, a pop-up box displays the Exclusions and Explanations text entered in the Plans and Benefits template for the benefit.

The following logic determines how coinsurance and copay information displays:

1. If the coinsurance is equal to “100%,” “Not Covered” displays.
2. If both the copay and coinsurance are greater than zero but the coinsurance is less than 100%, both the copay and coinsurance display with their text qualifiers (such as “50% Coinsurance after deductible”).
3. If the copay is greater than \$0 and the coinsurance equals “0%,” “0% Coinsurance after deductible,” “No Charge,” “No Charge after deductible,” or “Not Applicable,” only the copay displays with the copay qualifier. Likewise, if the coinsurance is greater than 0% and the copay equals “\$0,” “\$0 Copay after deductible,” “\$0 Copay with deductible,” “No Charge,” “No Charge after deductible,” or “Not Applicable,” only the coinsurance displays with the coinsurance qualifier.
4. “No Charge” displays if:
 - a. The copay equals “\$0,” “\$0 Copay with deductible,” or “No Charge” and the coinsurance equals “0%,” “No Charge,” or “Not Applicable.”
 - b. The copay equals “Not Applicable” and the coinsurance equals “0%” or “No Charge.”
5. “No Charge after deductible” displays if:
 - a. The copay equals “No Charge after deductible,” or “\$0 Copay after deductible,” and the coinsurance equals “0%,” “No Charge,” “Not Applicable,” “No Charge after deductible,” or “0% Coinsurance after deductible.”

- b. The copay equals “\$0,” “\$0 Copay with deductible,” “No Charge,” or “Not Applicable,” and the coinsurance equals “0% Coinsurance after deductible,” or “No Charge after deductible.”

6. “Not Applicable” displays if both the copay and coinsurance equal “Not Applicable.”

Copay qualifiers that include “per Day” or “per Stay” behave according to these same rules. For example, a copay equal to “\$25 Copay per Day after deductible” and a coinsurance equal to “No Charge” displays “\$25 Copay per Day after deductible.”

“\$0 Copay per Stay”, “\$0 Copay per Day”, “\$0 Copay per Stay with deductible”, and “\$0 Copay per Day with deductible” are equivalent to “No Charge”. “\$0 Copay per Stay after deductible” and “\$0 Copay per Day after deductible” are equivalent to “No Charge after deductible”.

5.4.5 Stand Alone Dental Plan Details

When you view a dental plan, you see the Dental-only Plan Details page, which also displays an overview header. However, the Dental-only Plan Details page differs in the following ways:

- Monthly premium will display estimated premiums.
- If premium is guaranteed, then a checkmark and “Guaranteed Rate” will be displayed underneath the premium value.
- Only Adult Dental coverage and Child Dental coverage sections will display.
- Deductible and Out-of-pocket maximum values for Stand Alone Dental Plans will display “See plan brochure”.
- Level of Coverage (High or Low) will not display.


NOTE: Small Group (SHOP) child-only dental plans will not display in Plan Preview.

NOTE: Deductible and Out-of-pocket-maximum values for Stand Alone Dental Plans apply to child essential health benefits only. Deductible and Out-of-pocket-maximum values will always be displayed as “See plan brochure”.

Figure below shows a sample Plan Preview page for a stand-alone dental plan.

Plan Card

This is the initial view of the plan that will be displayed in the Plan Search Results on the Exchange portal.

 **Quick tips**
[Think about all costs, not just the premium](#)

Estimated monthly premium
\$100.00
✓ Guaranteed Rate

[Plan Details](#)

[Like This Plan](#)

Blue Cross & Blue Shield of Rhode Island

Dent Ind 1

PPO | Plan ID: 15287RI0390001

[See plan brochure](#)

Deductible ⓘ

[See plan brochure](#)

Out-of-pocket maximum ⓘ


[Add Your Medical Providers](#)

Add your medical providers and we'll show you which plans cover them

[Compare](#)

Plan Details

[View all limits and exclusions](#)

 **PRINT**

- [Highlights](#) ▼
- [Plan documents](#) ▼
- [Adult dental coverage](#) ▼
- [Child dental coverage](#) ▼

Figure 5-24: Plan Details Page – Stand-Alone Dental Plan

5.5 Benefit Details Page

The Benefit Details Page displays the details of the rating scenario used to generate the plan data and list benefits for your plan with their respective limits and exclusions. The information is displayed according to the plan ID listed in the Ratings Scenario. The text for the limits and exclusions field will be populated from the respective Benefits Package of the Plans and Benefits template. To access the Benefit Details page, click the ***View all limits and exclusions*** link at the top of the benefits table on the Plan Details page. The corresponding Benefit Details page will load in a new tab in your browser. The ***Print*** button allows you to print the page with your browser's standard print feature.

