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

FFE Plan Management
Plan Preview User Guide

Version 12.1
Plan Year 2019
May 2018

consulting | technology | outsourcing

Approvals

Submitting Organization's Approving Authority:

Signature	Printed Name	Date	Phone Number

CMS's Approving Authority:

Signature	Printed Name	Date	Phone Number

Revision History

Version	Date	Organization/Point of Contact	Description of Changes
9.0	04/22/2015	Accenture/Plan Management	Development for 2016 Plan Management Templates & System Functionality
9.1	05/11/2015	Accenture/Plan Management	Development for 2016 Plan Management Templates & System Functionality
10.0	04/08/2016	Accenture/Plan Management	Development for 2017 Plan Management Templates & System Functionality
11.0	04/11/2017	Accenture/Plan Management	Development for 2018 Plan Management Templates & System Functionality
12.0	04/02/2018	Accenture/Plan Management	Development for 2019 Plan Management Templates & System Functionality
12.1	05/15/2018	Accenture/Plan Management	Incorporated feedback from CMS

Contents

Figures

Tables

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 2019 Plan Preview module. The 2019 Plan Preview system can be used to view only Plan Year 2019 plans and cannot be used to view Plan Year 2018 plans. To view Plan Year 2018 plans, please use the 2018 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 zONE 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:
    - Internet Explorer 11 (latest version available for supported operating systems as of 12/1/2016)
    - Firefox 56.0
3. Recommended Excel Versions include Excel 2013 and Excel 2016.

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 were cross-validated in the QHP Application modules or submitted via the System for Electronic Rate and Form Filing (SERFF). 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.

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 three main pages: the Summary page, The Rating Scenario page and the Plan 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.

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 1 shows the Issuer Summary page.

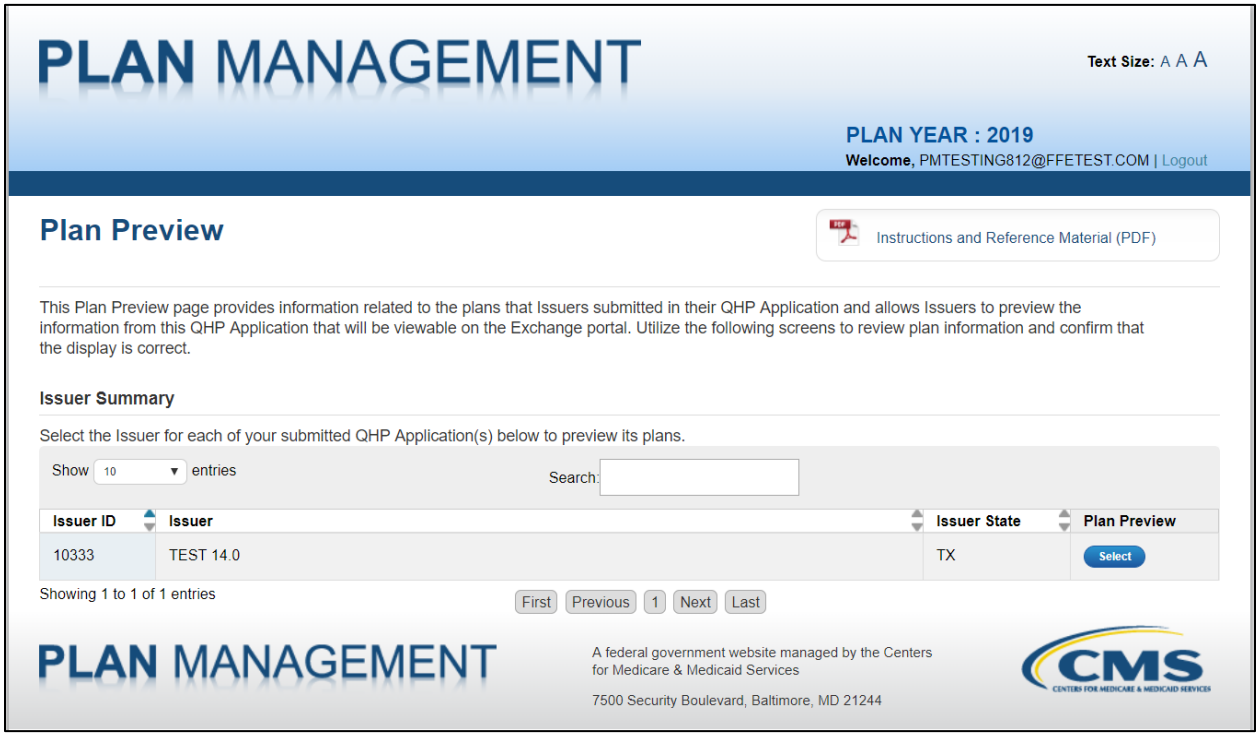


Figure 1: Issuer Summary Page

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 1 describes the fields on the Issuer Summary page.

Table 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 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 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.)

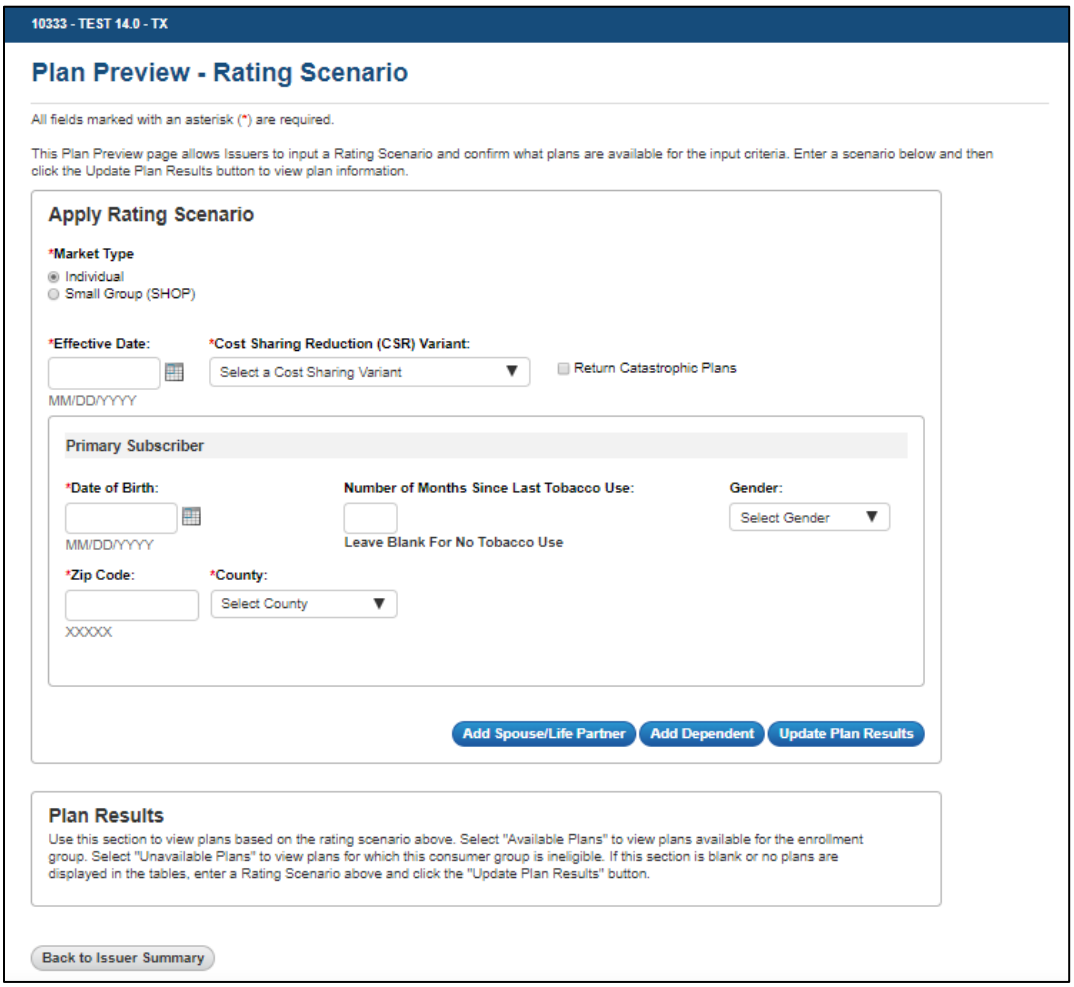


Figure 2: Rating Scenario – Apply Rating Scenario (Individual)

Enter your general plan criteria in the “Apply Rating Scenario” box and information about the primary subscriber in the “Primary Subscriber” box. Table 2 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 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 • Individual • Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY 2019 plans can be viewed in 2019 Plan Preview.	Date (MM/DD/YYYY)
Cost Sharing Reduction (CSR) Variant	Allows the user to select a CSR variation type to view.	Dropdown • Exchange variant (no CSR) • Zero Cost Sharing Plan Variation • Limited Cost Sharing Plan Variation • 73% AV Level Silver Plan CSR • 87% AV Level Silver Plan CSR • 94% AV Level Silver Plan CSR
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 3 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 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 • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown • Male • Female
Zip Code	Allows the user to enter a 5 digit zip code.	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 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.

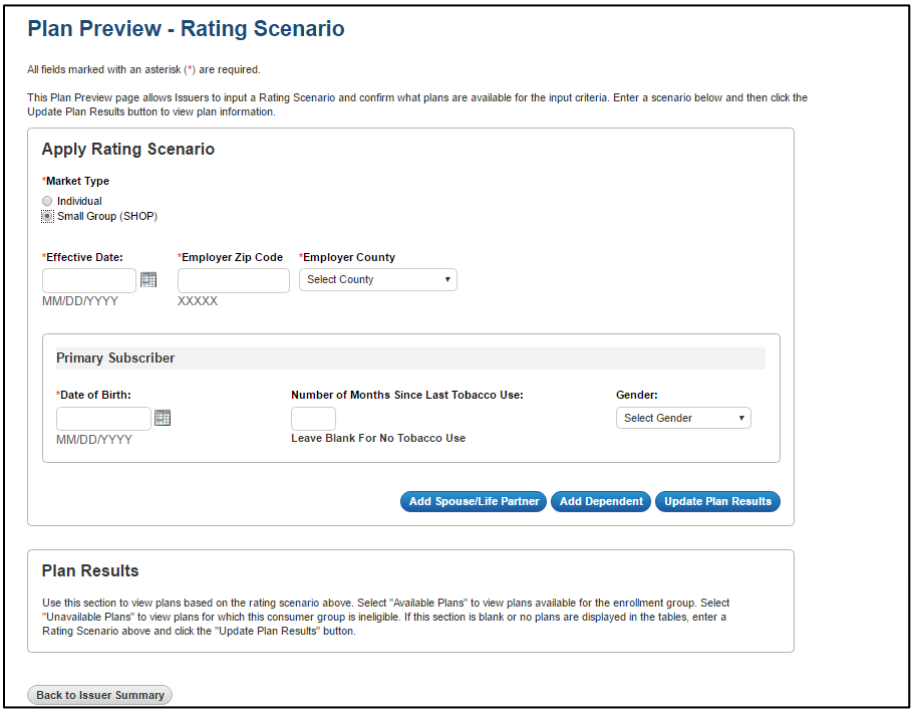


Figure 3: Rating Scenario – Apply Rating Scenario (SHOP)

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 4 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 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 • Individual • Small Group (SHOP)

Field Name	Description	Value
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY 2019 plans can be viewed in 2019 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 5 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: 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 • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown • Male • Female

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, Child, Brother or Sister, or Ward. 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 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 4 shows the Spouse/Life Partner box on the Rating Scenario page.

