Qualified Health Plan
Issuer Application Instructions

2021

[06/2020]

Version 1.1

PY2021 QHP Instructions: Version 1.1 Revisions

Changes made after initial document posting are listed by section.

Section	Change
Introduction: Supporting Documentation	Update to guide SERFF issuers on supplemental document file name format.
Section 1D: Accreditation	◆ Reference to the Quality Improvement Strategy (QIS) submission requirement for PY2021 QHP Application has been removed from "Data Requirements." ◆ Update to "Quick Reference: Key Changes for 2021" to note that CMS is suspending activities related to collection and reporting of QIS for PY2021.
Section 2E: Transparency in Coverage	◆ Updated to guide issuers on the process for submitting Transparency in Coverage Template and URL data, including instructions on the following: ▪ Steps for issuers who are submitting using dummy data ▪ Expanded submission instructions for issuers with plan offerings that are not required to report Transparency in Coverage data (e.g., off-Exchange SADPs) ▪ Guidance for issuers submitting the QHP Application using SERFF ▪ Assistance for issuers who submit Transparency in Coverage or URL data prior to the Transparency in Coverage submission deadline. ◆ Updates to United States Pharmacopeia (USP) drug categories in relation to pharmacy claims.
Section 3B: Business Rules	◆ Updated to clarify requirements for SERFF-submitting issuers, dual issuers submitting through SERFF binders, and multiple binder requirements. ◆ Language clarification for "What is the maximum number of rated underage dependents on this policy?"
Appendix B: Plan ID Crosswalk	Update correcting the plan year reference in the information table on the steps to complete the 2021 Plan Crosswalk tab, correcting "Crosswalk Reason: Renewing exact same product/plan combination."

Contents

Introduction: Qualified Health Plans for 2021

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

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

Overview of the QHP Certification Process

Issuers must complete the application and certification process annually and comply with the PPACA and all applicable regulations. To facilitate this process, issuers are encouraged to read all applicable published guidance, including the following items that can be found on the Center for Consumer Information and Insurance Oversight (CCIIO) website:

- Each year, the Centers for Medicare & Medicaid Services (CMS) publishes a Letter to Issuers before the certification process. This letter provides guidance for issuers seeking to offer QHPs, including stand-alone dental plans (SADPs) in the FFEs or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs). Issuers can find key dates for QHP certification, including application deadlines, in Table 1 of the Letter to Issuers.

- Each year, CMS provides an annual Notice of Benefit and Payment Parameters (Payment Notice). The notice sets payment parameters that apply to the benefit year and proposes new standards to improve consumers' Exchange experience.

- CMS has also released other relevant guidance and regulations in the past, including the Market Stabilization Final Rule in 2017, the PPACA Exchange and Insurance Market Standards for 2015, and Beyond Final Rule in 2014.

CMS also provides a variety of other guidance on the Health Insurance Market Reforms and on the Health Insurance Marketplaces in general.

QHP Application Submission Process

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

For PY2021, the QHP Application Rates Table Template deadline remains later than the other certification templates' initial submission deadline. By the initial submission deadline, issuers will submit a complete QHP Application except for the QHP Rates Table Template. To complete their initial QHP Application, issuers will then submit a QHP Rates Table Template by the initial Rates Table Template deadline. Both the initial submission deadline and the Rates Table Template deadline are published in the Letter to Issuers.

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

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

Issuers applying for QHP certification in states that do not perform plan management functions must submit their QHP Applications in the Health Insurance Oversight System (HIOS).

Some FFE states collect plan data, which may include copies of the QHP templates, in both HIOS and the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing

(SERFF). Issuers in these states who submit plan data via SERFF must also submit their complete QHP Application in HIOS because it will not be transferred from SERFF to CMS.

Issuers in FFE states performing plan management functions should submit QHP Applications in SERFF in accordance with state and CMS review deadlines. The state will submit all QHP issuer application data in accordance with state guidance. For all states, issuers seeking to offer QHPs must also submit the Unified Rate Review Template (URRT) to CMS via the Unified Rate Review Module in HIOS.

HIOS

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

The relevant HIOS modules are as follows:

- **Plan Finder Product Data Collection Module:** This is where all issuers submit, review, and modify issuer administrative data. Refer to the HIOS Plan Finder—Issuer User Manual for detailed instructions.

- **QHP Issuer Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to attestations, licensure and good standing, accreditation, essential community providers (ECPs), and network adequacy. The Issuer Module consists of sections that are accessible through tabs to submit the templates and documentation. Refer to the Issuer Module User Guide for detailed instructions.

- **QHP Benefits and Service Area Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to the Plans and Benefits, Service Area, Formularies, and Transparency in Coverage. The module allows issuers to submit all necessary information using a web-based user interface and Microsoft Excel templates. Refer to the Benefits and Service Area Module User Guide for detailed instructions.

- **QHP Rating Module:** This is where FFE issuers submit, review, and modify QHP Application data pertaining to plan rates and business rules. Refer to the Rating Module User Guide for detailed instructions.

- **Unified Rate Review System Module:** This is where all issuers submit the URRT. Refer to the Unified Rate Review System Module User Guide for detailed instructions.

- **QHP Plan Preview Module:** QHP and on-Exchange SADP issuers use Plan Preview to view plan data and issuer data similar to the way it will display in Plan Compare on HealthCare.gov. Issuers can refer to the Plan Preview Module User Guide for more information.

- **Supplemental Submission Module (SSM):** This is where all issuers can submit URL data that will display in Plan Compare on HealthCare.gov.

SERFF

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

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

Plan Management (PM) Community

All issuers also participate in the PM Community to complete a number of QHP certification activities and receive communications regarding their QHP Applications from CMS. Issuers required to submit Plan ID Crosswalk Templates and supporting documentation to CMS should do so in the "Plan ID Crosswalk" tab of the PM Community. Refer to the PM Community page of the QHP certification website for more information on using this system.

QHP Application Sections and Associated Templates

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

Table 1. Required Templates

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

* Plan Management Community is not a HIOS Module.

Supporting Documentation

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

Table 2 lists the supporting documentation and justifications in each application section; it also includes a description of the files, the submission criteria that determine whether an issuer must submit supporting

documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention to be used by issuers when naming the supporting documentation or justification.

Table 2. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Section	Suggested File Name
State Partnership Exchange (SPE) Issuer Program Attestation Response Form (only for issuers in states performing plan management functions)	Provides attestations for issuers in states performing plan management functions who are not able to respond to attestations via HIOS.	Required for all issuers in states performing plan management functions (see **Section 1A: Program Attestations**).	Attestation	[Issuer ID]_SPEissuer Attestations
Compliance Plan	Provides documentation that the issuer has a compliance plan that adheres to all applicable laws, regulations, and guidance; that the compliance plan is ready for implementation; and that the issuer agrees to reasonably adhere to the compliance plan provided.	Required if a **Yes** response is provided to the Optional Program Attestations (see **Section 1A: Program Attestations**).	Attestation	[Issuer ID]_Compliance PlanandCoverSheet.pdf
QHP Compliance Plan and Organizational Chart Cover Sheet	Accompanies the issuer's compliance plan and identifies the page numbers where the required compliance plan elements are found.	Required if a **Yes** response is provided to the Optional Program Attestations (see **Section 1A: Program Attestations**).	Attestation	[Issuer ID]_Compliance PlanandCoverSheet.pdf
Organizational Chart	Provides documentation that the issuer has an organizational chart.	Required if a **Yes** response is provided to the Attestations required of both Medical QHP and SADP issuers (see **Section 1A: Program Attestations**).	Attestation	[Issuer ID]_Organizational Chart.doc
Optional Program Attestation Justification for the Federally-facilitated Exchange	Describes why the issuer is not submitting a compliance plan.	Required if a **No** response is provided to the Optional Program Attestations (see **Section 1A: Program Attestations**).	Attestation	[Issuer ID]_Compliance JustificationForm

Title	Description	Submission Criteria	Section	Suggested File Name
Licensure Documentation	Provides documentation that the issuer is licensed.	Required if a **Yes** response is provided to Question 1 or 2 in the HIOS interface [see **Section 1B: State Licensure (Optional)**]. *Note:* Required only if an issuer chooses to complete the Licensure section.	State Licensure	[Issuer ID]_Certificateof Compliance, or [Issuer ID]_COA or [Issuer ID]_StateLicense
Good Standing Supplemental Response	Describes how the issuer intends to comply with state solvency standards and provides a justification for noncompliance that explains the conditions that caused the issuer to become financially insolvent.	Required if a **Yes** response is provided to Question 1 in the HIOS interface [see **Section 1C: Good Standing (Optional)**]. *Note:* Required only if an issuer chooses to complete the Good Standing section.	Good Standing	[Issuer ID]_GoodStanding SupplementalResponse
Corrective Action Plan	Describes how the issuer intends to respond to corrective actions and provides a justification that explains how a corrective action plan or equivalent document will address the issues identified by the state.	Required if a **Yes** response is provided to Question 2 in the HIOS interface [see **Section 1C: Good Standing (Optional)**]. *Note:* Required only if an issuer chooses to complete the Good Standing section.	Good Standing	[Issuer ID]_Corrective ActionPlan
Accreditation Certificate	Demonstrates that the issuer is accredited.	Optional for all accredited issuers.	Accreditation	[Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes an implementation plan and progress of a payment structure that provides increased reimbursement or other market-based incentives to improve health outcomes of plan enrollees.	Required for QHP issuers that have participated in an Exchange for two or more consecutive years, that offer family and/or adult-only medical coverage, and that meet the QIS minimum enrollment threshold in the individual market or Small Business Health Option Program (SHOP) Exchange. Specific participation criteria can be found in the	The QIS Guidance and QIS Implementation Plan and Progress Report form can be found here	[Issuer ID]_[Issuer Name]_QIS If submitting more than one QIS: [Issuer ID]_[Issuer Name]_QIS_[#]

Title	Description	Submission Criteria	Section	Suggested File Name
		QIS Technical Guidance and User Guide for the 2021 Plan Year (QIS Guidance).		
Supplementary Response: Inclusion of Essential Community Providers	Describes why the issuer cannot meet the ECP requirements. Justifications for medical ECPs and dental ECPs have different requirements.	For medical ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area, who do not offer a contract to all Indian health care providers in the service area, and who do not offer a contract to at least one ECP in each available ECP category in each county in the service area. For dental ECPs, issuers whose plan network does not include at least 20 percent of available ECPs in the service area and who do not offer a contract to all Indian health care providers in the service area.	ECP/Network Adequacy	[Issuer ID]_ECP_ supplemental_response Dual-product issuers should submit two files with the following naming conventions: ◆ [Issuer ID]_ECP_ supplemental_ response_QHP ◆ [Issuer ID]_ECP_ supplemental_ response_SADP
Network Adequacy Access Plan and Cover Sheet	Cover Sheet and Access Plan that address and reference the 11 areas in the Supporting Documentation table in **Section 1E: Essential Community Providers/Network Adequacy**. Recommend the Cover Sheet be inserted in front of the Access Plan (rather than submitted as a separate document).	QHPs and SADPs that need to submit access plans will be notified directly by email.	ECP/Network Adequacy	[Issuer ID]_Access_Plan (may include Cover Sheet if it is included as part of the Access Plan) [Issuer ID]_Access_Plan_ Cover_Sheet (if Cover Sheet is submitted as a separate document)
Service Area Partial County Supplemental Response	Describes why the issuer cannot provide service to an entire county.	Required if the issuer is requesting a partial county service area.	Service Area	[Issuer ID]_[State Abbreviation]_service_ area_partial_county

Title	Description	Submission Criteria	Section	Suggested File Name
Combined Prescription Drug Supporting Documentation and Justification	Identifies reasons why correction occurs in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count and how they are not discriminatory.	Required if a correction occurs in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ combineddrug
Discrimination— Treatment Protocol Supporting Documentation and Justification	Identifies reasons why a drug list may be an outlier in terms of out-of-pocket cost but is not discriminatory.	Required if the out-of-pocket cost is determined to be an outlier.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ treatmentprotocol
Discrimination— Language: Supporting Documentation and Justification	Identifies reasons why language identified as discriminatory is not.	Required if language is found to be discriminatory.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ discrimination_language
Discrimination—Cost-Sharing Outlier: Supporting Documentation and Justification	Identifies reasons why cost-sharing values found to be outliers should be allowed and are not discriminatory.	Issuers submit in HIOS when the cost-sharing values are identified as outliers at the national and state levels and remain uncorrected; SERFF submission requirements depend on the state.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ discrimination_cost_ sharing
Unique Plan Design—Supporting Documentation and Justification	Describes the reasons that a plan qualifies as unique (it is not compatible with the standard Actuarial Value Calculator) and the methods used to calculate actuarial value (AV).	Required if *Unique Plan Design*? is Yes.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ unique_plan_design
Silver/Gold: Supporting Documentation and Justification	Identifies the reasons why the silver/gold plan requirement is not met.	Required for issuers who fail silver/gold plan review.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_silvergold
Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification	Describes the methods used to calculate AV and notes the certified AV level of pediatric EHB.	Required for all SADP issuers.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_SADP_ actuarial_value
Stand-Alone Dental Plan—Description of EHB Allocation	Details the methods and specific analysis used to determine the EHB apportionment for pediatric dental.	Required for all SADP issuers.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ description_EHB_ allocation

Saving Supporting Documents

Issuers should save supporting documentation and justifications using the file-naming conventions in the last column of **Table 2**. When saving the file, do not include spaces in the file name. A period, a hyphen, and an underscore are the only special characters that can be used for a file name. The file name may include both lowercase and capital letters. Its full path length must not exceed 255 characters if the file is being uploaded to HIOS. The following document formats should be used when uploading supporting documentation and justifications: **.doc**, **.docx**, and **.pdf**.

Note for SERFF Issuers: Supplemental documents with a file name containing the characters below will be rejected by the HIOS system during the binder transfer process. Issuers will not be able to submit any data if the supplemental document is rejected during transfer. Issuers should either entirely remove the character from the file name or replace the character (e.g., replace "&" with "and") to avoid receiving errors:

- < (less than sign)
- \> (greater than sign)
- & (ampersand)
- \ (backslash or reverse solidus)
- " (quotation mark)

Uploading Supporting Documents

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

Review Periods, Revision Process, and Certification

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

Following the review period, CMS will notify applicants of results, summarizing any need for corrections identified during review. For issuers applying to offer one or more QHPs on-Exchange, these review results will also include critical data errors. The results will detail the section in the application where the error has been found. Further, it will describe how the corrections should be addressed to eliminate the error.

During the QHP Application review period, issuers will be able to make necessary changes to their QHP Applications, including as a response to their results, and upload revised QHP data templates. After the deadline for issuers to change their QHP Applications and the final review, CMS will conduct outreach to issuers who are required to enter the limited data correction window to correct critical data errors before Open Enrollment. Data submitted during the limited data correction window may be subject to compliance action by CMS. Issuer changes made in the limited data correction window that are not approved by CMS and/or the state may result in compliance action by CMS, including decertification and suppression of the issuer's plans on HealthCare.gov. All errors and corrections must be addressed before the affected QHPs may be certified and/or displayed on HealthCare.gov.