5.5.1 Benefit Details – Rating Scenario Section

Below is the header in the Benefit Details you will find the Ratings Scenario section. This section allows you to quickly view the variables entered in the Rating Scenario page to generate the benefit details being viewed.

Figure below shows the Rating Scenario section for a sample scenario used to generate an Individual Market plan.

Plan Preview - Rating Scenario and Benefit Details				
Rating Scenario				
This section displays the rating scenario entered to generate the benefit details shown below in the Benefit Details Section.				
Plan ID: 10055TX0040001 Exchange variant (no CSR) 1/1/2020 Zip Code: 77565 County: Galveston				
Subscriber	Date of Birth	Age	Last Tobacco Use (months)	Resides with Primary Subscriber?
Primary Subscriber	1/1/1980	40	None	Not Applicable
Spouse	12/1/1981	38	None	Yes
Dependent 1 (Child)	1/1/2015	5	None	Yes

Figure 5-25: Benefit Details Page – Rating Scenario Section

Table below describes the Rating Scenario section and will contain the same data as the respective Plan Details Page.

Table 5-22: Benefit Details Page - Rating Scenarios

Field Name	Description
Plan ID and CSR Variant	Displays the 14-digit HIOS Plan ID (Standard Component) and CSR Plan Variant: <ul style="list-style-type: none"> • Exchange variant (no CSR) • Zero Cost Sharing Plan Variation • Limited Cost Sharing Plan Variation • 73% AV Level Silver Plan CSR • 87% AV Level Silver Plan CSR • 94% AV Level Silver Plan CSR CSR Variant does not display for Small Group (SHOP) plans
Effective Date	The effective date of coverage for the rating scenario in a MM/DD/YYYY format.
Zip code	The 5-digit selected zip code.
County name	The name of the selected US county.

Field Name	Description
Subscriber name and relationship for each subscriber	<p>The type of subscriber and dependent relationship for the subscriber/dependent:</p> <ul style="list-style-type: none"> • Primary Subscriber • Spouse • Life partner • Child • Brother or Sister • Ward • Stepson or Stepdaughter • Grandson or Granddaughter • Nephew or Niece • Collateral Dependent • Ex-Spouse • Foster Child • Sponsored Dependent • Other Relationship • Other Relative
Date of birth for each subscriber and/or dependent	<ul style="list-style-type: none"> • The date of birth in DD/MM/YYYY format for each subscriber and/or dependent.
Age for each subscriber and/or dependent	<ul style="list-style-type: none"> • The age in years for each subscriber and/or dependent based on the age rating method in the Business Rules template, Effective Date entered in the Ratings Scenario, and Date of birth entered in the Ratings Scenario.
Number of months since last tobacco use for each subscriber	<p>The number of months since last tobacco use:</p> <ul style="list-style-type: none"> • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Indicator for residence with the primary subscriber for each dependent	<p>Indicates if a dependent resides with the primary subscriber:</p> <ul style="list-style-type: none"> • Yes • No • Not Applicable <p>NOTE: Does not display for SHOP</p>

5.5.2 Benefit Details – Medical Plan Benefit Section

Medical plans will display benefits as listed below:

- Primary Care doctor visit
- Specialist visit
- X-Rays and diagnostic imaging
- Laboratory outpatient and professional services
- Outpatient facility
- Outpatient professional services

- Hearing aids
- Routine eye exams for adults
- Routine eye exam for children
- Eyeglasses for children
- Generic drugs
- Preferred brand drugs
- Non-preferred brand drugs
- Specialty drugs
- Emergency room care
- Inpatient doctor and surgical services
- Inpatient hospital services (like a hospital stay)
- Routine dental care (adult) – Adult
- Basic dental care – Adult
- Major dental care – Adult
- Orthodontia – Adult
- Check-up – Child
- Major dental care – Child
- Basic dental care – Child
- Medically necessary orthodontia – Child
- Acupuncture
- Chiropractic care
- Infertility treatment
- Mental/behavioral health outpatient services
- Mental/behavioral health inpatient services
- Habilitative services
- Bariatric services
- Outpatient rehabilitation services
- Skilled nursing facility
- Private-duty nursing

Figure below displays the Benefit Details section for a medical plan.