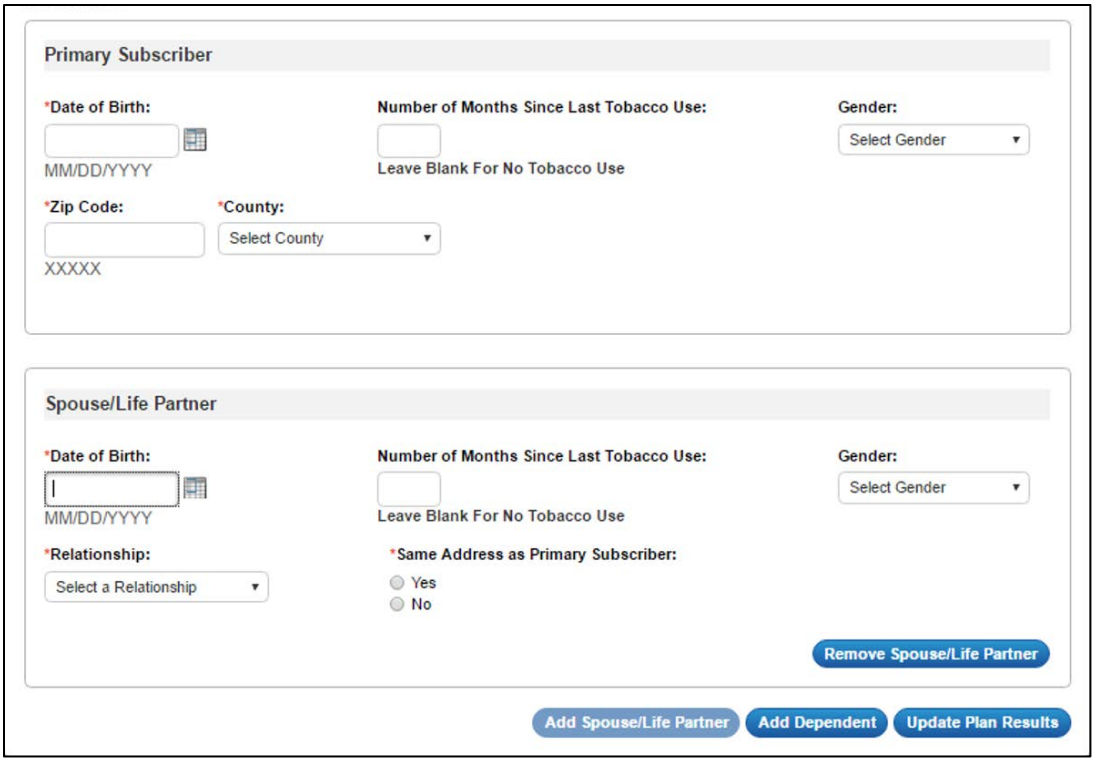


Figure 4: Rating Scenario – Add Spouse/Life Partner

Table 6 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 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 • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the spouse/life partner (not required).	Dropdown • Male • Female
Relationship	Allows the user to identify the relationship type.	Dropdown • Spouse • Life Partner
Same address as Primary Subscriber	Allows the user to indicate whether or not the spouse/life partner's address is the same as the primary subscriber's address. (**NOTE**: Does not appear for SHOP.)	Radio button • Yes • No

To add a 'child,' 'brother or sister,' or 'ward' 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 5 shows an enrollment group with a child, ward and brother or sister as dependents on the Rating Scenario page.

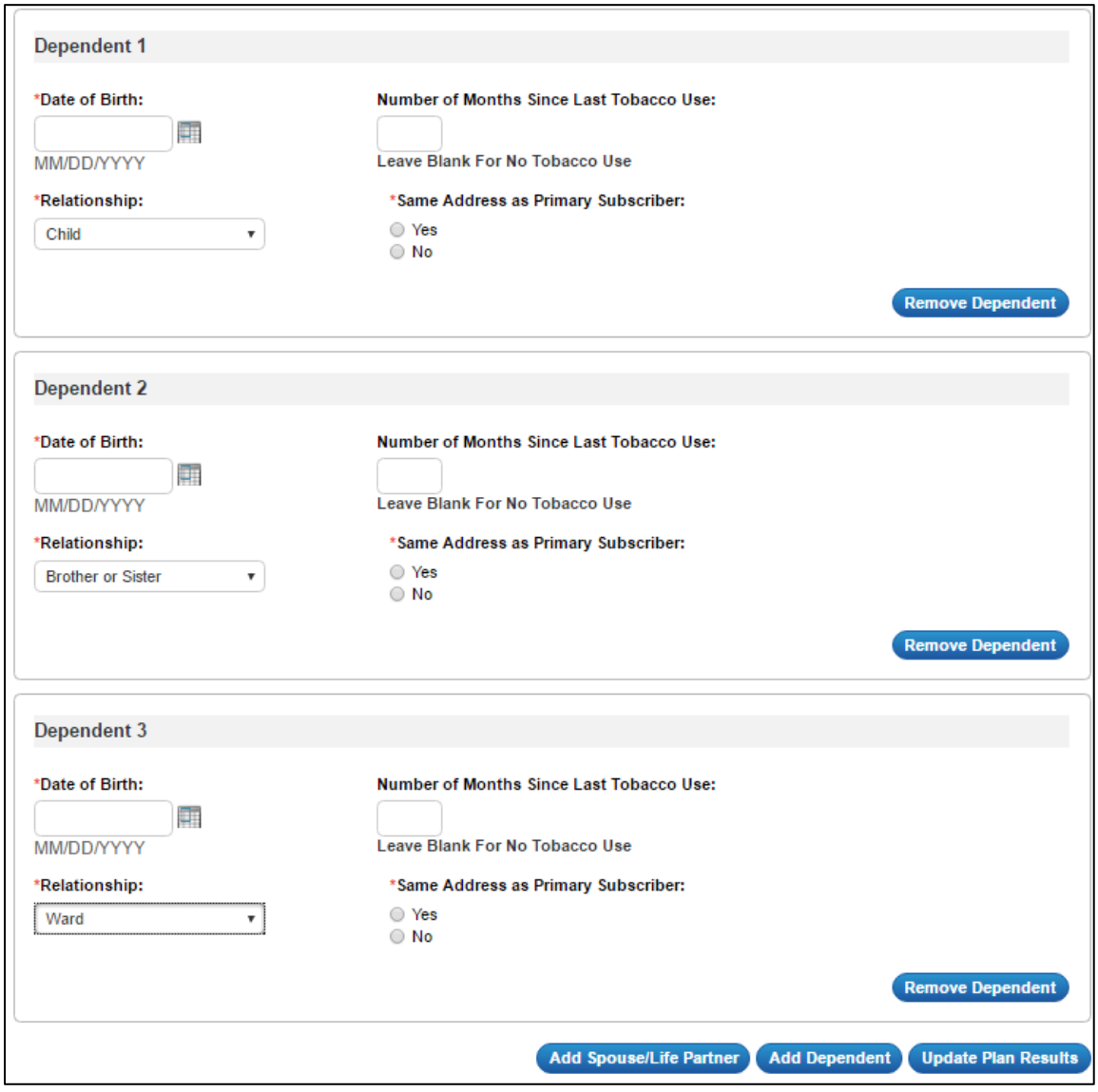


Figure 5: Rating Scenario – Add Dependent

Table 7 describes the fields in the dependent box on the Rating Scenario page and provides instructions about how to enter data in these fields.

Table 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 • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Relationship	Allows the user to identify the relationship type.	Dropdown • Child • Brother or Sister • Ward
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 • 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 6 shows the Plan Results table with a list of available plans for the rating scenario.

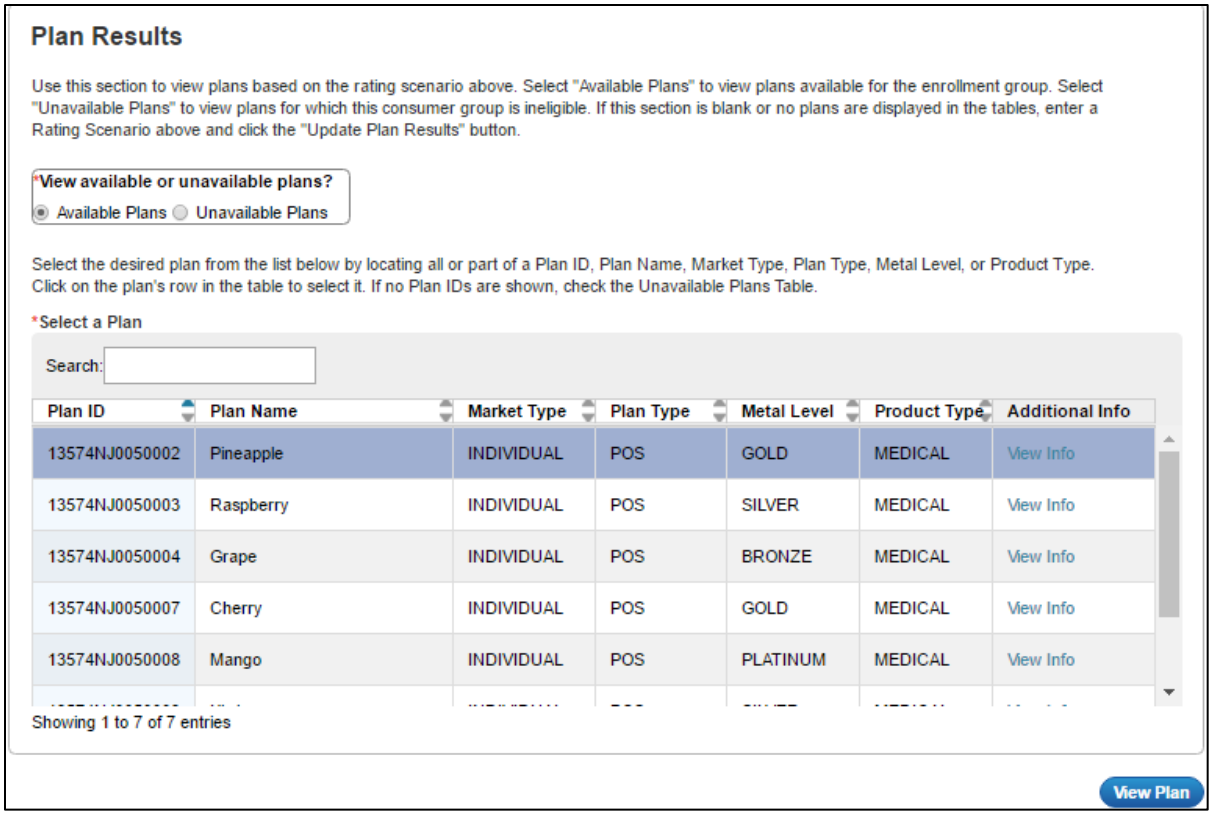


Figure 6: Plan Results – Available Plans

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 submitted Plans and Benefits template. Customer Service Phone Number, Customer Service URL, and Billing Address fields are populated via data entered in HIOS in the "Marketplace" tab.