CMS will continue to offer an optional "Early Bird" review round in PY2021. Issuers who submit complete QHP Applications prior to the Early Bird deadline will have their applications reviewed before the initial submission deadline, allowing those issuers the opportunity to resubmit and correct errors prior to the initial submission deadline.

CMS's certification determination for the plans listed in the issuer's application is based on the information contained in the application. CMS reserves the right to revisit the certification status of any plan if there are any changes to the information an issuer supplied during the application process. Issuers must notify CMS of any changes to their QHP Application. Issuers' plans may be decertified during the plan year if CMS determines that

any of the information contained in the issuer's application is inaccurate or incomplete or that it no longer meets all applicable certification standards or other program requirements.

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

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

New for PY2021, CMS will implement a URL collection process for issuers who submit completed QHP Applications. URLs will be collected using .csv files, not via templates, for PY2021. All issuers will submit their URLs using the Supplemental Submission Module (SSM).

URL Collection Process: This year, issuers must make all URL changes in the SSM. URLs are no longer collected in the Plans & Benefits, Prescription Drug, Network, or Transparency in Coverage templates for PY2021. Issuers must continue to submit and update their URL data via the SSM, which was rolled out in August 2019.

On-exchange Summary of Benefits and Coverage (SBC), Plan Brochure, Formulary, Network, and Transparency in Coverage URLs submitted in the SSM shall be reviewed to ensure the following:

1. URLs lead to live, active webpages.
2. Consumers view accurate issuer marketing materials when a URL is selected.
3. Identify potential inaccuracies in issuer marketing material when compared to data within an issuer-submitted QHP application.
4. Issuers meet provider directory accessibility standards when a Network URL is selected.
5. The formulary information posted on a plan website reflects the same exact data submitted in the issuers corresponding Prescription Drug Template.

Service Area Data Change Request Process

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

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

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

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

Data Integrity Tool and Review Tools

CMS provides issuers with a number of review tools to check for errors in their QHP Application that would result in correction notices following submission. Issuers should run each of the following tools, as applicable to their issuer type (SADP, QHP), to identify and correct data errors before uploading materials to HIOS or SERFF. Given the limited review cycle, it is critical that issuers use the tools to ensure that all data submitted are free of

errors so that their plans will be reviewed for certification on time. **Table 3** provides a high-level description of each tool's functionality.

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

Tool	Purpose
Data Integrity Tool*	Identifies critical data errors within and across templates. Provides immediate feedback about data, reducing issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports QHP and SADP data from most application templates. Conducts validation checks beyond the standard HIOS and SERFF checks. Looks across templates for consistency in key fields. Produces error reports that describe the error and its location in the template.
Plan ID Crosswalk Tool*	Checks that the Plan ID Crosswalk Template has been completed accurately, by ensuring that all counties in all FFE plans that were offered in 2020 are included in the crosswalk, the plans are crosswalked to valid 2021 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 Code of Federal Regulations (CFR) 155.335(j).
Master Review Tool*	Aggregates data from the Plans & Benefits, Service Area, ECP/Network Adequacy, and Prescription Drug Templates and serves as a data input file to the other standalone tools.
Essential Community Providers Tool for QHPs	Calculates the total number of medical ECPs an issuer has in each plan's network and compares this to the number of available medical ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.
Essential Community Providers Tool* for SADPs	Calculates the total number of dental ECPs an issuer has in each plan's network and compares this to the number of available dental ECPs in that service area. This tool will check whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235.
Non-Discrimination Tool	Performs an outlier analysis for "QHP Discriminatory Benefit Design" as discussed in the 2021 Letter to Issuers. This tool looks at all plans in the state, goes through a group of predetermined benefits, and determines whether any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
Cost Sharing Tool*	Runs four different checks (when they are applicable to the plan) for cost-sharing standards. This includes Maximum Out of Pocket (MOOP) Cost Review, Cost-Sharing Reduction (CSR) Plan Variation Review, Expanded Bronze Plan Review, and Catastrophic Plan Review.
Category & Class Drug Count Tool	Compares the count of unique chemically distinct drugs in each United States Pharmacopeia (USP) v7 category and class for each drug list against a state's benchmark.
Formulary Review Suite: Non-Discrimination Formulary Outlier Review	Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization or step therapy requirements in 28 USP classes.
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with certain conditions as recommended in clinical guidelines, to ensure that issuers are offering sufficient types and numbers of drugs.

* Indicates tools that apply for SADP issuers.

Stand-Alone Dental Issuers

An issuer who participates solely in the dental market—a dental-only issuer—or one who participates in both the medical and dental markets—a dual-product issuer—may offer SADPs. Certain sections of the QHP Application do not apply to, and are not required for, dental-only issuers.

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

Table 4. Instruction Location for Application Sections

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

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

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

1. Issuer Module

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

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

Figure 1-1. Three Module Tabs

The Data Submitter page allows Issuer Submitters to work on an existing application or view a previously submitted application.

The Data Validator page allows Issuer Validators to view a list of all the applications that have been submitted. This section also allows Issuer Validators to upload supporting documentation and answer supplemental responses through the Health Insurance Oversight System (HIOS).

The Final Submission page allows either the Issuer Submitter or Issuer Validator to cross-validate data between modules, and allows the Issuer Validator to submit the Qualified Health Plan (QHP) Application.

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

Figure 1-2. Data Submitter Page Selection List

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

Figure 1-3. Review Page Snapshot

Data Submitter	Final Submission

✓ **You have successfully submitted this application**

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

Submitter Sections Table

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

Figure 1-4. Validator Sections Table

Data Validator	Final Submission

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

Validator Sections Table

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

Return to Submitter   Previous   Submit Application

Section 1A: Program Attestations

1. Introduction

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

- Attestations required of both Medical QHP and stand-alone dental plan (SADP) issuers
- Attestations required of Medical QHP issuers only
- Attestations required of SADP issuers only
- Optional Attestations.

These instructions only apply to FFE issuers filing through HIOS. Issuers in states performing plan management functions need to complete and submit the State Partnership Exchange Issuer Program Attestation Response Form through the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing (SERFF). The 2021 State Partnership Exchange Issuer Program Attestation Response Form is available at https://www.qhpcertification.cms.gov/s/Program%20Attestations.

2. Data Requirements

To complete this section, issuers need the following information:

1. Company organizational chart: Save the organizational chart using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_OrganizationalChart.doc."

2. Company compliance plan.

3. Compliance Plan and Organizational Chart Cover Sheet: The 2021 Compliance Plan and Organizational Chart Cover Sheet is available at https://www.qhpcertification.cms.gov/s/Program%20Attestations.

   a. To merge the Compliance Plan and Organizational Chart Cover Sheet PDF with an existing compliance plan PDF file, use the Document/Insert Pages function in Adobe Acrobat.

   b. Merge the Compliance Plan and the Compliance Plan Cover Sheet into a single PDF file and save the document using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_CompliancePlanandCoverSheet.PDF."

4. Justification Form, applicable only to those issuers attesting **No** to the optional compliance plan attestation. A blank justification form is available at https://www.qhpcertification.cms.gov/s/Program%20Attestations. Save the justification form using the following naming convention: [HIOS Issuer ID]_[Title of Document]. For example: "12345_ComplianceJustificationForm.PDF."

5. State Partnership Exchange Issuer Program Attestation Response Form, applicable only to issuers in states performing plan management functions submitting in SERFF. The 2021 State Partnership Exchange Issuer Program Attestation Response Form is available at https://www.qhpcertification.cms.gov/s/Program%20Attestations. Save the form using the following naming convention: [HIOS Issuer ID]_[SPEissuerAttestations]. For example: "12345_SPEissuerAttestations.PDF."

3. Quick Reference

Key Changes for 2021
No changes for the 2021 QHP Application.

<table>
<tr><td colspan="2" style="text-align:center">**Tips for the Program Attestations Section**</td></tr>
<tr><td colspan="2">

◆ **Issuers must respond to *all* attestation subsections.**

◆ **Medical QHP-only issuers may respond Not Applicable to the Attestations required of SADP-only issuers subsection.**

◆ **SADP-only issuers may respond Not Applicable to the Attestations required of Medical QHP-only issuers subsection.**

◆ **All issuers, including those submitting only Medical QHPs, only SADPs, or both, are strongly encouraged to respond Yes to the optional compliance plan attestation and upload a compliance plan and the Compliance Plan and Organizational Chart Cover Sheet. Issuers responding No to the optional compliance plan attestation are required to upload a justification form.**

◆ **All issuers are required to upload supporting documents for their responses to the attestations.**

◆ **The justification form is *only* for FFE issuers using HIOS.**

◆ **The State Partnership Exchange Issuer Program Attestation Response Form is only for issuers in states performing plan management functions.**

</td></tr>
</table>

4. Detailed Section Instructions

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

Attestation Area	Steps
Attestations required of both Medical QHP and SADP issuers	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if the issuer agrees to the listed issuer attestation. If **Yes** is selected, issuers are required to submit the Organizational Chart. Use the document upload feature in the Attestations required of both Medical QHP and SADP issuers subsection and select "Organizational Chart" as the document type. ◆ **No**—if the issuer does *not* agree to the listed issuer attestation. If **No** is selected, issuers must still submit an Organizational Chart or "Other" document. *Note:* All issuers who wish to offer either certified QHPs or SADPs are required to respond **Yes**.
Attestations required of Medical QHP issuers only	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if the issuer agrees to the listed issuer attestation. ◆ **No**—if the issuer does *not* agree to the listed issuer attestation. ◆ **Not Applicable**—if the issuer is not submitting for Medical QHP certification. *Note:* Applicants applying to offer Medical QHPs are required to respond **Yes** with regard to those Medical QHPs. All applicants not applying to offer Medical QHPs should select **Not Applicable**.
Attestations required of SADP issuers only	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if the issuer agrees to the listed issuer attestation. ◆ **No**—if the issuer does *not* agree to the listed issuer attestation. ◆ **Not Applicable**—if the issuer is not submitting for SADP certification. *Note:* Applicants applying to offer SADPs are required to respond **Yes** with regard to those SADPs. All applicants not applying to offer SADPs should select **Not Applicable**.
Optional Attestations	Choose from the following to attest to the attestations in this section: ◆ **Yes**—if the issuer agrees to the listed compliance plan attestation. If **Yes** is selected, submit the Compliance Plan and the Compliance Plan and Organizational Chart Cover Sheet. Use the document upload feature in the Optional Attestations subsection and select "Compliance Plan" as the document type.

Attestation Area	Steps
	◆ **No**—if the issuer does *not* agree to the listed compliance plan attestation. If **No** is selected, complete and submit the justification form. Use the document upload feature in the Optional Attestations subsection and select "Other" as the document type. Issuers may still submit a Compliance Plan. *Note:* CMS strongly encourages all applicants, including those submitting Medical QHPs, SADPs, or both, to respond **Yes** and upload a Compliance Plan and the Compliance Plan Cover Sheet.

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

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

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

Figure 1A-1. Sample Justification Form

Optional Program Attestation Justification for the Federally-facilitated Exchange

Note: This form is only for Federally-facilitated Exchange (FFE) issuers who submit their Qualified Health Plan (QHP) Application in the Health Insurance Oversight System (HIOS). Issuers who apply via the System for Electronic Rate and Form Filing (SERFF) should submit a justification on the State Partnership Exchange Issuer Program Attestations Response form.

The compliance plan attestation is optional. CMS highly encourages all applicants, including those submitting only Medical QHPs, only stand-alone dental plans (SADPs), or both, to respond **Yes** and upload a Compliance Plan and the Compliance Plan Cover Sheet in the Issuer Module.

If you responded **No** to the optional Compliance Plan Program attestation, provide an explanation below.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Issuer Name: _____

HIOS ID: _____

If you do not have enough space here to list your justifications, print out another form to augment them as needed.

Issuers completing the Compliance Plan and Organizational Chart Cover Sheet should respond **Yes** or **No** to each evaluation criterion and should identify the applicable page number in the compliance plan where language supporting the evaluation criterion is found. They should provide any organizational chart information requested on the same cover sheet.

CMS expects issuers to acknowledge that their compliance plans are applicable to Exchange products and operations and to provide examples of specific plans or processes to comply with Exchange requirements (see the Compliance Plan Contents section of the Compliance Plan and Organizational Chart Cover Sheet). For example, issuers may have an Exchange module as a part of employees' compliance training, or they may develop audit plans to evaluate compliance risks in the Exchange line of business.

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

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

QHP Issuer Compliance Plan and Organizational Chart

Review Cover Sheet
Issuers will be asked to submit a Compliance Plan and Organizational Chart as part of the application process for certification of qualified health plans. The criteria listed below contain minimum requirements for this review. Compliance Plans will be reviewed based on these criteria. Issuers should respond to the evaluation criteria and, where applicable, state the page number where language supporting the response can be found. This initial evaluation and review cover sheet will be used to evaluate the adequacy of the Compliance Plan and Organizational Chart and will assist in the ongoing monitoring of issuer compliance.

Certification of a health plan does not prevent CMS from identifying or addressing weaknesses in the Compliance Plan or the Organizational Chart submitted by an issuer as part of its application at a later date.

Evaluation Criteria	Yes	No	Page Number
Compliance Plan and Organizational Chart Submissions			
Applicant included a completed PY2021 cover sheet in the QHP application.	◉	◯	N/A
Applicant uploaded a copy of its Compliance Plan.	◉	◯	N/A
Applicant uploaded a copy of the Organizational Chart.	◉	◯	N/A
Compliance Plan Contents			
A. Written Policies and Procedures			
1. Does the Compliance Plan include a statement that articulates the issuer's commitment to comply with all applicable federal and state rules, regulations, and standards?	◉	◯	13-14
2. Does the Compliance Plan include written standards of conduct for employees?	◉	◯	15
3. Does the Compliance Plan provide guidance for employees, contractors, subcontractors, or other applicable entities on the process for dealing with potential compliance issues?	◉	◯	22
4. Does the Compliance Plan describe the methods, process, and procedures used to implement the Compliance Program?	◉	◯	23

CMS Final   1 of 3   2021 QHP Application Instructions

Section 1B: State Licensure (Optional)

1. Introduction

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

2. Data Requirements

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

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

3. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for the State Licensure Section
◆ **The State Licensure section remains optional for the 2021 QHP Application.**
◆ **Issuers provide licensure documentation for all products and service areas in which they intend to offer a QHP. This applies to all licensed issuers, including any affiliated or other issuers underwriting the dental benefits that the QHP proposes to offer.**
◆ **Issuers submit *one* form of licensure documentation (state license, COA, certificate of compliance, or the equivalent).**
◆ **If the issuer is not yet licensed and therefore unable to provide licensure documentation during the initial application submission, the issuer submits evidence of licensure during the QHP Application resubmission window.**
◆ **Save documents using the following naming convention: [HIOS Issuer ID]_[Title of Document], for example, "12345_StateLicense.doc," "12345_COA.doc," or "12345_CertificateofCompliance.doc."**

4. Detailed Section Instructions

Licensure Question	Steps
Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document authorizing it to offer every product type in every service area that it is currently applying for in the identified state?	Choose from the following options: ◆ **Yes**—if the applicant is licensed for every product type and every service area for which it is applying. If **Yes** is selected, upload supporting documentation. ◆ **No**—if the applicant is *not* licensed for every product type and every service area for which it is applying. If **No** is selected, proceed to the next step.
Does the applicant have either a license, COA, certificate of compliance, or equivalent form or document for some but not all products, or some but not all service areas, for which the	Choose from the following options: ◆ **Yes**—if the applicant is licensed for some but not all product types or service areas for which it is applying. If **Yes** is selected, upload supporting documentation.