Benefit Details		
Benefit Name	Limit	Exclusions
Primary care doctor visit	None	None
Specialist visit	None	None
X-rays and diagnostic imaging	None	None
Laboratory outpatient and professional services	None	None
Outpatient facility	None	None
Outpatient professional services	None	None
Hearing aids	None	None
Routine eye exam for adults	None	None
Routine eye exam for children	None	None
Eyeglasses for children	None	None
Generic drugs	None	None
Preferred brand drugs	None	None
Non-preferred brand drugs	None	None
Specialty drugs	None	None
Emergency room care	None	None
Inpatient doctor and surgical services	None	None
Inpatient hospital services (like a hospital stay)	None	None
Routine dental care (adults) - Adult	None	None
Basic dental care - Adult	None	None
Major dental care - Adult	None	None
Orthodontia - Adult	None	None
Check-up - Child	None	None
Major dental care - Child	None	None
Basic dental care - Child	None	None
Medically necessary orthodontia - Child	None	None
Acupuncture	None	None
Chiropractic care	35 Visit(s) per Year	None
Infertility treatment	None	None
Mental/behavioral health outpatient services	None	None
Mental/behavioral health inpatient services	None	None
Habilitative services	35 Visit(s) per Year	None
Bariatric services	None	None
Outpatient rehabilitation services	35 Visit(s) per Year	None
Skilled Nursing Facility care	25 Visit(s) per Year	None
Private-duty nursing	None	None

Figure 5-26: Benefit Details Page – Medical Plan Benefit Details

Table below describes the Benefit Details section and will contain the limits and exclusions data for the selected plan.

Table 5-23: Benefit Details – Limits and Exclusions Fields

Field Name	Description
Benefit Name	Displays the benefit name pulled from the Plan Details page. Issuer Marketing Name (pulled from HIOS “Marketplace” tab), plus the Plan Variant Marketing Name (pulled from the Cost Share Variances tab of the Plans and Benefits template). If the Issuer Marketing name is blank, displays the Issuer Legal Name (pulled from HIOS), plus the Plan Variant Marketing Name.

Field Name	Description
Limit	Displays the limit of the respective benefit (pulled from the Benefits Package tab of the Plans and Benefits template). If no limit was populated, displays "None".
Exclusions	Displays the exclusions of the respective benefit (pulled from the Benefits Package tab of the Plans and Benefits template). If no exclusions were populated, displays "None".

5.5.3 Benefit Details – Stand-Alone Dental Plan

Stand-Alone Dental Plans will display benefits as listed below:

- Routine dental care (adults) – Adult
- Basic dental care – Adult
- Major dental care – Adult
- Orthodontia – Adult
- Check-up – Child
- Major dental care – Child
- Basic dental care – Child
- Medically necessary orthodontia – Child

Figure below displays the Benefit Details section for a Stand-Alone Dental Plan.

Benefit Details PRINT		
Benefit Name	Limit	Exclusions
Routine dental care (adults) - Adult	None	None
Basic dental care - Adult	None	None
Major dental care - Adult	None	None
Orthodontia - Adult	None	None
Check-up - Child	None	None
Major dental care - Child	None	None
Basic dental care - Child	None	None
Medically necessary orthodontia - Child	None	None

Figure 5-27: Benefit Details Page – Stand-Alone Dental Plan

6 Troubleshooting and Support

6.1 Error Messages

In rare cases, a system error may occur, and you will see an error message at the top of the page as shown in Figure 6-1. If this occurs, log out of HIOS completely, delete your browser's cache history, and try using Plan Preview again. These steps resolve almost all system errors, but if a system error continues to occur, contact the CMS Helpdesk at 1-855-CMS-1515.

The screenshot shows a web application interface for 'Plan Preview - Rating Scenario'. At the top, a blue header bar contains the text '13574 - Insurance Company - NJ'. Below this, a red error banner displays a message: 'A system error has occurred. If the problem persists, please contact the Help Desk. Error Code: 300'. The main heading is 'Plan Preview - Rating Scenario'. A note states: 'All fields marked with an asterisk (*) are required.' Below this, a paragraph explains: 'This Plan Preview page allows issuers to input a Rating Scenario and confirm what plans are available for the input criteria. Enter a scenario below and then click the Update Plan Results button to view plan information.'