Figure 7 shows the Additional Info pop-up.

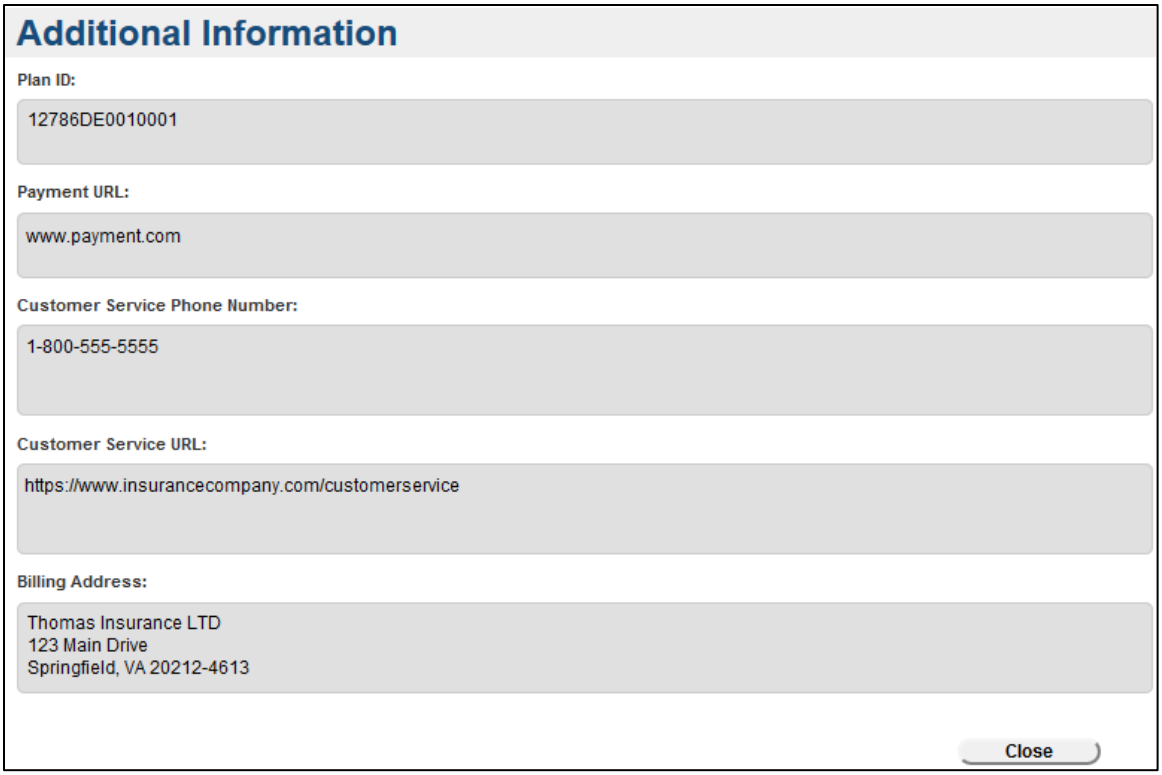


Figure 7: Available Plans – Additional Information

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.

Only cross-validated plans will display on the Available or Unavailable Plans Table. For your reference a complete list of unavailable reasons and codes is provided in Table 8 below.

Table 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. "Spouse 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. • 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, or life partner 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
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 8 shows the Plan Results table with a list of unavailable plans. Figure 9 shows the same table after clicking the ***View Info*** button for the plans shown.

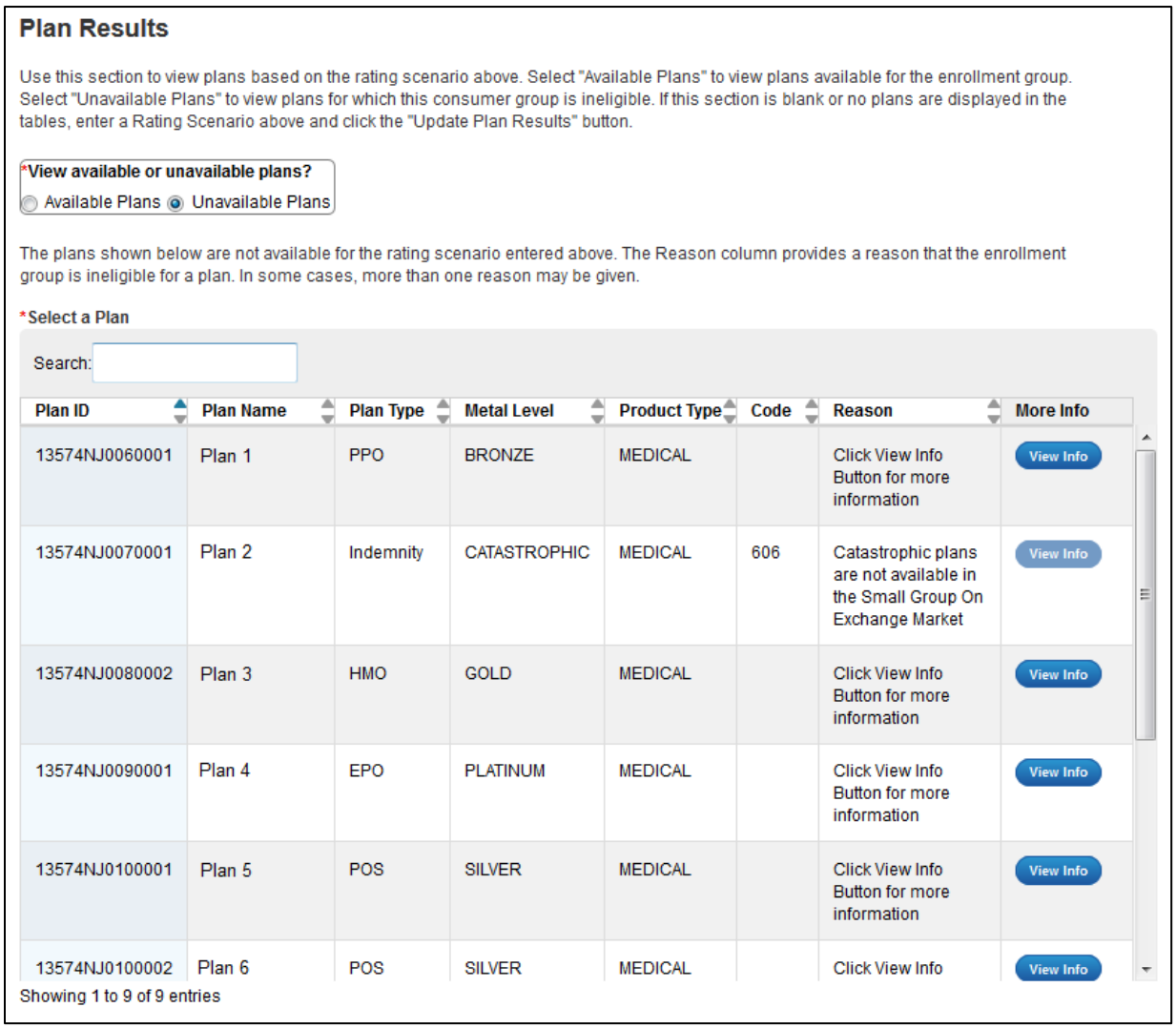


Figure 8: Plan Results – Unavailable Plans

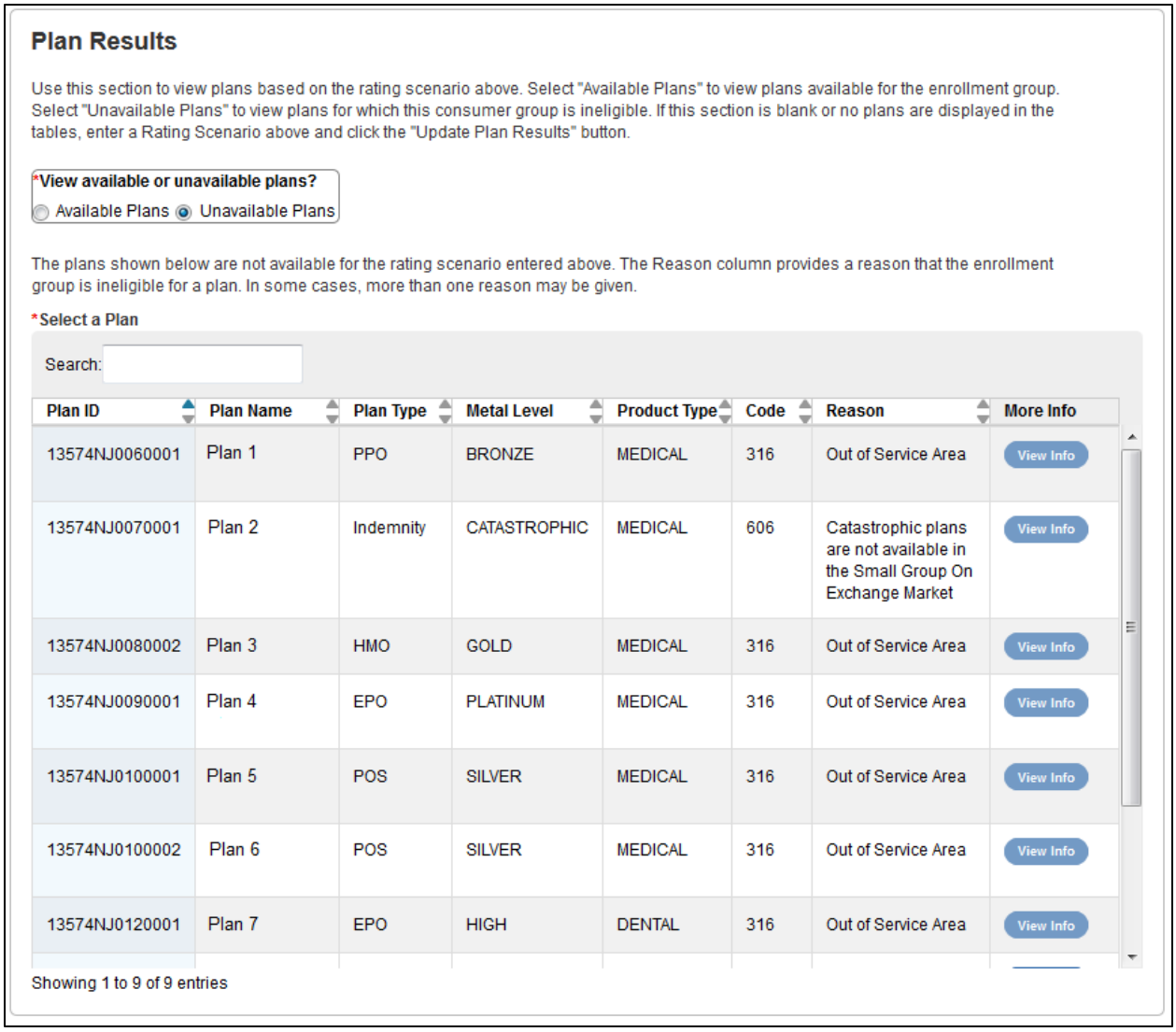


Figure 9: Plan Results – Unavailable Plans after *View Info* Button is clicked

You can search the list of plans by Plan ID, Plan Name, Plan Type, Metal Level, or Product Type (see Table 9).