Licensure Question	Steps
applicant is currently applying in this QHP Application?	◆ **No**—if the applicant is *not* licensed for any of the product types or service areas for which it is applying. If **No** is selected, enter the estimated date of licensure.

Section 1C: Good Standing (Optional)

1. Introduction

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

2. Data Requirements

If an issuer does not comply with the good standing standard, they must provide the following information:

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

3. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for the Good Standing Section
◆ **The Good Standing section remains optional for the 2021 QHP Application.** ◆ **If the issuer does not comply with the state solvency requirements or the issuer is under corrective action related to financial review, it completes supporting documentation and provides a justification.** ◆ **Save documents using the following naming convention: [HIOS Issuer ID]_[Title of Document], for example, "12345_GoodStanding.doc."**

4. Detailed Section Instructions

Good Standing Questions	Steps
Is the applicant seeking QHP certification for this state currently out of compliance with any applicable state solvency requirements for the calendar year in which it is applying to offer QHPs?	Choose from the following options: ◆ **Yes**—if the applicant does *not* comply with state solvency requirements. If **Yes** is selected, supporting documentation and a justification are submitted. Upload the supporting documentation in the Good Standing Module and select "Solvency Compliance" as the document type. ◆ **No**—if the applicant *complies* with state solvency requirements. If **No** is selected, proceed to the next step.
Is the applicant currently under any corrective action related to financial review?	Choose from the following options: ◆ **Yes**—if the applicant *is* under corrective action related to financial review. If **Yes** is selected, supporting documentation and a justification are submitted. Upload the supporting documentation in the Good Standing Module and select **Corrective Action** as the document type. ◆ **No**—if the applicant is *not* under corrective action related to financial review. If **No** is selected, proceed to the next section of the application.

Issuers that do not comply with the good standing standard are required to submit supporting documentation and a justification.

Good Standing Supporting Documentation

If the response to question 1 is **Yes** (the issuer does *not* comply with state solvency standards), the issuer uploads a description of how it intends to comply and provides a justification for noncompliance.
◆ The description should include the following:
  ▪ List of solvency requirements with which the issuer currently does not comply
  ▪ Detailed explanation of the plan to comply
  ▪ Timeframe for complying.
The justification should explain the conditions that caused the issuer to become financially insolvent (such as insufficient premium income or catastrophic medical expenses).

If the response to question 2 is **Yes** (the issuer *is* under corrective action), the issuer uploads a description of how it intends to respond to corrective actions and provides a justification.
◆ The description should include the following:
  ▪ List of corrective actions issued
  ▪ Detailed explanation of the plan to respond to corrective actions
  ▪ Timeframe for implementing the corrective actions plan.
The justification should explain how a corrective action plan or equivalent document will address the issues identified by the state.

Section 1D: Accreditation

1. Introduction

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

Issuers in states performing plan management functions and State-based Exchanges on the Federal Platform should comply with the requirements for accreditation data collection specified by their state.

2. Data Requirements

To complete this section, an issuer needs information about which accrediting entity the issuer is accredited by—the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC).

3. Quick Reference

Key Changes for 2021
◆ CMS suspended activities related to the collection and reporting of quality improvement information for the Quality Improvement Strategy (QIS) for the Plan Year 2021 QHP Certification Period. Additional information is available in the [COVID-19 Marketplace Quality Initiatives Memo (PDF)](#).

Tips for the Accreditation Section
◆ **If an issuer is entering its initial year of QHP certification, it must schedule (or plan to schedule) a review with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). An issuer is not required to be accredited in its initial year of QHP certification.**
◆ **Any information provided on accredited products must be for the same legal entity in the same state that submits the QHP Application.**
◆ **If an issuer is entering its fourth consecutive year of QHP participation, it must be accredited in the Exchange market and with one of the following statuses:**
▪ **AAAHC: Accredited**
▪ **NCQA: Excellent, Commendable, Accredited, or Provisional**
▪ **URAC: Full or Conditional.**
◆ **An issuer must provide its accrediting entities with the issuer legal name and HIOS Issuer ID used in its QHP Application to ensure the HIOS Issuer ID is included in the data file provided by the accrediting entity to CMS.**
◆ **Second year issuers who are not yet accredited can meet the second year requirement by submitting documentation from their accrediting entity that indicates the issuer completed the policies and procedures review and are scheduled or in process for additional review.**
◆ **Use the following naming convention for the accreditation certificate: [HIOS Issuer ID]_[Name of Accrediting entity], for example, "12345_NCQA.pdf."**

4. Detailed Section Instructions

Accreditation Questions	Steps
Does the applicant currently have any Commercial, Medicaid, or Marketplace health plans in this state, [*state of issuer identified*], accredited by an HHS-recognized accrediting entity?	Choose from the following options: ◆ **Yes**—if the issuer has existing health plan accreditations on any products in the Exchange, Commercial, or Medicaid market from NCQA or URAC. Dual-product issuers with an accredited medical plan should also select **Yes**. Proceed to the next step. ◆ **No**—if the issuer is accredited by AAAHC, is offering SADPs, or is not currently accredited by NCQA or URAC.

Accreditation Questions	Steps
Issuers who respond **Yes** to the above question must then select the accrediting entity.	Choose from the following options: ◆ **NCQA**—if the issuer is accredited by NCQA. ◆ **URAC**—if the issuer is accredited by URAC. ◆ **NCQA & URAC**—if the issuer is accredited by both NCQA and URAC.

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

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

An issuer may upload copies of its accreditation certificates into HIOS.

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

Figure 1D-1 through **Figure 1D-3** show sample accreditation certificates.

Figure 1D-1. Sample NCQA Accreditation Certificate

Figure 1D-2. Sample URAC Accreditation Certificate

Figure 1D-3. Sample AAAHC Accreditation Certificate

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

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

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

Section 1E: Essential Community Providers/Network Adequacy

1. Introduction

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

2. HIOS Interface

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

1. Does the applicant meet the General ECP Standard or the Alternate ECP Standard (as defined in the annual Letter to Issuers)?

   a. To meet the General ECP Standard, the applicant has

      i. contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network;

      ii. offered contracts in good faith to all available Indian health care providers in the plan's service area for the respective QHP certification plan year; and

      iii. offered contracts in good faith to at least one ECP in each ECP category in each county in the service area for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants).

   b. To meet the Alternate ECP Standard, the applicant has

      i. contracted with at least 20 percent of available ECPs in each plan's service area to participate in the plan's provider network and

      ii. offered all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the General ECP Standard, or otherwise offered a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area (not applicable to SADP applicants).

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

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

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

   Yes.

   No.

3. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID.

2. Issuer state.

3. Completed Network ID Template.

4. If completing the network adequacy portion of the template, a list of providers in each of the proposed networks, including providers outside the service area (such as in contiguous counties, even if they are across state lines). If a provider is in-network and enrollees can access that service, include the provider name, National Provider Information (NPI), specialty and facility type, street address of the location providing services, city, state, county, and ZIP code.

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

5. A list of ECPs in each of the proposed networks, including the provider name, NPI, ECP category, street address of the location providing services, city, state, county, ZIP code, number of contracted providers, and associated issuer network IDs.

6. An ECP Write-in Worksheet (as applicable).

7. Supplemental ECP Response—QHP (as applicable).

8. Supplemental ECP Response—SADP (as applicable).

9. Network Adequacy Access Plan with Cover Sheet (issuers who are required to submit access plans will be notified by email).

4. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for the ECP/Network Adequacy Section
General
◆ **Issuers must complete the Issuer Information section on the User Control tab before creating and entering the rest of their data into the other tabs.**
◆ **Issuers *should not* change the file names on their ECP/Network Adequacy files after finalizing the template. This file-naming convention allows the Centers for Medicare & Medicaid Services (CMS) to easily identify an issuer's ECP/Network Adequacy Template. Changing the file name could cause the issuer to receive a correction.**
◆ **Complete the Network ID Template before completing the ECP/Network Adequacy Template.**
◆ **The PY2021 ECP/Network Adequacy Template includes the ability to delete rows.**
ECP
◆ **Issuers will provide hospital bed-count information as part of the ECP portion of their ECP/Network Adequacy Template.**
◆ **Issuers will be evaluated against a 20 percent ECP standard.**
◆ **The Available ECP Write-in List for purposes of the PY2021 QHP certification process will be made available within the rolling Draft PY2022 ECP List accessible at https://data.healthcare.gov/cciio/ecp_petition.**
Network Adequacy
◆ **Except for Medical QHP issuers in network breadth pilot states who will be notified by email, issuers are *not* required to submit network adequacy data (Individual and Facility/Pharmacy) via the ECP/Network Adequacy Template. Medical QHP issuers who are notified by email that they are in a network breadth pilot state must submit the network adequacy data.**
◆ **Issuers notified by email that they must complete the network adequacy sections of the ECP/Network Adequacy Template (i.e., medical issuers in network breadth pilot states) must include within the Individual Providers and Facilities & Pharmacies tabs all providers in the network, including ECP providers, even if they are also included in the ECP tabs.**
◆ **For the Individual Providers and Facilities & Pharmacies tabs, include all providers in the network, including ECP providers, even if they are also included in the ECP tabs. Remember this may include providers in another state that are part of the network but may be within the time and distance allowed for reasonable access.**
◆ **CMS will not request network adequacy justifications.**
◆ **If a QHP and SADP issuer is required to submit an Access Plan with Cover Sheet, they will be notified by email. Access plans must be uploaded as supporting documents (see the Supporting Documents table at the end of this section for details).**

5. Detailed Section Instructions

User Control Tab	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Source System	Select the name of the system used to submit the QHP Application: ◆ **HIOS**—if the user is an FFE issuer. ◆ **SERFF**—if the user is an issuer in a state performing plan management functions.
State	Select the state in which the issuer is applying to offer QHPs using the drop-down menu.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: ◆ **Yes**—if the user is an Alternate ECP Standard issuer as described under 45 CFR 156.235(b). ◆ **No**—if the user is a General ECP Standard issuer.

Create Individual Provider (MD/DO) Tab: Click the **Create Individual (MD/DO) Tab** button. This action creates one **Individual Provider1** tab (clicking this button more than once creates multiple tabs, such as Individual Providers2, Individual Providers3, etc.). CMS will only collect individual provider data from issuers participating in the continued network breadth pilot project for PY2021. *Do not* click the **Create Individual (MD/DO) Tab** button unless you have been notified by email to submit these data. *Note:* When populating the **Individual (MD/DO) Tab**, include all providers in the network including ECP providers even if they are also included in the ECP tabs.

Create Facility, Pharmacy, Non-MD/DO Tab: Click the **Create Facility, Pharmacy, Non-MD/DO Tab** button. This action creates one **Facilities & Pharmacies1** tab (clicking this button more than once creates multiple tabs, such as Facilities & Pharmacies2, Facilities & Pharmacies3, etc.). CMS will only collect facility provider data from issuers participating in the continued network breadth pilot project for PY2021. *Do not* click the **Create Facility, Pharmacy, Non-MD/DO Tab** button unless you have been notified by email to submit these data. *Note:* When populating the **Facility, Pharmacy, Non-MD/DO Tab**, include all providers in the network including ECP providers even if they are also included in the ECP tabs.

Import Network IDs: Click on the **Import Network IDs** button to import data from the Network ID Template (please refer to **Section 2A: Network ID** for detailed instructions on this template). Once the Network ID Template is imported, it will automatically populate networks into the **Network IDs** field as a drop-down menu in the **Facility ECPs**, **Individual ECPs**, **Individual Providers**, and **Facilities & Pharmacies** tabs.

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

Figure 1E-1. Sample User Control Tab

ECPs:

Select ECPs Tab	Steps
Filter ECPs	The columns on the **Select ECPs** tab can be filtered to make selecting ECPs easier. For example, filter the Site State column to show only ECPs available in the issuer's state. SADP issuers may want to filter Column F, ECP Category, for any provider with "Dental Providers" listed to display only dental providers.
Add ECPs	Double-click anywhere on the row for the ECPs the user wants to add to the ECP tabs. Once selected, the row will be highlighted in blue and "add" will appear in the **Add ECP?** column. Continue selecting the ECPs until all contracted ECPs from the ECP list are selected.
	◆ To unselect an ECP, double-click on the selected row. The blue highlighting will be removed, and the ECP will not be added to the ECP tabs.
	◆ To clear *all* selected ECPs, click the **Clear All** button at the top of the tab, and all highlighted ECPs will be deselected and will not be added to the ECP tabs.
	◆ To show only those ECPs that have been selected, click the **Show Selected ECPs** button at the top of the tab, and all highlighted ECPs will be displayed. To undo this action and show all ECPs, click the **Show All ECPs** button.

Select ECPs Tab	Steps
Insert ECPs	◆ Click the **Insert Selected ECPs** button. The selected ECPs will be added to the **Facility ECPs** tab (if the sum of providers with more than one full-time-equivalent [FTE] practitioner in the Number of Medical FTEs and the Number of Dental FTEs and the number of inpatient hospital beds in the Hospital Bed Count is greater than one) or the **Individual ECPs** tab (providers with one or fewer FTE practitioners) of the ECP/Network Adequacy Template. The template will not populate duplicate ECPs into the **Facility ECPs** or **Individual ECPs** tabs. The issuer must complete any field within the **Facility ECPs** tab and **Individual ECPs** tab that is not populated from the **Select ECPs** tab before the template is validated. ◆ For each ECP facility that was selected and inserted from the **Select ECPs** tab, a record will be added to the **Facility ECPs** tab that includes the following: the row number, NPI, facility name, provider name, street address, city, state, ZIP, county, and ECP category. ◆ For each individual ECP that was selected and inserted from the **Select ECPs** tab, a record will be added to the **Individual ECPs** tab that includes the following: the row number, NPI, name of provider, specialty type, street address, city, state, ZIP, county, and ECP category.

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

Figure 1E-2. Sample ECPs Tab

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

Facility ECPs Tab	Steps
Network IDs	Select the network IDs for each ECP. Issuers may select multiple network IDs for each ECP, as applicable. Dual-product issuers must create separate network IDs for their medical and dental plans.
Hospital Bed Count	Enter the number of inpatient hospital beds reported by the respective provider at each site location, as reflected in Column F (Hospital Bed Count) of the **Select ECPs** tab.
Number of Medical FTEs	Enter the number of medical FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: Medical Doctor (MD), Doctor of Osteopathy (DO), Physician Assistant (PA), and Nurse Practitioner (NP). Decimal values may be entered as appropriate to reflect the contracted number of FTEs. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column G (Number of Medical FTEs) of the **Select ECPs** tab.

| Facility ECPs Tab	Steps
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP facility with which the issuer has contracted. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: Doctor of Dental Medicine (DMD) and Doctor of Dental Surgery (DDS). Decimal values may be entered as appropriate. Note that the maximum allowable number of FTEs is equal to the available FTEs reported by the respective provider at each site location, as reflected in Column H (Number of Dental FTEs) of the **Select ECPs** tab.