The 'Apply Rating Scenario' form includes the following fields and options:

- Market Type:** Radio buttons for 'Individual' (selected) and 'Small Group (SHOP)'.
- Effective Date:** A date picker showing '01/01/2016' with the format 'MM/DD/YYYY' below it.
- Cost Sharing Reduction (CSR) Variant:** A dropdown menu currently showing 'Exchange Variant (no CSR)'.
- Return Catastrophic Plans:** A checkbox that is currently unchecked.
- Primary Subscriber Section:**
 - Date of Birth:** A date picker showing '01/01/1980' with the format 'MM/DD/YYYY' below it.
 - Number of Months Since Last Tobacco Use:** A text input field with the instruction 'Leave Blank For No Tobacco Use' below it.
 - Gender:** A dropdown menu showing 'Male'.
 - Zip Code:** A text input field showing '07047' with the format 'XXXXX' below it.
 - County:** A dropdown menu showing 'Hudson'.

At the bottom of the form, there are three blue buttons: 'Add Spouse/Life Partner', 'Add Dependent', and 'Update Plan Results'.

Figure 6-1: Error Message

On the Rating Scenario Page, you may see errors about required or invalid data fields for either Individual Market (see Figure 6-2) or SHOP plans (see Figure 6-3). Errors could be the result of the examples provided in Table 6-1 (for Individual Market) or Table 6-2 (for SHOP).

Figure below shows potential field errors on the Rating Scenario Page for Individual Market plans.

10333 - TEST 14.0 - TX

Your information contains 7 errors

- *Effective Date: Important:This field is required
- *Cost Sharing Reduction (CSR) Variant: Important:This field is required
- *Date of Birth: Important:This field is required
- *Zip Code: Important:This field is required
- *Date of Birth: Important:This field is required
- *Relationship: Important:This field is required
- *Same Address as Primary Subscriber: Important:This field is required

Plan Preview - Rating Scenario

All fields marked with an asterisk (*) are required.

This Plan Preview page allows Issuers to input a Rating Scenario and confirm what plans are available for the input criteria. Enter a scenario below and then click the Update Plan Results button to view plan information.

Apply Rating Scenario

***Market Type**

Individual
 Small Group (SHOP)

***Effective Date:** Important:This field is required

***Cost Sharing Reduction (CSR) Variant:** Select a Cost Sharing Variant Important:This field is required Return Catastrophic Plans

Primary Subscriber

***Date of Birth:** Important:This field is required **Number of Months Since Last Tobacco Use:** Leave Blank For No Tobacco Use **Gender:** Select Gender

***Zip Code:** Important:This field is required ***County:** Select County

Spouse/Life Partner

***Date of Birth:** Important:This field is required **Number of Months Since Last Tobacco Use:** Leave Blank For No Tobacco Use **Gender:** Select Gender

***Relationship:** Select a Relationship Important:This field is required ***Same Address as Primary Subscriber:** Yes No Important:This field is required

[Remove Spouse/Life Partner](#)

Add Spouse/Life Partner
Add Dependent
Update Plan Results

Figure 6-2: Individual Market Plan Field Validation Errors

Table below describes potential validation error messages that display on the top of the Rating Scenario page for Individual Market plans.

Table 6-1: Individual Market Plan Field Validation Error Messages

Error Message Reason	Error Message Text
User did not select a state	State: Important: This field is required.
User enters an effective date prior to 1/1/2021 or after 12/31/2021	Effective Date: Important: Please enter a valid date.

Error Message Reason	Error Message Text
User enters an effective date with fewer than 8 digits	Effective Date: Important: This is not a valid date.
User does not enter an effective date	Effective Date: Important: This field is required.
User does not select Cost Sharing Variant	Cost Sharing Reduction (CSR) Variant: Important: This field is required.
User does not enter date of birth for primary subscriber	Date of Birth: Important: This field is required.
User enters invalid date of birth for primary subscriber	Date of Birth: Important: This is not a valid date.
User enters incorrect zip code	Zip Code: Important: This field is required.
User does not select a county	County: Important: This field is required.
User does not enter date of birth for dependent	Date of Birth: Important: This field is required.
User enters invalid date of birth for dependent	Date of Birth: Important: This is not a valid date.
User does not enter relationship for dependent	Relationship: Important: This field is required.
User does not select whether the dependent resides with the primary subscriber	Same address as primary: Please select at least 1 item(s).
No plans are available	No Plans Available for Input Criteria.

Figure below shows potential field errors on the Rating Scenario Page for SHOP plans.

10333 - TEST 14.0 - TX

Plan Preview - Rating Scenario

All fields marked with an asterisk (*) are required.

This Plan Preview page allows Issuers to input a Rating Scenario and confirm what plans are available for the input criteria. Enter a scenario below and then click the Update Plan Results button to view plan information.