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 9: Plan Results – Available Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric

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

Table 10 describes the fields for unavailable plans in the Select a Plan section on the Rating Scenario Page.

Table 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.	• PPO • HMO • POS • EPO • Indemnity
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans: • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans: • High • Low

Field Name	Description	Value
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	• Medical • Dental
Code	Numerical value referencing why a plan shows as unavailable	Numeric
Reason	Provides a description of the reason code for why plan is unavailable	Text

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

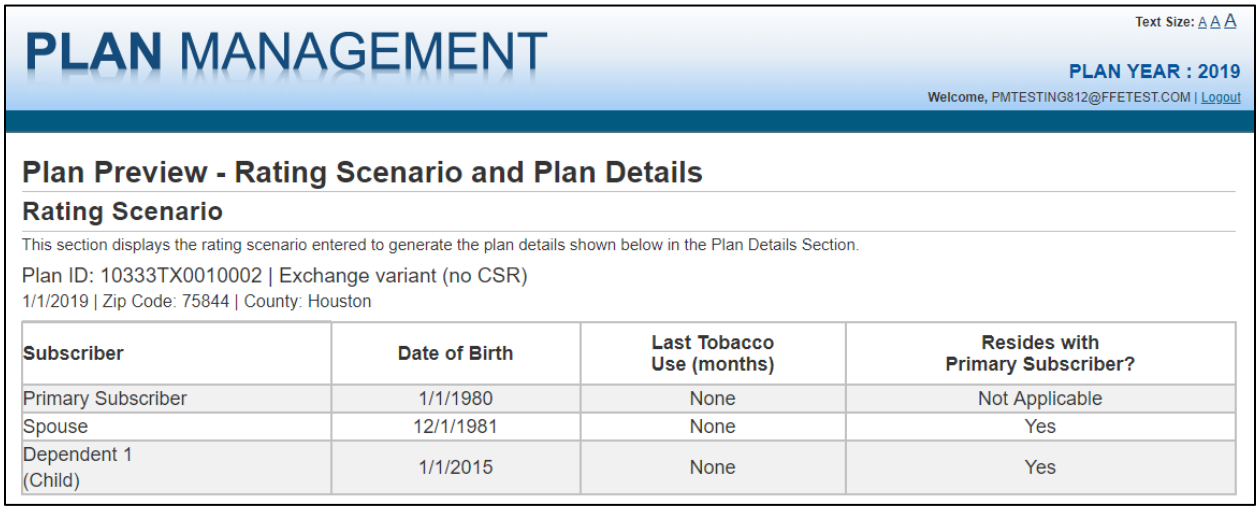


Figure 10: Plan Details Page – Rating Scenario Section

Table 11 describes the fields on the Ratings Scenario section of the Plan Details Page for Individual and Small Group (SHOP).

Table 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: • 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: • Primary Subscriber • Spouse • Life partner • Child • Brother or Sister • Ward
Date of birth for each subscriber and/or dependent	• The date of birth in DD/MM/YYYY format for each subscriber and/or dependent.
Number of months since last tobacco use for each subscriber	The number of months since last tobacco use: • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Indicator for residence with the primary subscriber for each dependent	Indicates if a dependent resides with the primary subscriber: • Yes • No • Not Applicable **NOTE**: Does not display for SHOP

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 12 describes the fields on the overview section of the Plan Details Page for Individual and Small Group (SHOP). CMS is not specifying standardized plan designs, so the "Simple Choice" indicator will no longer appear. 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.

Figure 11 shows the Plan Overview section for a sample plan in the Individual Exchange.

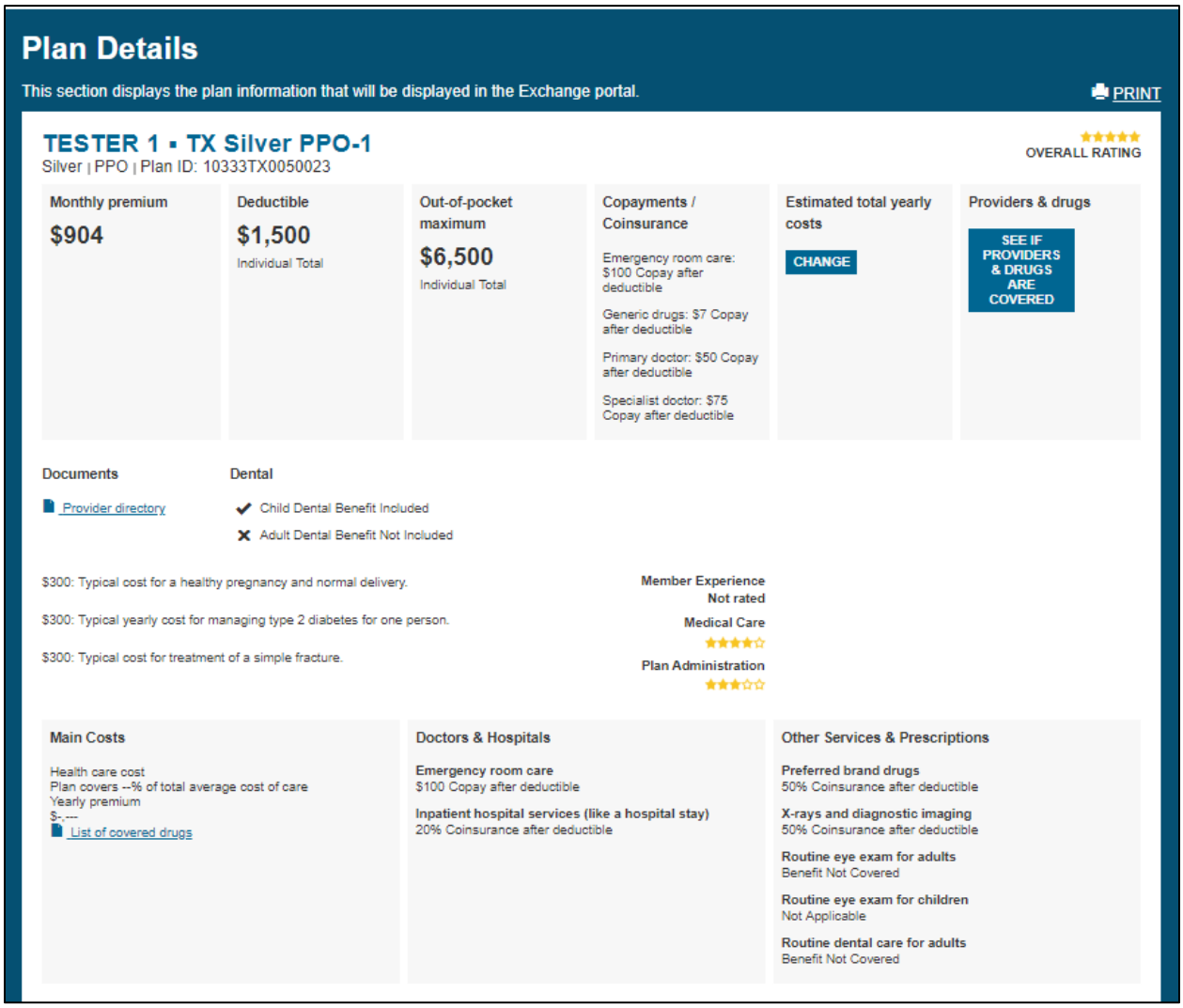


Figure 11: Plan Details Page – Overview Fields

Table 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.

Field Name	Description
Plan Attributes	Displays the following details of the selected plan, in this order (if applicable): 1) Level of Coverage 2) Plan Type 3) "National Provider Network" displays if the "National Network" field in the Plans and Benefits template is equal to "Yes." No text displays if the "National Network" field is equal to "No" 4) Plan ID
Overall Rating (Quality Measures)	Displays the overall quality rating as 1-5 stars for the selected plan. **NOTE**: If no quality data is available for the plan, the Rating will display 'Not rated.' If the plan is ineligible for scoring because it is a new plan, then 'New Plan – Quality Ratings unavailable' will display.
Other Rating (Other Quality Measures)	Displays the Member Experience, Medical Care, and Plan Administration rating as 1-5 stars for the selected plan. **NOTE**: If no quality data is available for the plan, or if the plan is ineligible for scoring because it is a new plan, then 'Not rated' will display.
Monthly Premium	Displays the monthly premium amount that the rating engine calculates based on the individuals in the enrollment group and the plan effective date. For Stand Alone Dental Plans, displays either "Guaranteed Rate" or "Estimated Rate" along with the premium amount, based on the "Guaranteed vs. Estimated Rates" field in the Plans and Benefits template.

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

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

Field Name	Description
Copayments /Coinsurance	For Primary Doctor, Specialist Doctor, or Generic Prescription, displays cost-sharing information according to the Copay/Coinsurance mapping logic in section 5.4.1. Displays information from the following fields in the Plans and Benefits template: • Emergency Room Services • Generic Drugs • Primary Care Visit to Treat an Injury or Illness • Specialist Visit
Estimated total yearly costs	This field is included to mimic what will display in Plan Compare, however, the "CHANGE" button will be inactive in Plan Preview. **NOTE**: In Plan Preview this is a placeholder and will not display values for the costs.
Providers & Drugs	This field is included to mimic what will display in Plan Compare, however, the "SEE IF PROVIDERS & DRUG ARE COVERED" button will be inactive in Plan Preview. **NOTE**: In Plan Preview this is a placeholder and will not display covered provider or drugs.
Documents	The "Summary of Benefits" field displays the Summary of Benefits & Coverage URL as entered in in the Plans and Benefits template. The "Plan Brochure" field displays the Plan Brochure URL as entered in the Plans and Benefits template. The "Provider Directory" field displays the Network URL as entered in the Network ID template.