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

Figure 1E-3. Sample Facility ECPs Tab

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

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

Individual ECPs Tab	Steps
	reported by the respective provider at each site location, as reflected in Column H (Number of Dental FTEs) of the **Select ECPs** tab.

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

Figure 1E-4. Sample Individual ECPs Tab

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

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

Table 1E-1. Dummy Data Information

Facility ECPs Tab	Steps
Row Number	Leave blank.
NPI	Enter **0000000000**.
Facility Name	Enter **ZZZZZ**.
Provider Name	Enter **ZZZZZ**.
ECP Category	Select **Other ECP Providers**.
Street Address	Enter **00000**.
Street Address 2	Leave blank.
City	Enter **ZZZZZ**.
State	Select the state in which the service area is located from the drop-down menu.
County	Select a county from the drop-down menu.
ZIP Code	Select a ZIP code from the health professional shortage area (**HPSA**) tab that is in the same state in which the service area is located.
Network IDs	Using the drop-down menu, select any network IDs associated with the network that does not have an available ECP.
Hospital Bed Count	Enter **0**.

Facility ECPs Tab	Steps
Number of Medical FTEs	Enter **0**.
Number of Dental FTEs	Enter **0**.

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

Figure 1E-5. Sample Facility ECPs Tab Proposing a Network
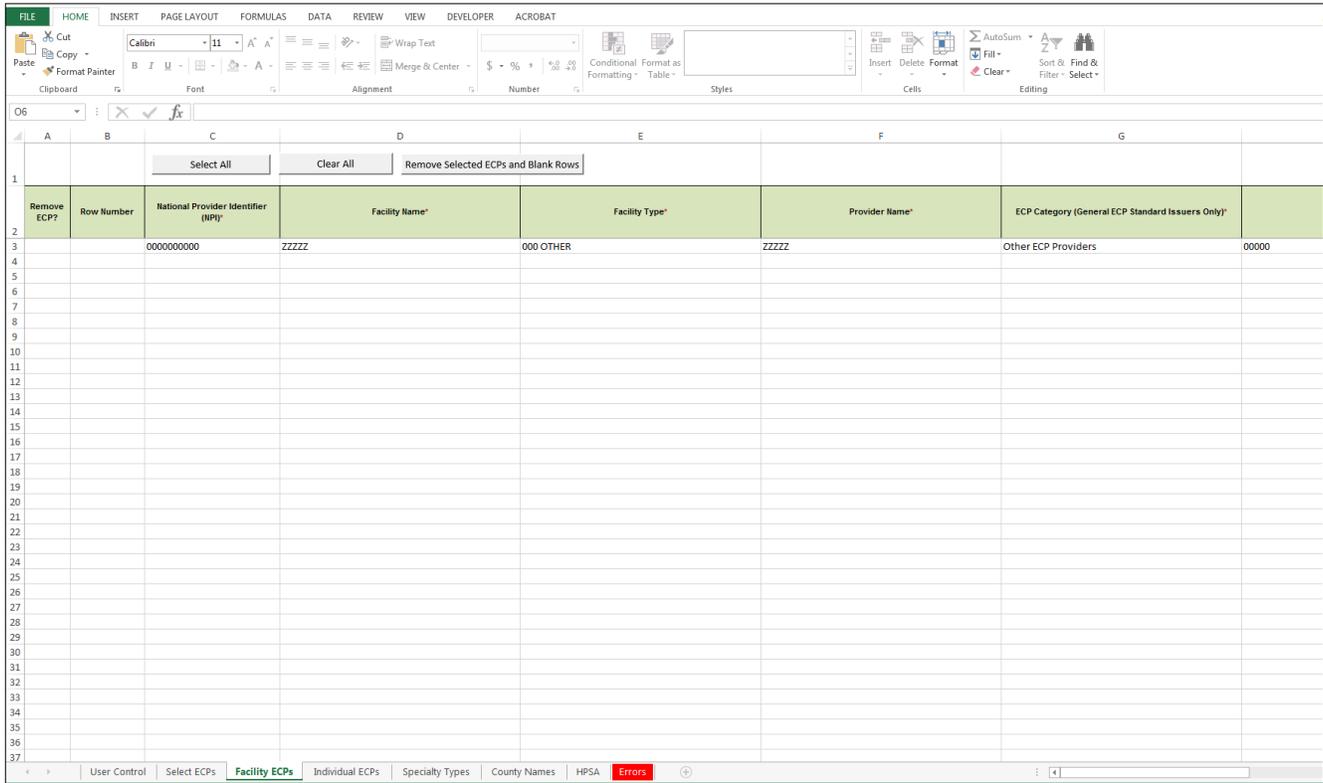
Note: Issuers planning to submit write-in ECPs should complete the ECP Write-in Worksheet.

HHS will release the PY2021 Available ECP Write-in List and ECP Write-in Worksheet approximately two weeks prior to each QHP certification submission cycle. These documents will be made available at the QHP certification website (https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy). The Available ECP Write-in List for purposes of the PY2021 QHP certification process will also be made available within the rolling Draft PY2022 ECP List accessible at https://data.healthcare.gov/cciio/ecp_petition. For General ECP Standard issuers, only those providers included on the PY2021 Available ECP Write-in List will count as qualified ECP write-ins.

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

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

ECP Write-in Worksheet	Steps
HIOS ID	Enter the five-digit HIOS Issuer ID.

ECP Write-in Worksheet	Steps
Issuer State	Select the state in which the issuer is applying to offer QHPs.
Is this an Alternate ECP Standard Issuer?	Choose from the following options: ◆ **Yes**—if the user is an Alternate ECP Standard issuer as described in 45 CFR 156.235(b). ◆ **No**—if the user is a General ECP Standard issuer.
Import Network IDs	Click on the **Import Network IDs** button to import data from the Network ID Template (please refer to **Section 2A: Network ID** for detailed instructions on this template). The network IDs will automatically be imported to the write-in worksheet, and you will receive a message indicating that the network IDs were successfully added.
Approved Write-in Row Number	Enter the row number as it appears on the PY2021 Available ECP Write-in List. For Alternate ECP Standard issuers reporting ECPs that are not required to submit an ECP provider petition (providers who are employed by the issuer or a single contracted medical group), enter "N/A" in this column.
Provider Name	Enter the provider name as it appears on the PY2021 Available ECP Write-in List.
Site Name	Enter the site name as it appears on the PY2021 Available ECP Write-in List.
Organization Name	Enter the organization name as it appears on the PY2021 Available ECP Write-in List.
NPI	Enter the NPI as it appears on the PY2021 Available ECP Write-in List.
ECP Category	Select the appropriate ECP category for each ECP. Multiple ECP categories for each ECP may be selected, as applicable. If none of the listed menu selections apply to the ECP, select **Other ECP Providers**.
Hospital Bed Count	Enter the number of inpatient hospital beds reported by the identified provider for each ECP.
Number of Medical FTEs	Enter the number of medical FTEs that are included in the identified provider networks for each ECP. Allowable medical FTEs include only individuals who hold one of the following licenses to practice medicine: MD, DO, PA, and NP. Decimal values may be entered as appropriate to reflect the contracted number of FTEs.
Number of Dental FTEs	Enter the number of dental FTEs that are included in the identified provider networks for each ECP. Allowable dental FTEs include only individuals who hold one of the following licenses to practice dental medicine: DMD and DDS. Decimal values may be entered as appropriate to reflect the contracted number of FTEs.
Site Street Address 1	Enter the site street address of the contracted provider as it appears on the PY2021 Available ECP Write-in List.
Site Street Address 2	Enter additional street address information as it appears on the PY2021 Available ECP Write-in List, as applicable.
Site City	Enter the city as it appears on the PY2021 Available ECP Write-in List.
Site State	Select the site state from the drop-down list, as it appears on the PY2021 Available ECP Write-in List.
Site ZIP Code	Enter the site ZIP code as it appears on the PY2021 Available ECP Write-in List. For Alternate ECP Standard issuers, all ECPs must be in an HPSA or low-income ZIP code.
Site County	Select the site county from the drop-down list, as it appears on the PY2021 Available ECP Write-in List.
Network IDs	Use the drop-down menu to select the network IDs for the networks to which the ECP belongs.
Validate the worksheet	Once all desired write-in ECPs are added to the worksheet, click the **Validate** button at the top of the worksheet. If there are errors identified, the worksheet will highlight the cells in red. Correct any errors and click **Validate** again. When all errors are corrected, a message will appear indicating that no validation errors were found.

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

Network Adequacy: CMS will only collect individual and facility provider data from issuers participating in the continued network breadth pilot project for PY2021. *Do not* click on the **Create Facility, Pharmacy, Non-MD/DO Tab** button unless you are a medical issuer notified by email to submit these data.

To complete the **Individual Providers** and **Facilities & Pharmacies** tabs, follow the steps in the tables below. *Note:* Include a list of providers in each of the proposed networks, including providers outside the geographic area (such as in contiguous counties). Also, include all providers in the network, including ECP providers, even if they are also included in the ECP tabs.

Individual Providers Tab	Steps
National Provider Identifier (required)	Enter the provider's 10digit NPI in the NPI column. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if the NPI is unknown. If the issuer is unable to obtain the provider's NPI for PY2021, enter **0000000000** (10 zeros) in the NPI field. Also, please ensure the NPI is active in the National Plan & Provider Enumeration System (NPPES) database.
Provider Name Prefix	Enter the prefix for the provider, such as "Dr."
First Name of Provider	Enter the first name of the provider.
Middle Initial of Provider	Enter the middle initial of the provider.
Last Name of Provider	Enter the last name of the provider. If a provider has multiple office locations, each with a unique address, add a number to the provider's last name to distinguish each location, for example, Provider Name-001.
Suffix of Provider	Enter the provider suffix, as applicable, such as "Jr." or "Sr."
Physician/Non-Physician	Indicate the type of provider. Choose from the following options: ◆ **Physician**—if the provider is a physician practitioner. ◆ **Non-Physician**—if the provider is a non-physician practitioner.
Specialty Type (area of medicine)	From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, all specialties should be selected in the same record. ◆ The template does not allow direct entry into this field. However, issuers may copy and paste data into the template if the specialty type names appear exactly as they appear in the **Specialty Types** tab data, such as **001 General Practice**. If pasted data do not exactly match the specialty type format used in the **Individual Providers** tab, errors will appear when the data are pasted. ◆ If the issuer would like to enter more than one specialty type for a provider, each specialty type must be separated by a comma and a space. ◆ If the specialty type is not listed in the **Specialty Types** tab, please select specialty type **000 OTHER** from the drop-down menu.
Street Address	Enter the street address of the provider. If the provider has multiple locations, enter each street address in a separate row. *Do not* use a PO box in the address, as these cannot be geocoded for analysis. All providers with a PO box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, if applicable.

Individual Providers Tab	Steps
City	Enter the city where the provider is located.
State	Enter the state where the provider is located, or select the state using the drop-down menu.
County	Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the **County Names** tab. Do not include the Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP	Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit (12345) or a nine-digit (12345-6789) code.
Network ID	When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and the Plans & Benefits Template. Dual-product issuers must create separate network IDs for their medical and dental plans. Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.

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

Figure 1E-6. Sample Individual Providers Tab
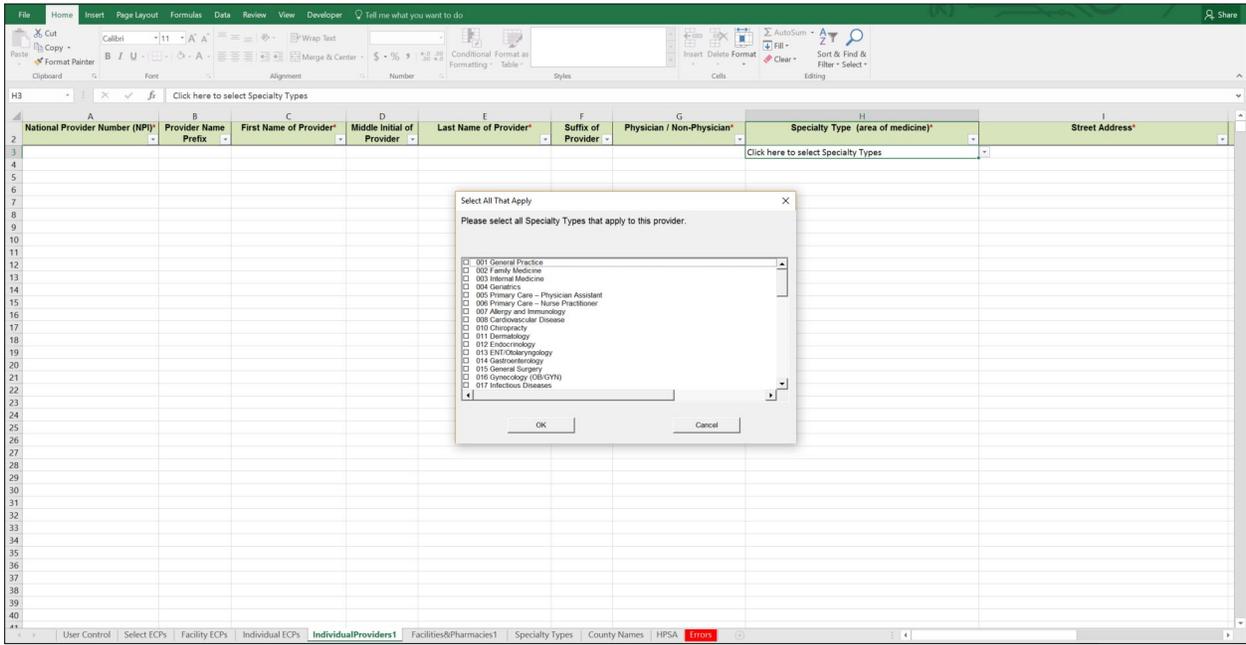
Individual Provider tabs can be removed from the template by using the **Delete** function, which is located in Column P of the **User Control** tab. Note that once a tab is deleted, it cannot be recovered, so save the template before deleting tabs.

Facilities & Pharmacies Tab	Steps
National Provider Identifier	Enter the provider's 10-digit NPI. It is very important for CMS to have the proper NPI number for a provider, so please contact the provider directly to acquire it if it is unknown. If the issuer is unable to obtain the provider's NPI for PY2021, enter **0000000000** (10 zeros) in the NPI field. Also, please ensure that the NPI is active in the NPPES database.
Facility Name	Enter the name of the facility or pharmacy.