Apply Rating Scenario

***Market Type**

Individual

Small Group (SHOP)

***Effective Date:** ***Employer Zip Code:** ***Employer County:**

Important: This field is required
 Important: This field is required

Primary Subscriber

***Date of Birth:** **Number of Months Since Last Tobacco Use:** **Gender:**

Important: This field is required

 Leave Blank For No Tobacco Use

Spouse/Life Partner

***Date of Birth:** **Number of Months Since Last Tobacco Use:** **Gender:**

Important: This field is required

 Leave Blank For No Tobacco Use

***Relationship:**

Important: This field is required

[Remove Spouse/Life Partner](#)

[Add Spouse/Life Partner](#)
[Add Dependent](#)
[Update Plan Results](#)

Figure 6-3: SHOP Plan Field Validation Errors

Table below describes potential validation error messages that display on the top of the Rating Scenario page for SHOP plans.

Table 6-2: SHOP Plan Field Validation Error Messages

Error Message Reason	Error Message Text
User did not select a state	State: Important: This field is required.
User enters an effective date prior to 1/1/2021 or after 12/31/2021	Effective Date: Important: Please enter a valid date.
User enters an effective date with fewer than 8 digits	Effective Date: Important: This is not a valid date.
User does not enter an effective date	Effective Date: Important: This field is required.
User does not enter date of birth for primary subscriber	Date of Birth: Important: This field is required.
User enters invalid date of birth for primary subscriber	Date of Birth: Important: This is not a valid date.
User enters incorrect zip code	Zip Code: Important: This field is required.
User does not select a county	County: Important: This field is required.
User does not enter date of birth for dependent	Important: This field is required.
User enters invalid date of birth for dependent	Important: This is not a valid date.
User does not enter relationship for dependent	Important: This field is required.
No plans are available	No Plans Available for Input Criteria.

6.2 Support

Table below provides a list of contacts.

Table 6-3: 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	1 st level user support & problem reporting

Appendix A: Acronyms and Abbreviations

Table 6-4: Acronyms and Abbreviations

Acronym/ Abbreviation	Literal Translation
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CSR	Cost Sharing Reduction
EHB	Essential Health Benefit
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
FFE	Federally Facilitated Exchange
MOOP	Maximum Out-of-Pocket
MSD	Marketplace Service Desk
QHP	Qualified Health Plans
SADP	Stand-Alone Dental Plan
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
XML	Extensible Markup Language

Appendix B: Plan Suppression and Display Logic

For your reference, Table below displays the display logic for Plan Preview based on plan certification and suppression.

Note: For HIOS submissions Benefits and Service Area & Issuer Module must be validated. For the Rating Module only Business Rules template is required in order to view the plans on Plan Preview. For SERFF submissions all templates except Rates need to be submitted in order to view plans on Plan Preview. For those who have not submitted their Rates Table Template, “No Rates Available” will be displayed on the Plan Preview Module under monthly premium.

Table 6-5: Display Logic for Plan Certification and Suppression

Cross-validation	Certification	Suppression	Plan Preview Display
Missing any template other than Rates	Any	Any	Excluded from display
Must have all templates except Rates template or Cross-validated	None	None	Displays available (based on enrollment criteria)
Must have all templates except Rates template or Cross-validated	Pending Review	Not Applicable	Displays available (based on enrollment criteria)
Must have all templates except Rates template or Cross-validated	Pending Review and Submission of Rates	Not Applicable	Displays available (based on enrollment criteria)
Must have all templates except Rates template or Cross-validated	Certified	Available	Displays available (based on enrollment criteria)
Must have all templates except Rates template or Cross-validated	Certified	Suspended	Displays available with warning message (based on enrollment criteria)
Must have all templates except Rates template or Cross-validated	Certified	Closed	Displays unavailable with specific reason text
Must have all templates except Rates template or Cross-validated	Certified	Not Applicable	Unexpected case; will display unavailable with reason code
Must have all templates except Rates template or Cross-validated	Not Eligible for CMS Certification	Not Applicable	Excluded from display

Cross-validation	Certification	Suppression	Plan Preview Display
Must have all templates except Rates template or Cross-validated	Decertified	Not Applicable	Excluded from display
Must have all templates except Rates template or Cross-validated	Certified Off-Exchange SADP	Not Applicable	Excluded from display
Must have all templates except Rates template or Cross-validated	SBE-Certified	Not Applicable	Excluded from display
Must have all templates except Rates template or Cross-validated	SBE-Not Certified	Not Applicable	Excluded from display