Field Name	Description
Dental	Indicates whether the plan includes dental coverage. If the plan offers Child Dental, displays “Child Dental Benefit Included” with a checkmark. If the plan does not offer Child Dental, displays “Child Dental Benefit Not Included” with an ‘X’. If the plan offers Adult Dental, displays “Adult Dental Benefit Included” with a checkmark. If the plan does not offer Adult Dental, displays “Adult Dental Benefit Not Included”, with an ‘X’. A plan is considered to cover adult dental benefits if it covers all three of the following benefits: • Routine Dental Services (Adult) • Basic Dental Care (Adult) • Major Dental Care (Adult) A plan is considered to cover child dental benefits if it covers all three of the following benefits: • Dental Check-Up for Children • Basic Dental Care (Child) • Major Dental Care (Child)
Typical cost for a healthy pregnancy and normal delivery	Displays the typical cost for a healthy pregnancy and normal delivery for your specific plan.
Typical yearly cost for managing type 2 diabetes for one person	Displays the typical annual cost for managing type 2 diabetes for one person.
Typical cost for treatment of a simple fracture	Displays the typical cost for the treatment of a simple fracture for your specific plan.
Main Costs	This field is included to mimic what will display in Plan Compare. The field includes the average percentage of costs covered under this plan and the plan’s yearly premium as static text. **NOTE**: In Plan Preview this is a placeholder and will not display values for the costs.
Doctors & Hospitals	Displays coverage descriptions for the following: • Emergency room care • Inpatient hospital services (like a hospital stay)

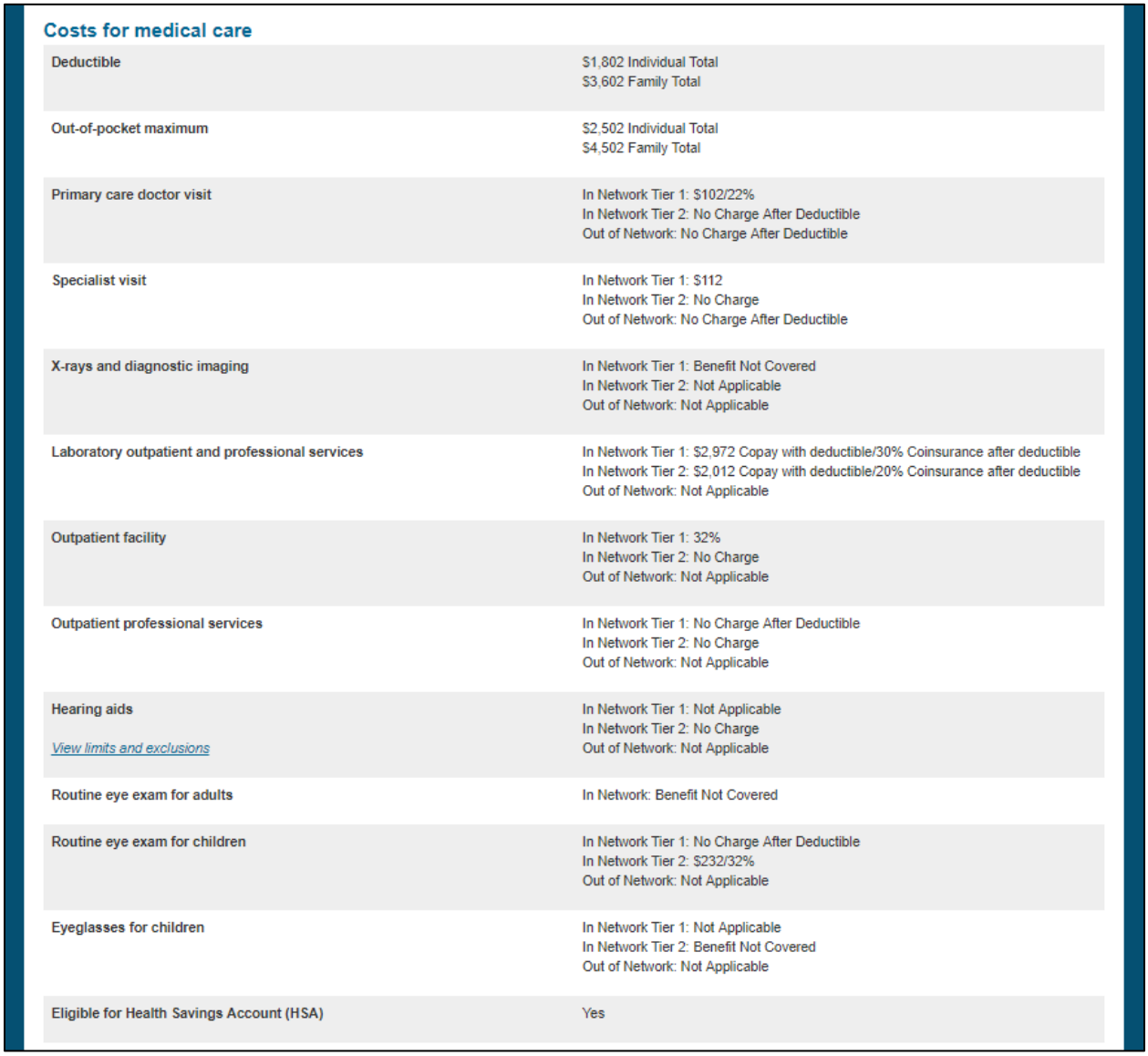
Field Name	Description
Other Services & Prescriptions	Displays coverage descriptions for the following: • Preferred brand drugs • X-rays and diagnostic imaging • Routine eye exams for adults • Routine eye exam for children • Routine dental care for children • Routine dental care for adults

5.4.3 Plan Details – Benefits Sections

The Plan Details page contains nine 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 Adult Dental Coverage and Child Dental Coverage fields.

Figure 12 shows the Medical Care Coverage section of the Plan Details page.



Costs for medical care

Deductible	$1,802 Individual Total $3,602 Family Total
Out-of-pocket maximum	$2,502 Individual Total $4,502 Family 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: Benefit Not Covered In Network Tier 2: Not Applicable Out of Network: Not Applicable
Laboratory outpatient and professional services	In Network Tier 1: $2,972 Copay with deductible/30% Coinsurance after deductible In Network Tier 2: $2,012 Copay with deductible/20% Coinsurance after deductible 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 *View limits and exclusions*	In Network Tier 1: Not Applicable In Network Tier 2: No Charge Out of Network: Not Applicable
Routine eye exam for adults	In Network: Benefit Not Covered
Routine eye exam for children	In Network Tier 1: No Charge After Deductible In Network Tier 2: $232/32% Out of Network: Not Applicable
Eyeglasses for children	In Network Tier 1: Not Applicable In Network Tier 2: Benefit Not Covered Out of Network: Not Applicable
Eligible for Health Savings Account (HSA)	Yes

Figure 12: Plan Details – Costs for Medical Care Section

Table 13 describes the fields in the Medical Care Coverage section of the Plan Details Page.

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

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

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

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

Figure 13 shows the Prescription Drug Coverage section of the Plan Details Page.

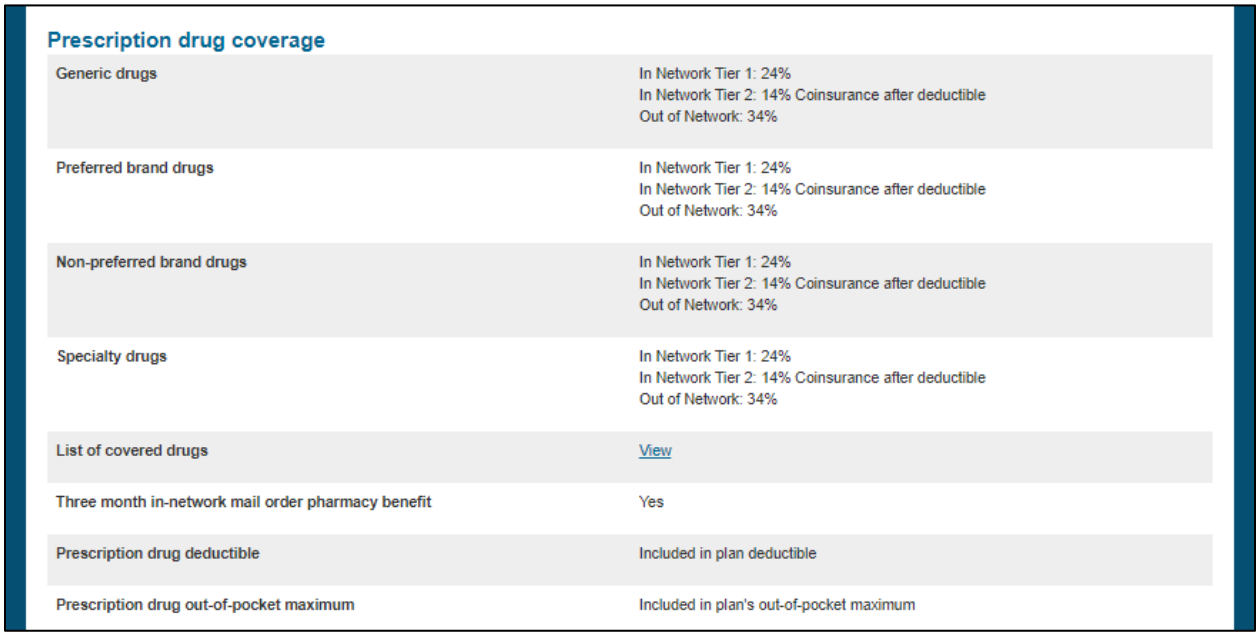


Figure 13: Plan Details – Prescription Drug Coverage Section

Table 14 describes the fields in the Prescription Drug Coverage section of the Plan Details page.

Table 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.

Field Name	Description
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 Plans and Benefits template.
Three month in-network mail order pharmacy benefit	Indicates whether this plan offers three month In-Network mail order pharmacy benefits. If either the “3 Month In Network Mail Order Pharmacy Benefit Offered?” or “3 Month Out of Network Mail Order Pharmacy Benefit Offered?” fields are listed as “Yes” in the Prescription Drug template, displays “Yes”; otherwise, displays “No.”

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

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

Figure 14 shows the Access to Doctors and Hospitals section of the Plan Details page.

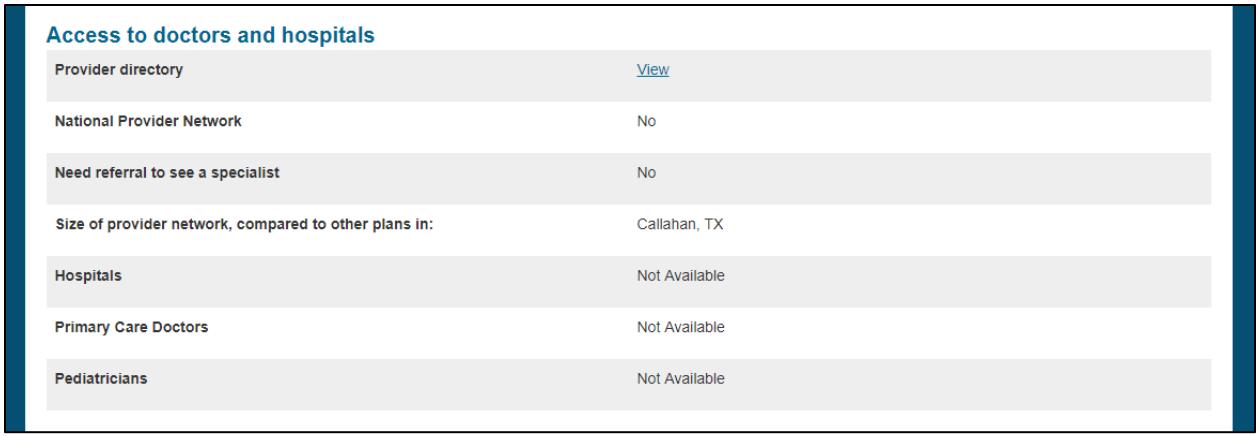


Figure 14: Plan Details – Access to Doctors and Hospitals Section

Table 15 describes the fields in the Access to Doctors and Hospitals section of the Plan Details page.