Facilities & Pharmacies Tab	Steps
Facility Type	From the drop-down menu, select all facility types that apply to the facility location. If a facility has multiple facility types at the same address, then all facility types should be selected in the same record. The accepted facility types are listed on the **Specialty Types** tab of the template. ◆ The template does not allow direct entry into this column. However, issuers may copy and paste data into the template if the facility type names appear exactly as they appear in the **Specialty Types** tab, such as **040 General Acute Care Hospital**. If pasted data do not exactly match the facility type format used in the **Facilities & Pharmacies** tab, errors will appear when the data are pasted. ◆ If entering more than one facility type, each facility type must be separated by a comma and a space. ◆ If the facility type is not listed in the **Specialty Types** tab, please select facility type **000 OTHER** from the drop-down menu.
Street Address	Enter the street address of the provider. This is the address where the enrollee obtains services and not the corporate location unless they are the same. If the provider has multiple locations, enter each street address in a separate row. *Do not* use a PO box in the address because it cannot be geocoded for analysis. All providers with a PO box in the address will be excluded from time and distance analysis.
Street Address 2	Enter additional street address information, as applicable.
City	Enter the city where the provider is located.
State	Enter the state where the provider is located, or select the state using the drop-down menu.
County	Enter the county where the provider is located, or select the county using the drop-down menu. A list of accepted county names is available on the **County Names** tab. Do not include the FIPS code when entering the county name.
ZIP	Enter the ZIP code where the provider is located. ZIP codes must be entered as either a five-digit (12345) or a nine-digit (12345-6789) code.
Network ID	When entering network IDs, assign networks the same IDs as those assigned in the Network ID Template and Plans & Benefits Template. **Dual-product issuers must create separate network IDs for their medical and dental plans.** Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, all networks should be selected in the same record.

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

Figure 1E-7. Sample Facilities & Pharmacies Tab
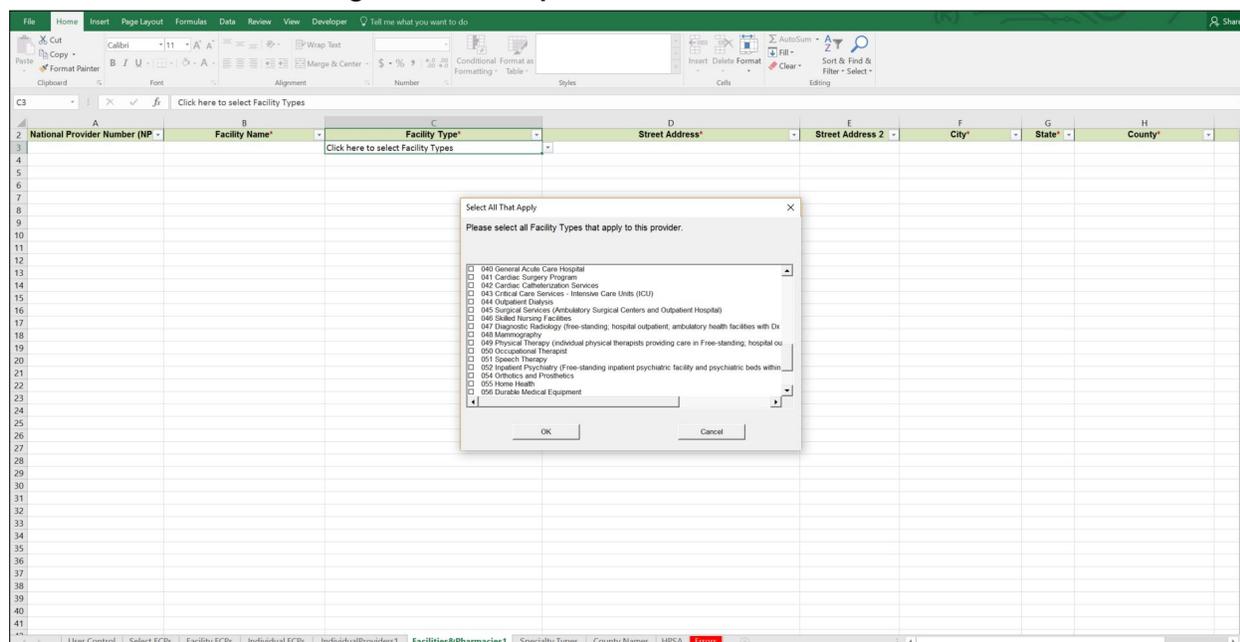
Reference information is provided in the three tabs listed below:

- The **Specialty Types** tab contains the specialty/facility and pharmacy types that can be added into the ECP/Network Adequacy Template.

- The **County Names** tab contains the county names that are used and accepted in the ECP/Network Adequacy Template.

- The **HPSA** tab contains the HPSA and low-income ZIP codes. The issuer can filter by ZIP code and by state.

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

1. Column A—Tab: indicates the tab that produced the error.

2. Column B—Cell: indicates the cell location for the specific error and a hyperlink that allows the issuer to navigate to the exact cell in the correct tab.

3. Column C—Validation Error Message: describes the error.

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

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

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

Supporting Documents	
General ECP Standard Issuers Supplemental ECP Response Form and Justification	◆ **An issuer needs to submit an ECP supplemental response form if *one of the following applies*:** ▪ **The issuer does not contract with at least 20 percent of the available ECPs in each applicable service area.** ▪ **The issuer does not offer a contract in good faith to all Indian health care providers in each plan's service area for the respective QHP certification plan year, applying the special terms and conditions required by federal law and regulations as referenced in the recommended model QHP Addendum for Indian Health Care Providers developed by HHS, available at https://www.qhpcertification.cms.gov/s/ECP%20and%20Network%20Adequacy.** ▪ **The issuer does not offer a contract in good faith to at least one ECP in each available ECP category in each county in the service area for the respective QHP certification plan year.** ◆ **The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20200601).**
Alternate ECP Standard Issuers Supplemental ECP Response Form and Justification	◆ **An issuer needs to submit an ECP supplemental response form if *one of the following applies*:** ▪ **The issuer does not include in each plan network at least the equivalent of 20 percent of available ECPs in each plan service area, and these providers are located within HPSAs or ZIP codes in which 30 percent or more of the population falls below 200 percent of the federal poverty line.** ▪ **The issuer does not offer an integrated delivery system that provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area, as outlined in the general ECP standard, or otherwise offer a contract to at least one ECP outside of the issuer's integrated delivery system in each available ECP category in each county in the plan's service area (not applicable to SADP applicants).** ◆ **The issuer should include its HIOS Issuer ID followed by "ecpsupplementalresponse" and the date in the ECP supplemental response file name (for example, 12345_ecpsupplementalresponse_20200601).**
Network Adequacy Cover Sheet and Access Plan	**QHPs and SADPs that need to submit access plans will be notified directly by email. These issuers will be required to submit a Cover Sheet and Access Plan that addresses the 11 areas below. The Cover Sheet must include page references to each of the 11 areas in the Access Plan:** 1. **The health carrier's network, including how the use of telemedicine or telehealth or other technology may be used to meet network access standards, if applicable.** 2. **The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable.** 3. **The health carrier's process for monitoring and ensuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in network plans.** 4. **The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select (and/or tier) providers.** 5. **The health carrier's efforts to address the needs of covered persons, including children and adults, and those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious,**

Supporting Documents	
	chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to have various types of ECPs in its network.
	6. The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services.
	7. The health carrier's method of informing covered persons of the plan's covered services and features, including
	a. the plan's grievance and appeals procedures;
	b. its process for choosing and changing providers;
	c. its process for updating its provider directories for each of its network plans;
	d. a statement of health care services offered, including those services offered through the preventive care benefit, if applicable; and
	e. its procedures for covering and approving emergency, urgent, and specialty care, if applicable.
	8. The health carrier's system for ensuring the coordination and continuity of care
	a. for covered persons referred to specialty physicians and
	b. for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning.
	9. The health carrier's process for enabling covered persons to change primary care professionals, if applicable.
	10. The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner.
	11. The health carrier's process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals.
	Note: It is recommended that the cover sheet be included in front of the Access Plan and submitted as one file. In this case, the file name for access plans should be the HIOS Issuer ID followed by "Access Plan" and any additional information deemed appropriate (for example, 12345_Access_Planv3). If a Cover Sheet is submitted as a separate file from the Access Plan, the file name should be the issuer's HIOS Issuer ID followed by "Access Plan Cover Sheet" and any additional information deemed appropriate (for example, 12345_Access_Plan_Cover_Sheetv3).

2. Benefits and Service Area Module

Users of the Benefits and Service Area Module are assigned to one or both of the following roles: Benefits Submitter (submits data and information to complete the Benefits and Service Area Module) and Benefits Validator (validates the correctness of the data and information submitted to complete the Benefits and Service Area Module).

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

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

The Data Submitter page allows Benefits Submitters to work on an existing application or view a previously submitted application (see **Figure 2-2**). The Data Validator page allows Benefits Validators to view a list of all the applications that have been submitted. This section also allows Benefits Validators to upload supporting documents and answer supplemental responses through the Health Insurance Oversight System (HIOS) (see **Figure 2-3**). The Final Submission page allows the Benefits Submitter and Benefits Validator to cross-validate data between modules, and allows the Benefits Validator to submit the Qualified Health Plan (QHP) Application.

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

Figure 2-2. Upload Documentation Page

Figure 2-3. Data Validator Page

Document Type:	File Name	Descripton	Last Update	Status
*Plan & Benefits Template (SHOP)	87296_NC_2016_PB_Med_SHOP.xlsm		02/17/2015 3:53:01 PM	Complete
*Plan & Benefits Template (Individual)	87296_NC_2016_PB_Med_Ind.xlsm		02/17/2015 3:52:52 PM	Complete
Dental Plan & Benefits Template (SHOP)	87296_NC_2016_PB_Dent_SHOP.xls		02/17/2015 3:52:32 PM	Complete
Dental Plan & Benefits Template (Individual)	87296_NC_2016_PB_Dent_Ind.xls		02/17/2015 3:52:38 PM	Complete
*Network ID Template	87296_NC_2016_Network.xls		02/17/2015 3:46:42 PM	Complete
*Service Area Template	87296_NC_2016_ServiceArea.xls		02/17/2015 3:46:53 PM	Complete
Prescription Drugs Template	87296_NC_2016_PrescriptionDrug.xls		02/17/2015 3:49:51 PM	Complete

Please review the completed templates and supplementary documents.
Fields marked with an asterisk (*) are required.

Showing 1 to 7 of 7 entries

Section 2A: Network ID

1. Introduction

In the Network ID section, issuers must assign each of their provider networks—groups of providers providing services in an area—to network IDs. These instructions apply to QHP and stand-alone dental plan (SADP) issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. List of provider networks.

3. Quick Reference

Key Changes for 2021
◆ Provider Directory URLs are no longer collected in the Network ID Template. Issuers must now submit their URLs via the Supplemental Submission Module (SSM).

Tips for the Network ID Section
◆ **Dual-product issuers offering QHPs and SADPs must create two different network IDs, one for use with each of the two plan types, regardless of whether the specific network is intended to serve both QHPs and SADPs.** ◆ **Dual-product issuers must use the word "dental" in the network area name for their dental service area to distinguish the QHP network from the dental network.**

4. Detailed Section Instructions

Perform the following steps to complete the Network ID Template.

Network ID Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Using the drop-down menu, select the state in which the proposed plan will be offered.
Generate Network IDs	Click the **Create Network IDs** button. This button generates the network IDs that will be used in a later step. Enter the number of networks when prompted and select **OK**. The network IDs are automatically generated based on the number of networks specified.
Network Name	Enter a network name. Dual-product issuers must use the word "dental" in the dental network name to distinguish the QHP network from the dental network.
Network ID	Select a network ID using the drop-down menu. The network IDs consist of the state abbreviation, the letter "N," and a sequenced number (such as MDN001 or MDN002). Dual-product issuers offering QHPs and SADPs must create separate network IDs for their QHP and dental networks.

Repeat these steps for each additional network ID.

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

Figure 2A-1. Sample Network ID Template

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

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

Section 2B: Service Area

1. Introduction

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

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

In almost all situations, the Department of Health and Human Services (HHS) will approve only service areas covering full counties. In the rare case in which the issuer proposes a service area covering a partial county, additional justification is required.

2. Data Requirements

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

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

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

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

3. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for the Service Area Section
◆ **An issuer may not change its service area after the initial submission deadline unless it submits a data change request to do so and makes this change only during the timeframe specified by CMS. This includes issuers submitting through National Association of Insurance Commissioners' (NAIC's) System for Electronic Rate and Form Filing (SERFF), even if the issuer is responding to an error issued by the state. See the Service Area Data Change Request Process in the Review Periods, Revision Process, and Certification section for more information.** ◆ **Dual-product issuers (issuers offering QHPs and SADPs) must create two different service area IDs for use with the two plan types, regardless of whether the service area is intended to serve both QHPs and dental plans.**

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[1] The columns these data are entered in appear in the Excel template when **Yes** is selected for Column E.

Tips for the Service Area Section

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

4. Detailed Section Instructions

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

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

Service Area Template	Steps
Service Area Name	Enter a name for the service area selected. *Note:* It may be helpful to name the service area so that it identifies a plan characteristic, such as health maintenance organization (HMO), or the actual plan name. Dual-product issuers must use the word "dental" in the service area name for their dental service area to distinguish the QHP service area from the dental service area. The service area name will not display to the public on HealthCare.gov.
State	Choose from the following options: ◆ **Yes**—if the service area includes the entire state. No additional information is required for the identified service area. Continue adding service areas until all service areas have been identified. ◆ **No**—if the service area includes only certain counties in the state. In the next step, county information must be provided for the identified service area. Continue adding service areas and counties as appropriate until all service areas have been identified. *Note:* The same service area ID *cannot* be used for both a service area that covers the entire state *and* a service area that covers only certain counties in the state.
County Name	Use the drop-down menu to select the name of each county included in the identified service area if the issuer indicated above that the identified service area does not cover the entire state. If a service area includes multiple counties, the issuer must add a new row for each new county using the same service area ID and service area name. If the issuer's service area counties do not appear in the drop-down menu, please contact the Marketplace Service Desk at 855-CMS-1515 or via email at CMS_FEPS@cms.hss.gov.
Partial County	Choose from the following options: ◆ **No**—if the service area includes the entire county. No additional information is required for the identified county. ◆ **Yes**—if the service area covers only part of the county. If **Yes** is selected, an informational box appears showing the HHS partial county policy. Select **OK**. A Service Area ZIP Code(s) column and a Partial County Justification Filename column will appear on the template.
Service Area ZIP Code	Enter the five-digit ZIP codes (12345) included in the partial county if the issuer identified that the county is only partially covered. If entering more than one ZIP code, use a comma to separate each ZIP code.
Partial County Justification Filename	Enter the file name for the partial county justification supplemental response. Use the following naming convention: [HIOS Issuer ID]_[State]_service_area_partial_county, for example, "12345_AZ_service_area_partial_county."