Table 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 Network template.
National Provider Network	Indicates whether this plan is a national provider network, based on the "National Network" field 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 in	Displays the user-entered county
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 15 shows the Hospital Services section of the Plan Details page.

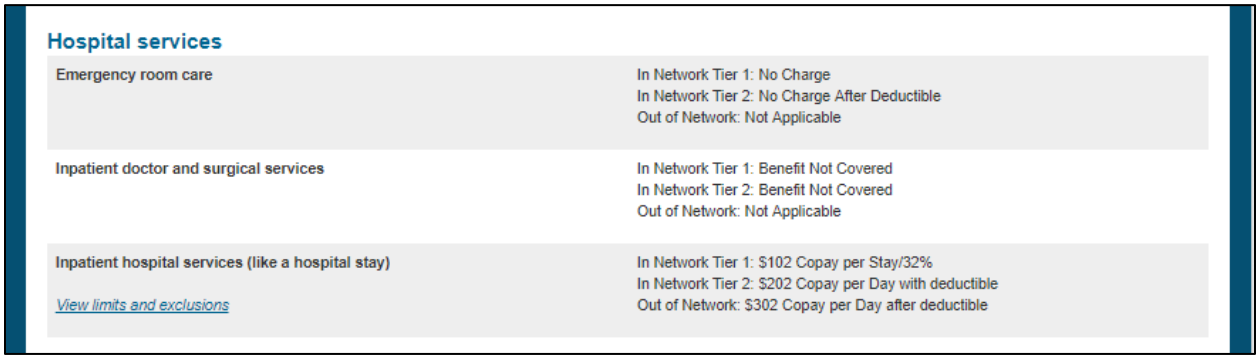


Figure 15: Plan Details – Hospital Services Section

Table 16 describes the fields in the Hospital Services section of the Plan Details page.

Table 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 16 shows the Cost and Coverage Examples section of the Plan Details page.

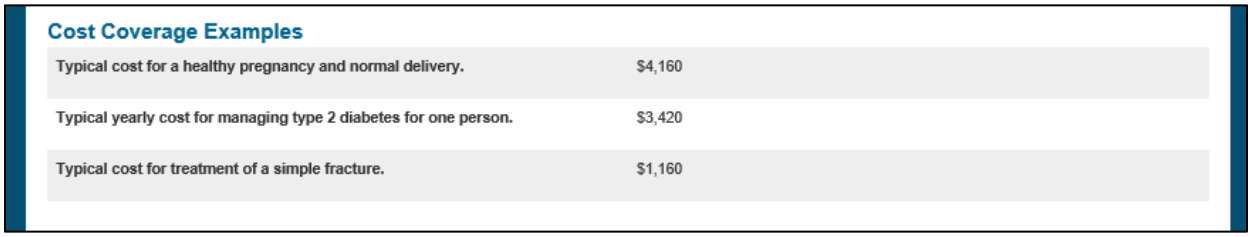


Figure 16: Plan Details – Cost and Coverage Examples Section

Table 17 describes the fields in the Cost and Coverage Examples section of the Plan Details page.

Table 17: Plan Details – Cost and Coverage Examples Section Fields

Field Name	Description
Typical cost for a healthy pregnancy and normal delivery	Displays the sum of the following four values from the Plans and Benefits template: • Having a Baby – Deductible • Having a Baby – Copayment • Having a Baby – Coinsurance • Having a Baby – Limit

Field Name	Description
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: • Having Diabetes – Deductible • Having Diabetes – Copayment • Having Diabetes – Coinsurance • Having Diabetes – Limit
Typical cost of treatment of a simple fracture	Displays the sum of the following four values from the Plans and Benefits template: • Treatment of a Simple Fracture – Deductible • Treatment of a Simple Fracture – Copayment • Treatment of a Simple Fracture – Coinsurance • Treatment of a Simple Fracture – Limit

Figure 17 shows the Adult Dental Coverage section of the Plan Details page.

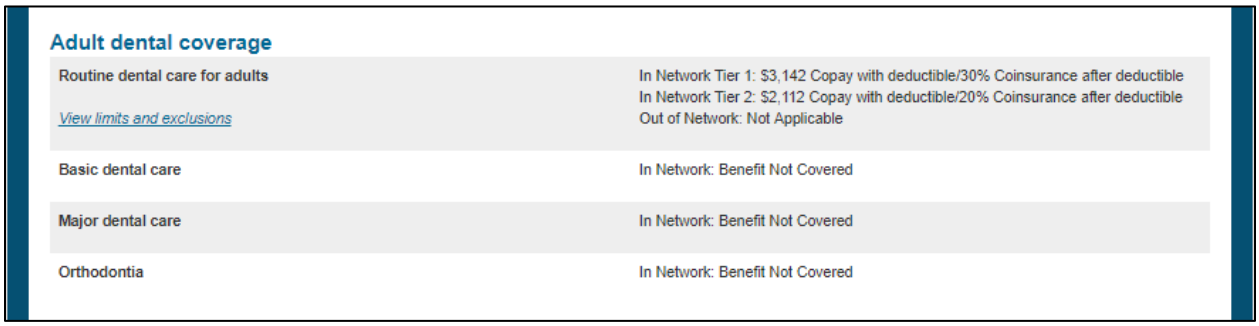


Figure 17: Plan Details – Adult Dental Coverage Section

Table 18 describes the fields in the Adult Dental Coverage section of the Plan Details page.

Table 18: Plan Details – Adult Dental Coverage Section Fields

Field Name	Description
Routine dental care for 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 18 shows the Child Dental Coverage section of the Plan Details page.

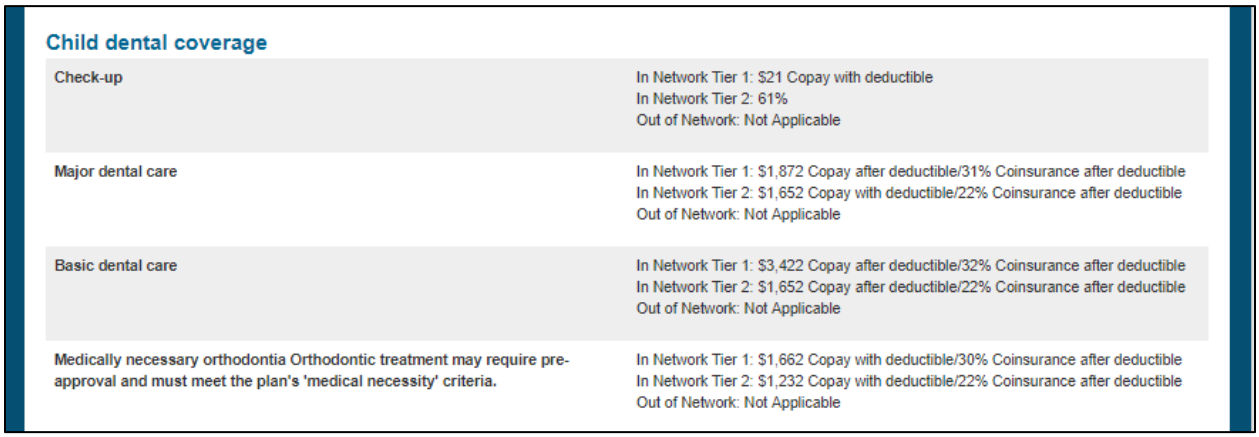


Figure 18: Plan Details – Child Dental Coverage Section

Table 19 describes the fields in the Child Dental Coverage section of the Plan Detail page.

Table 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	Provides cost sharing information for the benefit “Orthodontia – Child,” found in the Plans and Benefits template.

Figure 19 shows the Medical Management Programs section of the Plan Details page.

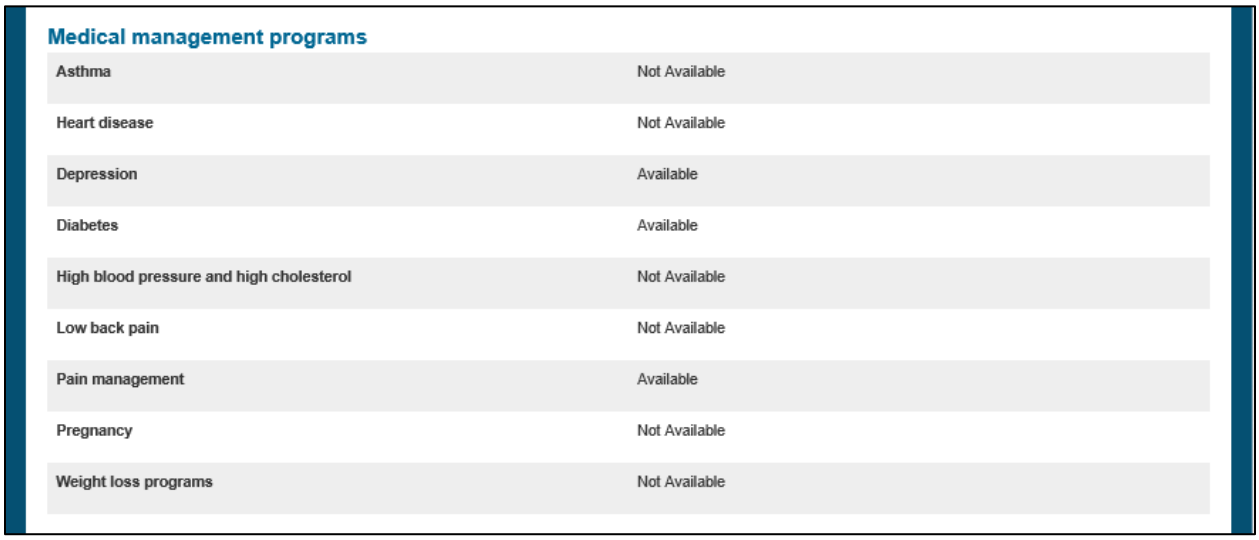


Figure 19: Plan Details – Medical Management Programs Section

Table 20 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.

Table 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 head 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 20 shows the Other Benefits section of the Plan Details page.