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

Figure 2B-1. Sample Service Area Template

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

Partial County Justification Supplemental Response
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. For each requested exception, the issuer must submit a detailed supplemental response substantiating why the entire county will not be served. The issuer must justify that the partial county service area is necessary, non-discriminatory, and in the best interests of potential enrollees and the Exchange program, consistent with 45 CFR 155.1055.
The specific questions to be answered are on the recommended form found at https://www.qhpcertification.cms.gov/s/Service%20Area. Failure to respond to each of these questions will result in the denial of the partial county request.
Issuers may request partial county service areas from the Centers for Medicare & Medicaid Services (CMS) only with state authorization. Issuers in FFE states that complete the QHP Application in HIOS should provide written evidence that their appropriate state regulator has authorized their partial county service area, such as an email correspondence with the state that lists the specific ZIP codes in the partial county requested.
Issuers in states performing plan management functions that request to serve partial counties must submit a partial county supplemental response but are not required to submit evidence of state approval. Successful transmission of the data will serve as state approval of the partial county request.
After completing the supplemental response form, do the following: ◆ Combine written evidence that the appropriate FFE state regulator has authorized the partial county service area and the partial county justification supplemental response into one PDF file. ◆ Name the PDF file using the following convention: [HIOS Issuer ID]_[State]_service_area_partial_county, for example, "12345_AZ_service_area_partial_county." Enter this file name in Column G, "Partial County Justification Filename," of the Service Area Template. ◆ Upload the combined document in the Plans & Benefits section of the Benefits and Service Area Module in HIOS using the document upload functionality. Select the document type **Service Area Justification** from the Document Type drop-down menu.

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

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

Section 2C: Prescription Drug

1. Introduction

In the Prescription Drug section, issuers create cost-sharing values for each tier of drug benefits along with specific drugs included in the formulary. They also select the drugs that will be offered at each tier level. These instructions do not apply to SADP only issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. A drug list with RxNorm Concept Unique Identifiers (RXCUIs), along with their formulary tier numbers. An issuer may offer drugs that do not have associated RXCUIs, but they cannot be included on the Prescription Drug Template.[2]

3. Quick Reference

Key Changes for 2021
◆ Formulary URLs are no longer collected in the Prescription Drug section. Issuers must now submit their URLs via the Supplemental Submission Module (SSM).

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

4. Detailed Section Instructions

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

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

Figure 2C-1. Drug Lists Worksheet

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

Drug List	Steps
RXCUI	◆ When selecting RXCUIs to include, use the October 7, 2019, full monthly release of RxNorm to find a list of valid RXCUIs. Download the RxNorm release at https://www.nlm.nih.gov/research/umls/rxnorm/docs/rxnormfiles.html. To download the file, the issuer will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. The issuer can obtain a license and account at no charge by following the instructions at http://www.nlm.nih.gov/databases/umls.html#license_request. ◆ CMS posts the EHB RX Crosswalk and a reformatted RxNorm database along with the state review tools at https://www.qhpcertification.cms.gov/s/Review%20Tools. ◆ RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK. ◆ The drug list should include all drugs on the issuer's formulary, even if they do not fall in one of the categories and classes identified in the summary of EHB benchmark information, available at https://www.qhpcertification.cms.gov/s/Prescription%20Drugs. This includes all drugs deemed by the issuer as "medical service drugs."
Tier Level	For each drug, select the RXCUI's cost-sharing tier level from the drop-down menu, or select "NA" if this drug is not part of the given drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following options: ◆ **Yes**—if prior authorization is required. ◆ **No**—if prior authorization is *not* required. If Tier Level is "NA," leave this column blank.
Step Therapy Required	Indicate whether the plan requires the enrollee to try at least one other drug before the plan covers the given drug. Choose from the following options: ◆ **Yes**—if step therapy is required. ◆ **No**—if step therapy is *not* required. If Tier Level is "NA," leave this column blank.

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

Figure 2C-2. Add Drug List Button

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

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

Figure 2C-3. Remove Drug List Button

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

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Select the state for which the template applies from the drop-down menu.
Generate Formulary IDs	Click the **Create Formulary IDs** button to create the formulary IDs. ◆ A pop-up dialog box appears and prompts the issuer to enter the number of formularies. ◆ After entering the number of formularies, the message "Formulary IDs have been generated successfully" appears. Click **OK**. The IDs are automatically generated, consisting of the state abbreviation, the letter "F," and a sequenced number (such as ALF001 and ALF002). ◆ Once completed, the formulary IDs appear in a drop-down menu in the Formulary ID column.

Formulary Tiers	Steps
Formulary ID	Select the formulary ID from the drop-down menu. ◆ After a formulary ID is selected, the template populates some cells and grays out others that do not apply. When a cell is grayed out, it is locked and cannot be edited. HIOS will not process data entered into the cell before it was grayed out. ◆ Select only formulary IDs that will be linked to a standard component ID used in the Plans & Benefits Template.
Drug List ID	Select the appropriate drug list ID from the drop-down menu. The menu is auto-populated with the drug list IDs that were created on the Drug Lists worksheet. If the Drug Lists worksheet has not been completed, do so now.
Number of Tiers	Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary should correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created within a tier. All drugs within the same tier should have the same cost-sharing structure.
Drug Tier ID	The template populates this column according to the selection in Number of Tiers. The other cells are grayed out, indicating they do not apply. The Drug Tier ID column is controlled by the template; do not edit it.
Drug Tier Type	Click the drop-down menu, and select the **Click here to select** option to open a pop-up dialog box. Choose from the following options, and select a maximum of two drug types (one generic type and one brand type) for each tier. No additional tier type can be selected for Zero Cost Share Preventive Drugs or Medical Service Drugs. ◆ If a tier contains both preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, then choose the tier type of preferred generic. The same applies for a tier with preferred and non-preferred brand drugs. ◆ Multiple tiers may have the same drug tier types, but tiers should have different cost sharing. ◆ If the issuer has both preferred and non-preferred specialty drugs, create two tiers and differentiate between the two using cost sharing. One way to represent this design is to designate the first as **Preferred Brand, Specialty** and the second as **Non-Preferred Brand**, **Specialty.** *Zero Cost Share Preventive Drugs:* ◆ When Zero Cost Share Preventive Drugs is selected, it is the only tier type that can be selected for the tier. It is preferred that the issuer place the Zero Cost Share Preventive Drug tier as Tier 1 if applicable, to represent the lowest-cost tier to the consumer. ◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance information will automatically be set to **$0** and **0 percent**, respectively, when this tier type is chosen. The remaining pharmacy benefit types can still be edited. If the remaining pharmacy benefits are offered, then the subsequent cost-sharing values should be entered as **$0** and **0 percent**. ◆ If the issuer has a tier that contains preventive drugs, but those drugs can incur cost sharing for different circumstances, then complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the **Explanation** field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page. *Medical Service Drugs:* ◆ Use this tier type to indicate if a formulary contains medical service drugs. CMS recognizes that there are some state benchmarks that contain medical service drugs in various categories and classes; a Medical Service Drugs tier can assist in identifying these drugs in the formulary. ◆ When Medical Service Drugs is selected, it is the only tier type that can be selected for the tier. ◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance will both be automatically set to **Not Applicable** when this tier type is chosen. The remaining pharmacy benefit types cannot be edited.
Tier Cost Sharing	This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance. The issuer must indicate whether each tier

Formulary Tiers	Steps
	offers these types of pharmacy benefits, but should only complete the information for the other three pharmacy types if they apply to the given drug tier. The pharmacy benefits are as follows: ◆ 1 Month In Network Retail Pharmacy (Copayment & Coinsurance) ◆ 1 Month Out of Network Retail Pharmacy Benefit Offered? ◆ 1 Month Out of Network Retail Pharmacy (Copayment & Coinsurance) ◆ 3 Month In Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month In Network Mail Order[3] Pharmacy (Copayment & Coinsurance) ◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance).
Benefit Offered	Select **Yes** if the pharmacy benefit is offered for the corresponding tier. Otherwise, select **No**.
Copayment	Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, *not* **No Charge**, if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. *Note:* When using **Not Applicable** for copay, **Not Applicable** cannot also be used for coinsurance (unless the drug tier type is **Medical Service Drugs**).
Coinsurance	Enter the coinsurance amount for the given pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, *not* **No Charge**, if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay. *Note:* When using **Not Applicable** for coinsurance, **Not Applicable** cannot also be used for copay (unless the drug tier type is **Medical Service Drugs**).

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

CMS will review tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing their formulary tier structure, issuers should use standard industry

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[3] Pursuant to 45 CFR 156.122, for plan years beginning on or after January 1, 2017, a health plan providing EHBs must have access to prescription drug benefits at in-network retail pharmacies, unless the drug meets an exception under 45 CFR 156.122(1)(i) and (ii).

practices. Tier 1 should be considered the lowest cost-sharing tier available, which means a Zero Cost Share Preventive tier should be listed first. Any and all subsequent tiers in the formulary structure will be higher cost-sharing tiers in ascending order. Place the Medical Service Drug tier as the last tier for all formulary designs.

Preventive services under the Patient Protection and Affordable Care Act (PPACA) must be covered without requiring the consumer to pay a copayment or coinsurance or meet a deductible. For more information on the coverage of preventive services, see https://www.healthcare.gov/coverage/preventive-care-benefits/.

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

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

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

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

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

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

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

Section 2D: Plans & Benefits

1. Introduction

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

2. Data Requirements

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

1. Completed Network ID (QHP and SADP), Service Area (QHP and SADP), and Prescription Drug Templates (QHP only)
2. Detailed benefit cost sharing for all plans.

3. Quick Reference

| Key Changes for 2021 |
| --- |
| ◆ The EHB benchmark, which is populated through the **Refresh EHB** button in the Plans & Benefits Add-In, has been updated to reflect plan year changes. |
| ◆ Plan URLs are no longer collected in the Plans & Benefits Template. Issuers must now submit their URLs via the Supplemental Submission Module (SSM). |
| ◆ The issuer's tax identification number is no longer required on this template. |

Tips for the Plans & Benefits Section
◆ **Download the most recent versions of the 2021 Plans & Benefits Template, Plans & Benefits Add-In file, and Actuarial Value Calculator (AVC).**
◆ **Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template for the macros to run properly.**
◆ **All data elements that CMS *anticipates* displaying to individual market consumers on Plan Compare are identified by a number sign (#) next to the field name in the instructions below.**
◆ **All data fields required for SADP issuers are identified by an asterisk (*) next to the field name in the instructions below. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variances worksheet, see Sections 4.11, 4.20–4.22, 4.24, and 4.25.**
◆ **All data fields used by the AVC are identified by a caret (^) next to the field name in the instructions below. See Appendix A for additional AVC instructions.**
◆ **Issuers should complete the Network, Service Area, and Prescription Drug Templates (QHPs only) and save the templates before filling out the Plans & Benefits Template. The Plans & Benefits Template requires issuers to assign a network, service area, and formulary ID to each plan based on the IDs already created in these three templates.**
◆ **Complete a separate Benefits Package worksheet for each unique benefits package the issuer wishes to offer. To create additional benefits packages, click the Create New Benefits Package button on the menu bar under the Plans & Benefits Add-In. The HIOS Issuer ID, Issuer State, Market Coverage, and Dental Only Plan fields are auto-populated.**
◆ **Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost-sharing reduction (CSR) plan variation the issuer wishes to offer.**
◆ **The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Appendix A for how these values relate to actuarial value (AV).**
◆ **When a cell is grayed out, it is locked and cannot be edited. HIOS will not process data entered into the cell before it was grayed out.**

4. Detailed Section Instructions

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

Figure 2D-1. Plans & Benefits Ribbon
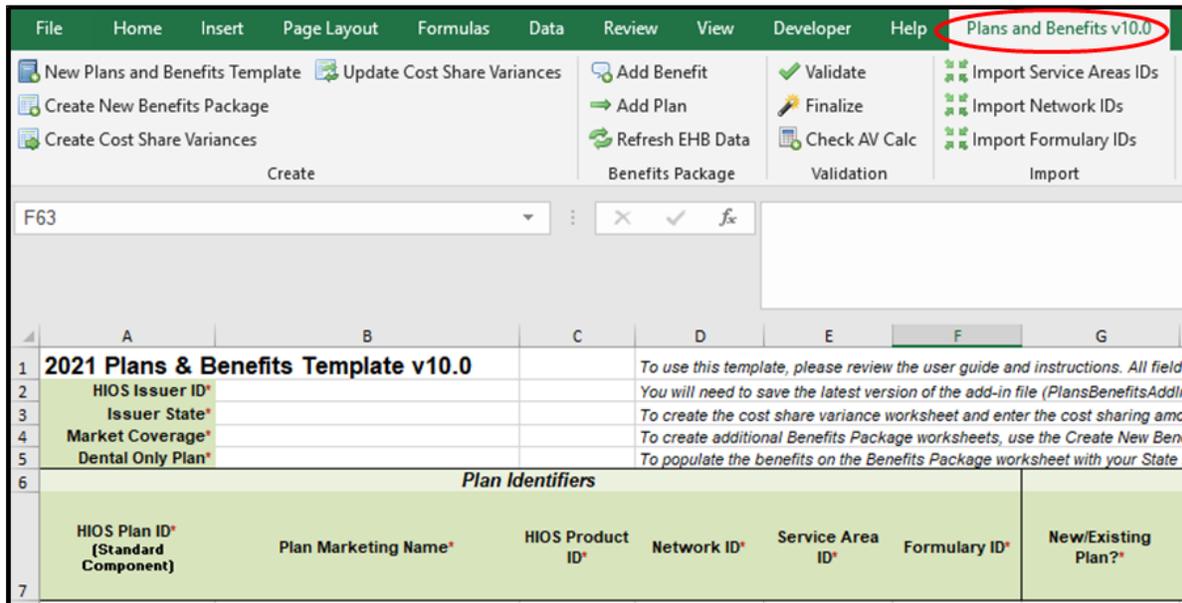
Note: Before proceeding, the issuer should confirm that it has downloaded the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the QHP certification website (https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits).

4.1 General Information

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

Figure 2D-2. Plans & Benefits Template

General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which the issuer is licensed to offer these plans using the dropdown menu.

General Plans & Benefits Information	Steps
Market Coverage*	Select the market coverage. Choose from the following options: ◆ **Individual**—if the plans are offered on the individual market. ◆ **Small Business Health Option Program (SHOP) (Small Group)**—if the plans are offered on the small group market.
Dental-Only Plan*	Indicate whether the plans contained in the template are dental-only plans. Choose from the following: ◆ **Yes**—if this is a dental-only package. When **Yes** is selected, the template grays out areas that do not apply to SADPs and prevents the fields from accepting data entry. ◆ **No**—if this is *not* a dental-only package.

4.2 Plan Identifiers

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

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

Figure 2D-3. Plan Identifiers Section

Plan Identifiers	Steps
HIOS Plan ID (Standard Component)*#	Enter the 14character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name*#	Enter the plan marketing name at the standard plan level.
HIOS Product ID*	Enter the 10character, HIOS-generated product ID number.
Network ID*	Click the **Import Network IDs** button on the menu bar under the **Plans & Benefits** ribbon and select the completed Network ID Template Excel file to import a list of network ID values from the Network ID Template, then select the appropriate network ID from the dropdown menu. (The Excel version of the Network ID Template must be completed and saved before importing the network IDs.)

Plan Identifiers	Steps
Service Area ID*	Click the **Import Service Area IDs** button on the menu bar under the **Plans & Benefits** ribbon and select the completed Service Area Template Excel file to import a list of service area ID values from the Service Area Template, then select the appropriate service area ID from the dropdown menu. (The Excel version of the Service Area Template must be completed and saved before importing the service area IDs.)
Formulary ID	Click the **Import Formulary IDs** button on the menu bar under the **Plans & Benefits** ribbon and select the completed Prescription Drug Template Excel file to import a list of values from the Prescription Drug Template, then select the appropriate formulary ID from the dropdown menu. (The Excel version of the Prescription Drug Template must be completed and saved before importing the formulary IDs.)