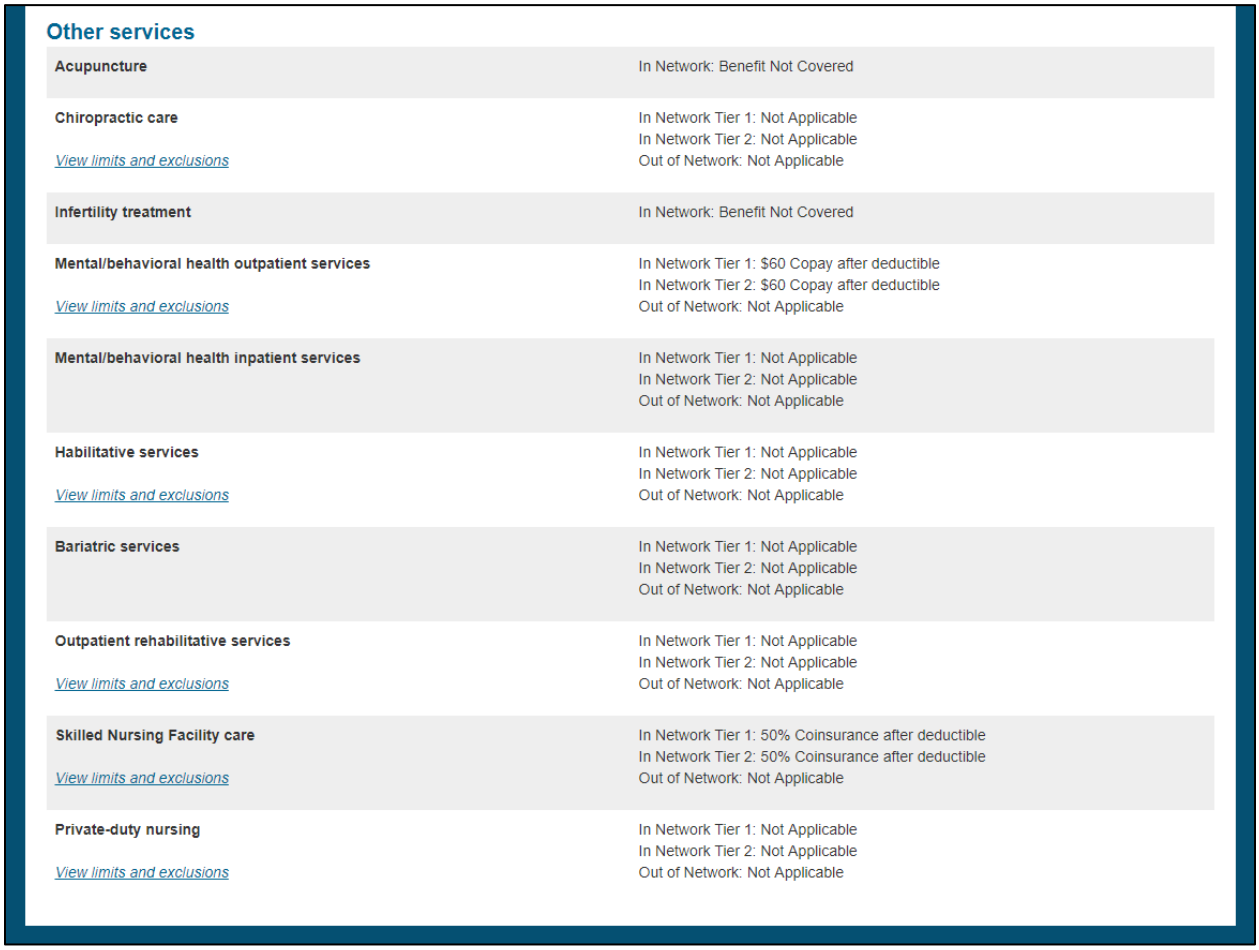


Figure 20: Plan Details – Other Benefits Section

Table 21 describes the fields in the Other Benefits section of the Plan Details page.

Table 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.
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 rehabilitative services	Provides cost sharing information for the benefit "Outpatient Rehabilitative 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 guaranteed or estimated premiums.
- 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 based on the number of enrollees under the age of 19.
- 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. These values will display only if there is one or more enrollee under 19 years of age, and text will indicate that the dollar amounts are specific to child benefits.

Figure 21 shows a sample Plan Preview page for a stand-alone dental plan.

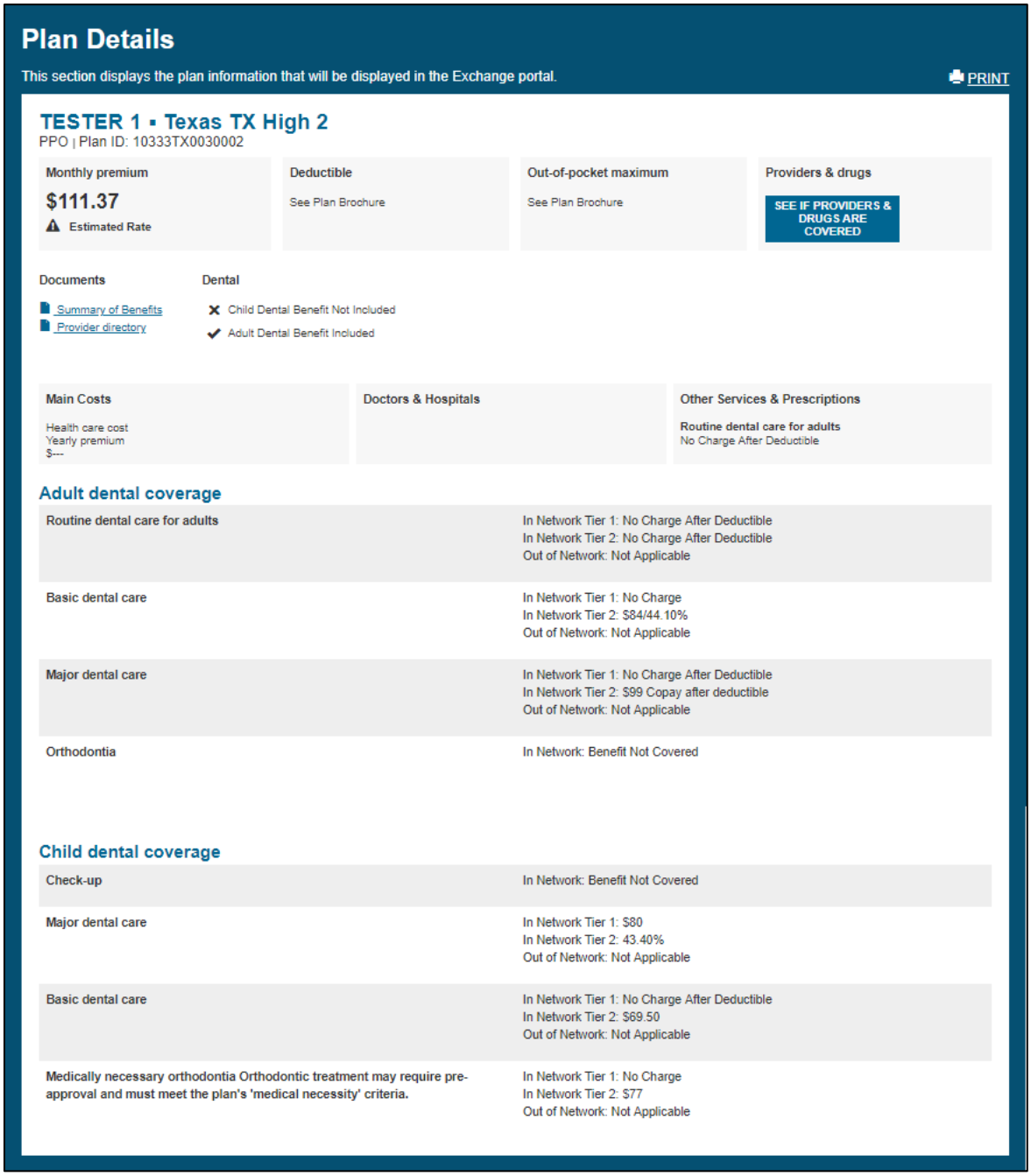


Figure 21: Plan Details Page – Stand-Alone Dental Plan

5.4.6 Plan Details – Benefit Cost Sharing Logic for Dental Plans

The summary section of the Plan Details page contains display of the Out-of-pocket Maximum and Deductible for SADPs. This display is being updated for 2019 to consider only enrollees under 19 years of age. The summary medical Deductible and Out-of-pocket maximum will display according to the following rules:

1. If there are no enrollees under 19:
    a) Display “See Plan Brochure”.
2. If there is exactly one enrollee under 19:
    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”.
3. If the enrollment group has more than one enrollee under 19:
    a) If both Family Per Group and Family Per Person are $X (including $0), then display both as “$X Individual Total” and “$X Family Total”
        i) Use In-Network value if it is $X
        ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value.
    b) If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display “$X Family Total” and do not display a per person value.
        i) Use In-Network value if it is $X
        ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value.
    c) If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display “$X Individual total” and do not display a per group value.
        i) Use In-Network value if it is $X
        ii) If In-network value is “Not Applicable”, use Combined In/Out-Network value.
    d) If both Family Per Group and Family Per Person are Not Applicable (for both In-Network and Combined In/Out-Network), then display “Not Applicable”.

NOTE: If a dollar amount is displayed for the Deductible and/or Out-of-pocket maximum fields for a SADP, then the text “(Applies to child essential health benefits only)” will display at the bottom of the field, regardless of whether the Individual Total amount is shown or both the Individual Total and Family Total values are shown.

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 22. 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.