4.3 Plan Attributes

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

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

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following options: ◆ **New**—if this is a new plan that was not offered last year. This includes a plan that was offered last year but is not considered to be the "same plan" as described in 45 CFR 144.103. This plan should use a new plan ID that was *not* used for the 2020 plan year. ◆ **Existing**—if this plan was offered last year and the plan is considered to be the "same plan" as described in 45 CFR 144.103. This plan should use *the same* plan ID that was used for the 2020 plan year.
Plan Type*#	Select the plan type that best corresponds to plan definitions provided in state law or regulations in the issuer's state. Plan type selections must be consistent with the issuer's state form-filing submissions. Choose from the following product network types: ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point-of-service) ◆ EPO (exclusive provider organization).
Level of Coverage^*#	Select the metal level of the plan based on its AV. A de minimis variation of −4/+2 percentage points is allowed for standard metal-level plans. Please note that, pursuant to 45 CFR 156.200(c), QHP issuers must offer at least one QHP in the silver coverage level and one QHP in the gold coverage level in each county they cover through the Exchange, as described in Section 1302(d)(1) of the PPACA. Choose from the following: ◆ **Bronze**—AV of 60 percent. ◆ **Expanded Bronze**—AV of 56–65 percent. A plan may use this option if it either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2). ◆ **Silver**—AV of 70 percent. ◆ **Gold**—AV of 80 percent.

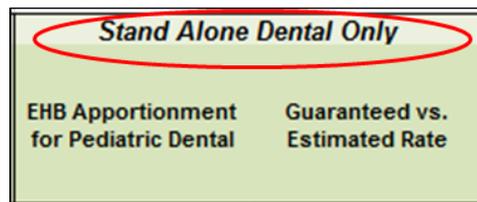| Plan Attributes	Steps
	◆ **Platinum**—AV of 90 percent.
	◆ **Catastrophic**—offered to certain qualified individuals and families; it does not meet a specific AV but must comply with several requirements, including the MOOP and deductible limits.
	Level of coverage for SADPs is required, however the AV for dental plans is optional. If an AV is provided, it must fall within the previous AV ranges of high or low, as described in 45 CFR 156.140:
	◆ **Low**—AV of 70 percent.
	◆ **High**—AV of 85 percent.
Design Type*	This field is not applicable for PY2021. All plans should select **Not Applicable** for this field.
Unique Plan Design	Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available for HHS for the given benefit year. For more information on determining whether a plan is unique, see **Appendix A**. Choose from the following options:
	◆ **Yes**—if the unique plan design features cause the use of the AVC to yield an AV result that materially differs from that of the other approved methods described in 45 CFR 156.135(b). This indicates that the plan is not compatible with the AVC. If **Yes** is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification (see **Supporting Documentation**). The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.
	◆ **No**—if the plan design is *not* unique.
QHP/Non-QHP*	Indicate whether the plan will be offered only through the Exchange, only outside the Exchange, or both through and outside the Exchange. Choose from the following options:
	◆ **On the Exchange**—if the plan will be offered only through the Exchange. *Note:* Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered through the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan outside the Exchange. Issuers that offer a plan through the Exchange should select **Both** unless an exception to guaranteed availability applies.
	◆ **Off the Exchange**—if the plan will be offered only outside the Exchange. This includes non-QHPs as well as plans that are substantially the same as a QHP offered through the Exchange for purposes of the risk corridor program (see 45 CFR 153.500 for more details).
	◆ **Both**—if the plan will be offered both through and outside the Exchange. A plan that is offered both through and outside the Exchange must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of whether it is offered through or outside of the Exchange. Selecting this option creates two separate plan variations in the Cost Share Variances worksheet when the worksheet is created: one on-Exchange plan and one off-Exchange plan.
Notice Required for Pregnancy	Indicate whether the issuer has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following options:
	◆ **Yes**—if a notice is required.
	◆ **No**—if a notice is *not* required.
Is a Referral Required for a Specialist?#	Indicate whether a referral is required to see a specialist. Choose from the following options:
	◆ **Yes**—if a referral is required to see a specialist.
	◆ **No**—if a referral is *not* required to see a specialist.
Specialist(s) Requiring a Referral#	(Required if **Yes** is entered for "Is a Referral Required for a Specialist?") Enter the types of specialists that require a referral.
Plan Level Exclusions*	Enter any plan exclusions.
Limited Cost-Sharing Plan Variation—Est. Advance Payment	This data element is not necessary for PY2021 because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost-sharing plan variations. Leave this field blank.

Plan Attributes	Steps
Does this plan offer Composite Rating?	This field is not applicable for PY2021. All plans should select **No** for this field.
Child-Only Offering*	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (offered only to individuals who, as of the beginning of the plan year, have not attained the age of 21 for QHPs and 19 for SADPs); one option must be selected consistent with the requirements at 45 CFR 156.200. This does not apply if the plan's level of coverage is catastrophic. Catastrophic plans must have a value of "Allows Adult and Child-Only" to validate. Choose from the following options: ◆ **Allows Adult and ChildOnly**—if the plan allows adult- and child-only enrollment and is offered at a child-only rate. ◆ **Allows AdultOnly**—if the plan does *not* allow child-only enrollment. This does not mean that only adults can enroll but that this plan requires an adult as the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Do not select this option for SADPs as they must have the option of being offered to child-only subscribers. ◆ **Allows ChildOnly**—if the plan is a child-only plan that allows only child subscribers. Do not select this option for catastrophic plans.
Child-Only Plan ID	Required if "Allows Adult-Only" is entered for **Child-Only Offering**. Enter the corresponding 14-character plan ID if this plan does *not* allow child-only enrollment. The entered plan ID must correspond to a plan in which the **Child-Only Offering** is "Allows Adult and Child-Only" or "Allows Child-Only." The corresponding plan must have the same **Level of Coverage** as the plan for which the issuer is entering data.
Tobacco Wellness Program Offered	Indicate whether, as required to rate for tobacco use in the small group market, the plan offers a wellness program designed to prevent or reduce tobacco use that meets the standards of Section 2705 of the Public Health Service (PHS) Act. (This is unrelated to whether the plan provides benefits for recommended preventive services, including tobacco-use counseling and interventions, under Section 2713 of the PHS Act.) Choose from the following options: ◆ **Yes**—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. ◆ **No**—if the plan does *not* offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter **No** if either of the following applies: ▪ The plan is offered in the individual market. ▪ The plan is offered in the small group market and does not rate for tobacco use.
Disease Management Programs Offered#	Indicate whether the plan offers disease management programs. Choose one or more of the following options: ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure and High Cholesterol ◆ Low Back Pain ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs.
EHB Percent of Total Premium	Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). This is required for all plans on the individual and SHOP markets except for catastrophic plans. Please note that if abortion services are included in the benefits package of the EHB benchmark plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below:

Plan Attributes	Steps
	◆ If the plan is a QHP offered in the FFE or a State-based Exchange (SBE), the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Because subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion. ◆ If the plan is not a QHP offered in the FFE or in an SBE, but is only offered outside of the Exchange, the percentage of the premium associated with abortion services should be included in the EHB percentage. If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state-mandated benefits portion or the other benefits portion regardless of whether the plan is sold through or outside of the Exchange.

4.4 Stand-Alone Dental Only

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

Figure 2D-5. SADP-Only Fields

Stand-Alone Dental Only	Steps
EHB Apportionment for Pediatric Dental*	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies to the pediatric rates. If the rates are family-tiered, use the EHB percent of the individual rate assuming a child enrollment. This percentage is used to determine the amount of the advance payment of the premium tax credit required under 45 CFR 155.340(e)(2). Issuers must also submit the Stand-Alone Dental Plans—Description of EHB Allocation Form (**Supporting Documentation**) as a supporting document.
Guaranteed vs. Estimated Rate*	This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the Rates Table Template and the Business Rules Template. By indicating the rate is a "Guaranteed Rate," the issuer commits to charging the premium shown to the consumer on the FFE website, which has been calculated by taking into account consumers' geographic location, age, and other permissible rating factors provided for in the Rates Table Template and Business Rules Template. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported. Select whether this plan offers guaranteed or estimated rates. Choose from the following options: ◆ **Guaranteed Rate**—if the plan offers a guaranteed rate. ◆ **Estimated Rate**—if the plan offers an estimated rate.

4.5 Plan Dates

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

Figure 2D-6. Plan Dates

Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2021 plan year—even for existing plans offered on-Exchange in 2020. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2021, for all plans that will be offered through the FFE and the Federally-facilitated Small Business Health Option Program (FF-SHOP).
Plan Expiration Date*	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (this must be December 31, 2021, for the individual market). In the context of FF-SHOP, the plan is effective for a 12-month plan year. The plan expiration date is 12 months after the original employer coverage effective date.

4.6 Geographic Coverage

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

Figure 2D-7. Geographic Coverage Fields

Geographic Coverage	Steps
Out of Country Coverage*	Indicate whether care obtained outside the country is covered under the plan. Choose from the following options: ◆ **Yes**—if the plan covers care obtained out of the country. ◆ **No**—if the plan does *not* cover care obtained out of the country.
Out of Country Coverage Description*	(Required if "Yes" is selected for Out of Country Coverage.) Enter a short description of the care obtained outside the country that the plan covers.
Out of Service Area Coverage*	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options: ◆ **Yes**—if the plan covers care obtained outside the plan service area. ◆ **No**—if the plan does *not* cover care obtained outside the plan service area.
Out of Service Area Coverage Description*	(Required if "Yes" is entered for Out of Service Area Coverage.) Enter a short description of the care obtained outside the service area that is covered under the plan.

Geographic Coverage	Steps
National Network*#	Indicate whether a national network is available. Choose from the following: ◆ **Yes**—if a national network is available. ◆ **No**—if a national network is *not* available.

4.7 Benefit Information

After completing the sections of the template detailed above, issuers will complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans (**Figure 2D-8**).

Figure 2D-8. Benefit Information Section

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

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

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

- Look through the dropdown menu to determine whether the benefit already exists as an option; if the benefit is an option, select it. If the benefit is not an option, click the **Custom** button and type in the benefit name. New benefit names must be different from the existing benefit names.

- A row for this benefit appears below the last row in the Benefit Information section.

- If a benefit is mistakenly added, it cannot be deleted, but an issuer may do one of the following:

  - Select **Not Covered** under the "Is this Benefit Covered?" column (see Section 4.9).

- Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but also removes any other data entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.

- If the benefit added is not found in the state's benchmark, and the issuer is not substituting for an EHB found in the state's benchmark, select **Not EHB** as the EHB variance reason.

- If the benefit added is not found in the state's benchmark, but the issuer is substituting for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the EHB variance reason.

- If the benefit added is a state-required benefit enacted after December 2011, select **Not EHB** as the EHB variance reason.

- For more information on how to select the correct EHB variance reason, see **5.6 EHB Variance Reason and EHB Designation**.

- A benefits package should not have multiple benefits with identical names. In the event of multiple cost-sharing schemas for a given benefit based on multiple limits, choose the cost-sharing type that applies to the limits in the **Limit Quantity** and **Limit Unit** fields for each of the network types.

4.8 General Information

This section contains fields that give more information on each benefit in the benefits package, such as benefit coverage, benefit limits, applicable exclusions, and benefit explanations (**Figure 2D-9**).

Figure 2D-9. General Information Fields

General Information	Steps
EHB*	This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. Issuers cannot edit this field. *Note:* Issuers should carefully review the benefits covered by their applicable EHB benchmark plan as identified on CMS's "Information on Essential Health Benefits (EHB) Benchmark Plans" website at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html. After reviewing the applicable EHB benchmark plan documents, issuers may need to update the Benefits Package worksheet with any changes required to accurately reflect their coverage of EHB benchmark benefits. See the **EHB Variance Reason** field instructions below for more information on updating the Benefits Package worksheet.
Is this Benefit Covered?*	This field is auto-populated with **Covered** for benefits identified in the template as EHBs. If the "Is this Benefit Covered?" data element is changed to **Not Covered**, the issuer must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see the **EHB Variance Reason** field and **Supporting Document** section). If a benefit is marked as **Not Covered**, it does not appear on the Cost Share Variances worksheet and the remaining fields for this benefit may be left blank. Choose from the following options: ◆ **Covered**—if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar coverage or in combination with a cost-sharing mechanism (e.g., copays, coinsurance, or deductibles). ◆ **Not Covered**—if this benefit is *not* covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.

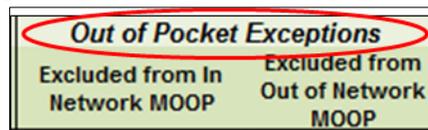| General Information	Steps
Quantitative Limit on Service?*	(Required if **Covered** is entered in the **Is this Benefit Covered?** field.) This field is auto-populated for benefits identified in the template as EHBs. If this data element is changed, an EHB variance reason must be provided, along with associated supporting documents. For any benefits not identified as EHBs, choose from the following options: ◆ **Yes**—if this benefit has quantitative limits. ◆ **No**—if this benefit does *not* have quantitative limits. *Note:* Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, issuers may not impose combined limits on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Plans & Benefits Template Benefits Package worksheet, issuers must provide a separate limit for those benefits.
Limit Quantity*#	(Required if **Yes** is entered for the **Quantitative Limit on Service?** field.) This field is auto-populated for benefits in the template identified as EHBs. If the issuer changes this data element, it must provide an EHB variance reason. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., to set a limit of two specialist visits per year, enter **2** here).
Limit Unit*#	(Required if **Yes** is entered for the **Quantitative Limit on Service?** field.) This field is auto-populated for benefits in the template identified as EHBs. If data are changed for this element, select the EHB variance reason of **Substantially Equal**. For any benefits not identified as EHBs, using the dropdown menus, enter the units being restricted per interval to show the quantitative limits that are placed on this benefit (e.g., if the plans have a limit of two specialist visits per year, enter **Visits per year** here). Choose from the following options: ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year ◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. If a benefit has limit units that do not align with the list above, the limit does not auto-populate in the **Limit Unit** field but does auto-populate in the **Benefit Explanation** field (such as a limit of one hearing aid per ear every 48 months for subscribers up to age 18). If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB benchmarks on the Center for Consumer Information and Insurance Oversight (CCIIO) website (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html). The message