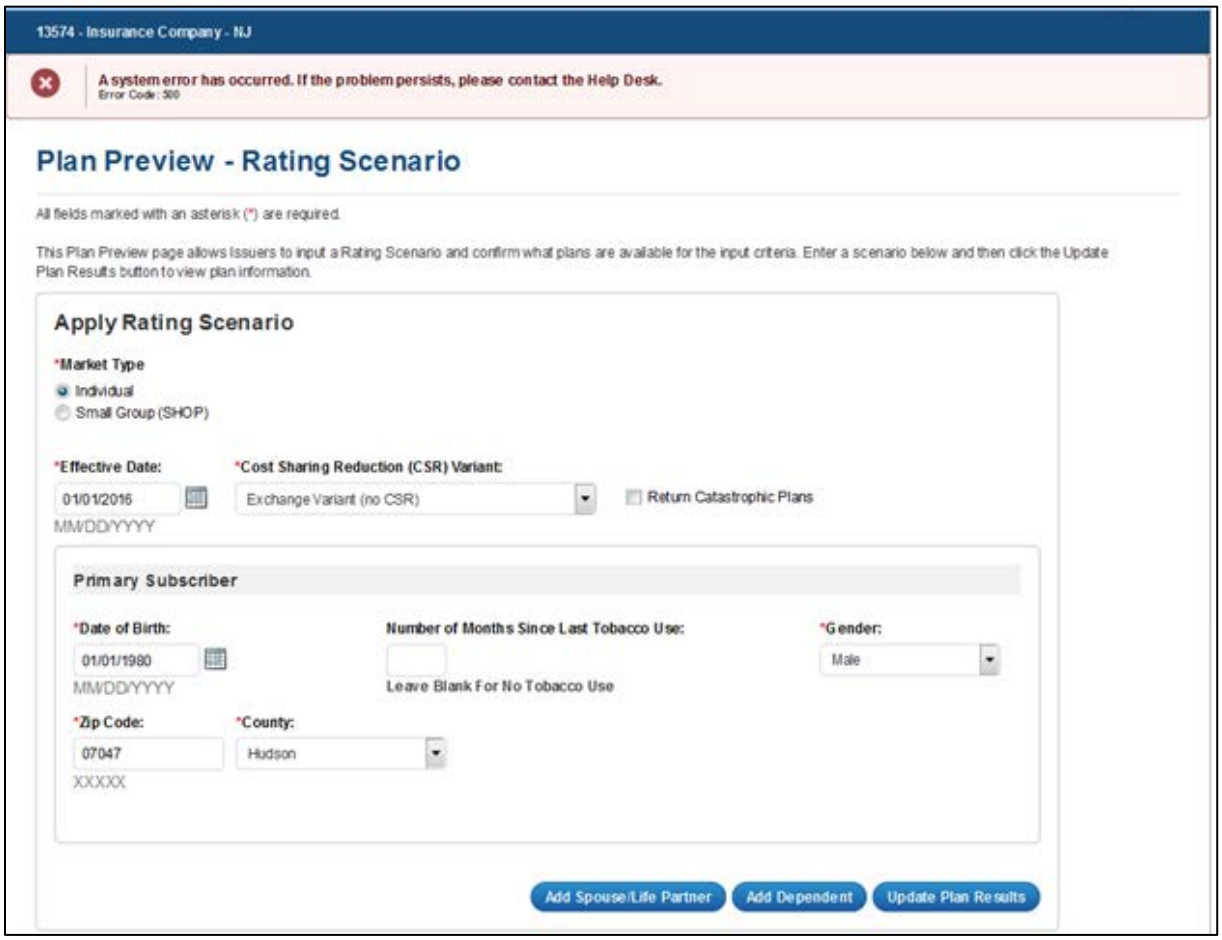


Figure 22: Error Message

On the Rating Scenario Page, you may see errors about required or invalid data fields for either Individual Market (see Figure 23) or SHOP plans (see Figure 24). Errors could be the result of the examples provided in Table 22 (for Individual Market) or Table 23 (for SHOP).

Figure 23 shows potential field errors on the Rating Scenario Page for Individual Market plans.

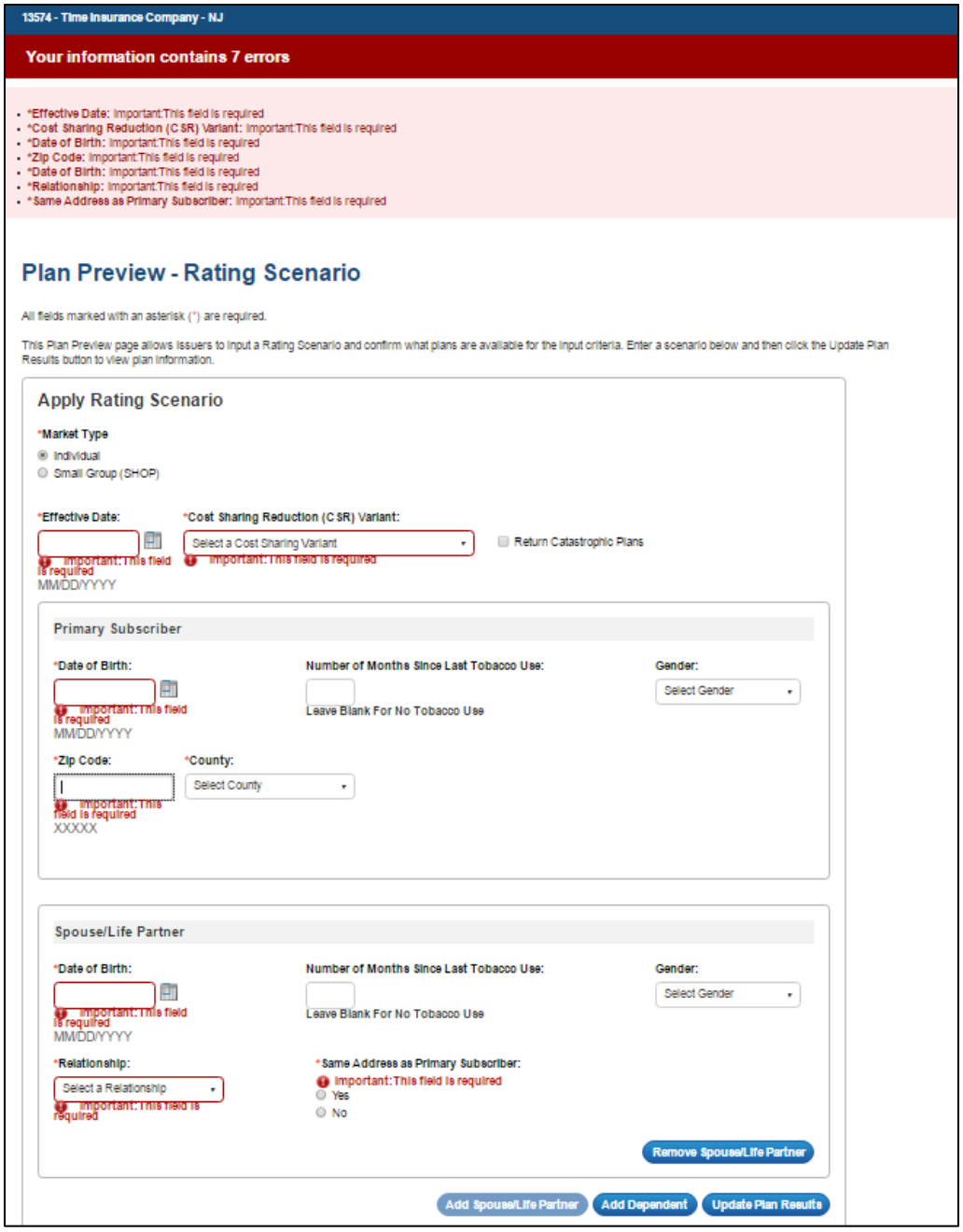


Figure 23: Individual Market Plan Field Validation Errors

Table 22 describes potential validation error messages that display on the top of the Rating Scenario page for Individual Market plans.

Table 22: 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 1/1/2019 or after 12/31/2019	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 24 shows potential field errors on the Rating Scenario Page for SHOP plans.

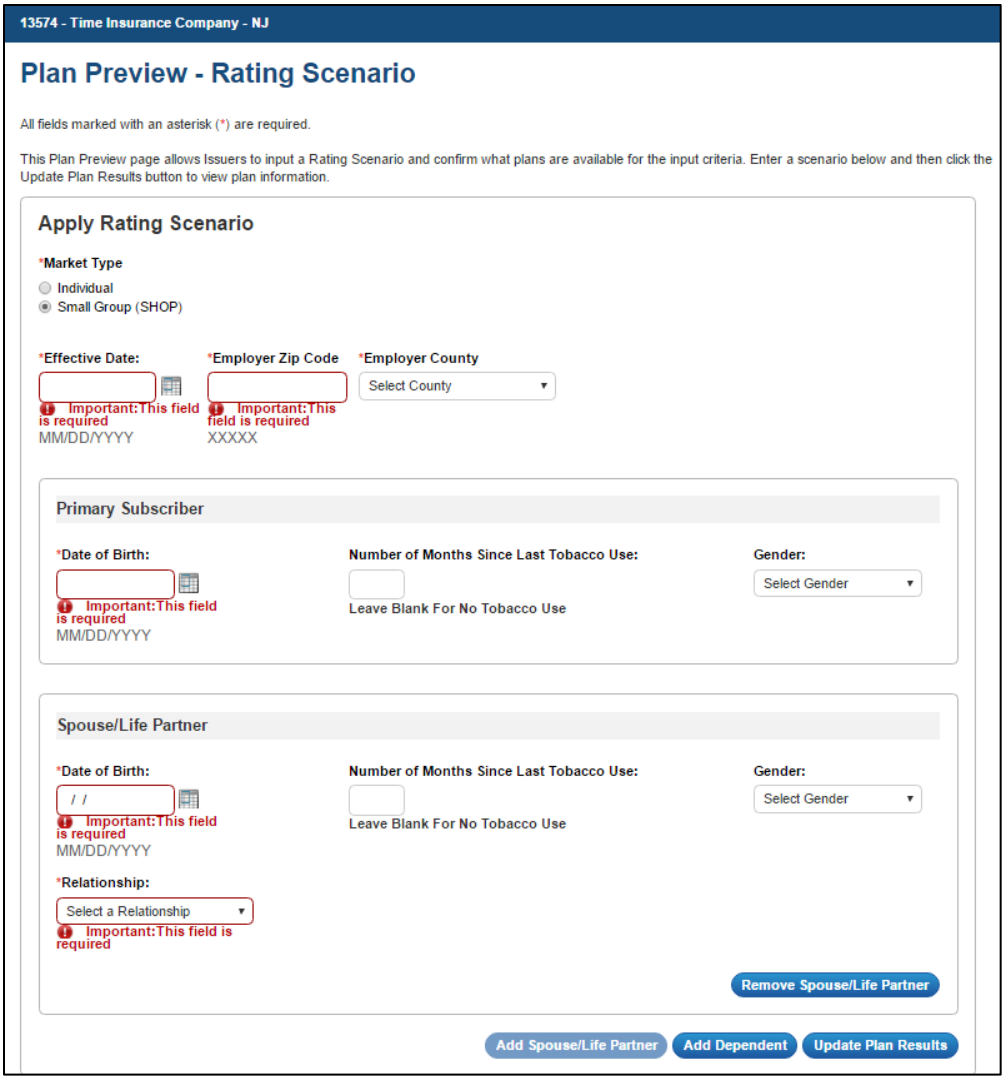


Figure 24: SHOP Plan Field Validation Errors

Table 23 describes potential validation error messages that display on the top of the Rating Scenario page for SHOP plans.

Table 23: 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 1/1/2019 or after 12/31/2019	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 24 below provides a list of contacts.

Table 24: Points of Contact

Contact	Organization	Phone	Email	Role	Responsibility
Exchange Operation Support Desk (XOSC)	CMS	855-CMS-1515 855-(267)-1515	CMS_FEPS@cms.hhs.gov	Help desk support	1st level user support & problem reporting

Appendix A: Acronyms and Abbreviations

Table 25: 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
QHP	Qualified Health Plans
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
XML	Extensible Markup Language
XOSC	Exchange Operation Support Desk

Appendix B: Plan Suppression and Display Logic

For your reference Table 26 displays the display logic for Plan Preview based on plan certification and suppression.

Table 26: Display Logic for Plan Certification and Suppression

Cross-validation	Certification	Suppression	Plan Preview Display
Not cross-validated	Any	Any	Excluded from display
Cross-validated	None	None	Displays available (based on enrollment criteria)
Cross-validated	Certified	Available	Displays available (based on enrollment criteria)
Cross-validated	Certified	Suspended	Displays available with warning message (based on enrollment criteria)
Cross-validated	Certified	Closed	Displays unavailable with specific reason text
Cross-validated	Certified	Not Applicable	Unexpected case; will display unavailable with reason code
Cross-validated	Not Certified	Not Applicable	Excluded from display
Cross-validated	Decertified	Not Applicable	Excluded from display
Cross-validated	Certified Off-Exchange SADP	Not Applicable	Excluded from display