General Information	Steps
	"Quantitative limit units apply, see EHB benchmark" appears in the **Benefit Explanation** field (e.g., "Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services").
	If a benefit has multiple limit units, they do not auto-populate. Put the limit quantity and limit unit that should be displayed on the Plan Compare function of the FFE website in these columns, and put all other quantitative limits in the **Benefit Explanation** field (such as "Outpatient Rehabilitative Services—90 days per year in the Limit Quantity and Limit Unit columns; two treatments per year in the benefit explanation").
	The message "Quantitative limit units apply, see EHB benchmark" may appear in the **Benefit Explanation** field for a benefit that does not have quantitative limits in the Benefits and Limits section of the EHB benchmark on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). This message appears because certain benefits, identified in the Other Benefits section of the EHB benchmark Benefit Template, may have quantitative limits, which may not apply to all services in the higher-level benefit category.
Exclusions*#	Enter any benefit-level exclusions.
	◆ If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions.
	◆ If *no* services or diagnoses are excluded, leave this field blank.
Benefit Explanation*#	Enter any benefit explanations.
	◆ Examples of benefit explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed descriptions of services provided, and alternate cost-sharing structures if they depend on provider type or place of service.
EHB Variance Reason*	(Required if the issuer changed the **Is this Benefit Covered?**, **Limit Units**, or **Limit Quantity** fields, or if the benchmark has an unallowable limit or exclusion under the PPACA.) Select from the following EHB variance reasons if this benefit differs from the state's benchmark:
	◆ **Not EHB**—if this benefit is *not* an EHB.
	▪ If the issuer has added a new benefit and it is not found in the state's benchmark, the **EHB** field will be blank and the issuer should set the EHB variance reason to **Not EHB**. This benefit is *not* considered an EHB.
	▪ If a benefit auto-populated as **Yes** in the EHB column, but the issuer has received guidance from CMS or the state indicating that it should not be considered an EHB, set the EHB variance reason to **Not EHB**. This benefit is *not* considered an EHB.
	◆ **Substituted**—if a benefit is included in the state's benchmark, the **EHB** field auto-populates as **Yes**. If substituting a different benefit for an EHB, set the EHB variance reason field to **Substituted** and the **Is this Benefit Covered?** field to **Not Covered**. The benefit that takes its place must be designated as an **Additional EHB Benefit.**
	◆ **Substantially Equal**—if the limit quantity for a benefit differs from the limit quantity in the EHB benchmark, but is still substantially equal to the EHB benchmark, select **Substantially Equal** as the variance reason. Also, if the limit unit for a benefit differs from the limit unit in the EHB benchmark, but is still substantially equal to the EHB benchmark, select **Substantially Equal** as the variance reason. For example, if the benchmark lists a limit of 40 hours per month, and the plan defines a day as 8 hours and lists a limit of 5 days per month, the issuer should use that variance reason.
	◆ **Using Alternate Benchmark**—Issuers should select this EHB variance reason for any benefit that has **Yes** for EHB but is not an EHB in the alternate benchmark.
	◆ **Other Law/Regulation**—if a benefit is required by a state or federal law or regulation that was enacted on or before December 31, 2011, and the benefit is not represented in the state's EHB benchmark plan, issuers should change the benefit to **Covered** and set the variance reason to **Other Law/Regulation**. (State-required benefits that were enacted after December 31, 2011, are *not* EHBs, and for those the issuer should use **Not EHB** as the variance reason instead.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan and coverage is only required by the state in the individual market.

General Information	Steps
	◆ **Additional EHB Benefit**—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state, change the benefit to **Covered,** and choose **Additional EHB Benefit** as the EHB variance reason. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are covered. This benefit is considered an EHB, and cost-sharing values for the plan variations should be entered accordingly.
	◆ **Dental Only Plan Available**—if a dental benefit auto-populates as **Covered**, but the issuer is not covering a benefit because it is a dental EHB covered by a separate dental-only plan, set the EHB variance reason to **Dental Only Plan Available**. For example, an issuer may offer SADPs to cover pediatric dental benefits, so they will not need to cover pediatric dental as part of the medical plans. The issuer would select **Not Covered** and select **Dental Only Plan Available** as the EHB variance reason for benefits, such as Dental Check-Up for Children, Basic Dental Care—Child, Orthodontia—Child, and Major Dental Care—Child if the benefits are designated as a **Covered** EHB. (This option is not applicable to SADPs.)
	Note: Because EHB benchmark plan benefits are based on plans that were sold previously, some of the benchmark plan designs may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Issuers should carefully review the information available on the CMS "Information on Essential Health Benefits (EHB) Benchmark Plans" website (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html).
	If more than one EHB variance reason applies, select the option related to EHB designation instead of the one related to limits. For example, if an issuer adds a new benefit that is an EHB and also changes its limits, the EHB variance reason that should be selected is **Additional EHB Benefit** instead of **Substantially Equal**. It is important that the issuer enters the correct EHB variance reason because it has implications for non-discrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to CSR plan variations.

4.9 Out of Pocket Exceptions

This section allows issuers to indicate whether each benefit is excluded from the MOOP. All plans in a benefits package must have the same MOOP structure and exclude the same benefits from the MOOP. To create plans with a different MOOP structure, issuers must create a new benefits package and then a new Cost Share Variances worksheet (**Figure 2D-10**).

Figure 2D-10. Out of Pocket Exceptions

Out of Pocket Exceptions	Steps
Excluded from In Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits that are not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following options: ◆ **Yes**—if this benefit is excluded from the in-network MOOP. ◆ **No**—if this benefit is *not* excluded from the in-network MOOP.
Excluded from Out of Network MOOP*	Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following options: ◆ **Yes**—if this benefit is excluded from the out-of-network MOOP. ◆ **No**—if this benefit is *not* excluded from the out-of-network MOOP.
◆ If the plans only have a combined (no separate in-network) MOOP, set **Excluded from In Network MOOP** equal to **Excluded from Out of Network MOOP**.	

Out of Pocket Exceptions	Steps
◆ If the Is this Benefit Covered? field for a benefit is Not Covered or blank, leave the Excluded from In Network MOOP and Excluded from Out of Network MOOP fields blank. ◆ If the plans do not have an out-of-network MOOP, set **Excluded from Out of Network MOOP** equal to **Yes**.	

After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon (**Figure 2D-11**). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2D-11. Create Cost Share Variances Button
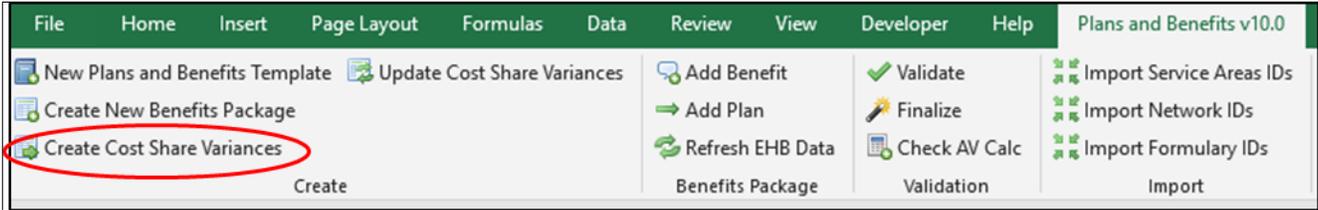
Click **OK** after reading the warnings (**Figure 2D-12**) and make any necessary changes.

Figure 2D-12. Warning Pop-Up Boxes
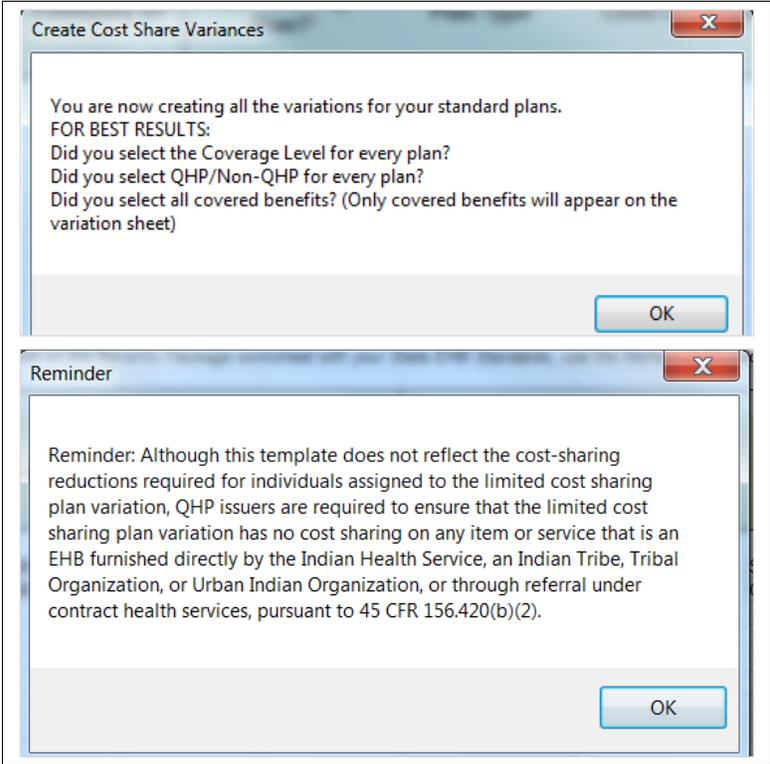
Once warnings are addressed, the following series of questions regarding deductible sub-groups (**Figure 2D-13**) appears. Deductible sub-groups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible sub-groups are not separate deductibles outside any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible sub-groups.

Figure 2D-13. Deductible Sub-Groups
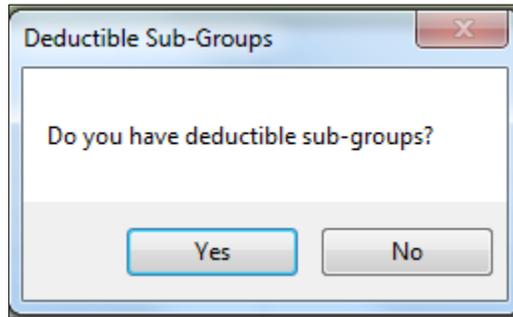
1. Do you have any deductible sub-groups?

    a. **Yes**—if the plan contains deductible sub-groups.

    b. **No**—if the plan does *not* contain deductible sub-groups.

2. If you selected Yes to the previous question, the following questions will appear:

    a. How many deductible sub-groups do you have?

        i. Enter the correct number and click **OK**.

    b. What is the name of this deductible sub-group?

        i. Enter the name of each sub-group and click **OK** after each. You must use a different name for each sub-group.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (**Figure 2D-14**). Corresponding worksheets are labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 2D-14. Cost Share Variances Worksheet

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

4.10 Plan Cost-Sharing Attributes

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

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

Plan Cost-Sharing Attributes	Steps

HIOS Plan ID*	The HIOS-generated number auto-populates for each cost-sharing plan variation.
	◆ Standard plans to be offered on the Exchange have a plan ID variant suffix of "−01," and standard plans to be offered outside the Exchange have a plan ID variant suffix of "−00."
	◆ For the individual market, each standard plan (except for catastrophic) has two CSR plan variations for American Indians and Alaska Natives: one with zero cost sharing and one with limited cost sharing. These are indicated with a plan ID variant suffix of "−02" and "−03," respectively.
	  ▪ In the zero cost-sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs.
	  ▪ In the limited cost-sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian health care provider or from another provider if they have a referral from an Indian health care provider.
	◆ In the individual market, each silver plan has three additional CSR plan variations created: a 73 percent AV plan, an 87 percent AV plan, and a 94 percent AV plan. These are indicated with a plan ID variant suffix of "−04," "−05," and "−06," respectively.
	  ▪ These silver plan variations offer a discount that lowers the amount consumers pay out-of-pocket for deductibles, coinsurance, and copayments, and lowers the MOOP. Consumers qualify for these plans if their income is below a certain level.

Plan Variant Marketing Name*#	The name of the plan auto-populates for all standard plans and plan variations with the standard plan's plan marketing name. The field can be edited on this worksheet for each of the plan variations. The marketing name entered for each plan variation on this worksheet will be the one that displays to consumers. The field has a limit of 255 characters.
Level of Coverage^*	The coverage level for the plan auto-populates for standard plans.
CSR Variation Type^	The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, a standard off-Exchange plan, or one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	(Required if **Yes** is entered for **Unique Plan Design**.) Enter the issuer-calculated AV. This applies to health plans that indicate they are a unique plan for AV purposes. *Note*: For SADP issuers, this field is optional. If an SADP issuer does provide an AV, it must fall within previous AV ranges of High (AV of 85 percent) or Low (AV of 70 percent). All SADP issuers must submit both the "Stand-Alone Dental Plan Actuarial Value" and "Stand-Alone Dental Plan Description of EHB Allocation" supporting documentation forms certifying the monthly premium allocable to the pediatric dental EHB of a child-only plan and certifying the value of each SADP's coverage of pediatric dental EHB. Both supporting documents must be certified by a member of the American Academy of Actuaries using generally accepted principles and methods.
AV Calculator Output Number	Clicking the **Check AV Calc** button on the **Plans & Benefits** ribbon and selecting the correct file populates this field with the AV for all plans on this worksheet with a non-unique plan design. All cost-sharing information and benefits package information must be completed before clicking this button. (For more information, see **Appendix A**.) This field is required for QHPs, but optional for SADPs.
Medical & Drug Deductibles Integrated?^	Indicate whether the medical and drug deductibles are integrated. An integrated deductible allows both medical and drug charges to contribute to a total plan-level deductible. Separate deductibles indicate medical and drug charges contribute to separate plan-level deductibles. Choose from the following options: ◆ **Yes**—if the medical and drug deductibles are integrated. If **Yes** is entered, issuers should not enter information in the **Medical Deductible** or **Drug Benefits Deductible** sections. ◆ **No**—if the medical and drug deductibles are *not* integrated. If **No** is entered, issuers should not enter information in the **Combined Medical & Drug Deductible** section.

Plan Cost-Sharing Attributes	Steps
Medical & Drug Maximum Out of Pocket Integrated?^	Indicate whether the medical and drug MOOPs are integrated. An integrated MOOP allows both medical and drug charges to contribute to a total plan-level MOOP. Separate MOOPs indicate medical and drug charges contribute to separate plan-level MOOP values. Choose from the following options: ◆ **Yes**—if the medical and drug MOOPs are integrated. If **Yes** is entered, issuers should not enter information in the **Maximum Out of Pocket for EHB Benefits** or **Maximum Out of Pocket for Drug Benefits** sections. ◆ **No**—if the medical and drug MOOPs are *not* integrated. If **No** is entered, issuers should not enter information in the **Maximum Out of Pocket for EHB and Drug Benefits (Total)** section.
Multiple In Network Tiers?^*	Indicate whether there are multiple in-network provider tiers, which would allow the plan to apply different levels of in-network cost sharing depending on the tier of the provider or facility. The value must be the same for all variations of a plan. Choose from the following options: ◆ **Yes**—if there are multiple in-network provider tiers. Enter Tier 1 information into the **In Network and In Network (Tier 1)** sections and Tier 2 information into the **In Network (Tier 2)** sections. ◆ **No**—if there are *not* multiple in-network provider tiers. Issuers will not be able to enter information into the **In Network (Tier 2)** sections, which will be grayed out and locked for editing.
1st Tier Utilization^*	If the answer to **Multiple In Network Tiers?** is **Yes**, enter the 1st Tier Utilization as a percentage here. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. If the answer to **Multiple In Network Tiers?** is **No**, the field auto-populates to **100%**. (All plan variations must have the same 1st tier utilization as the standard plan.)
2nd Tier Utilization^*	If the answer to **Multiple In Network Tiers?** is **Yes**, enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked for editing if the answer to **Multiple In Network Tiers?** is **No**. (All plan variations must have the same 2nd tier utilization as the standard plan.)

4.11 Summary of Benefits and Coverage Scenario

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

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

4.12 Maximum Out of Pocket and Deductible

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

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

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan ($8,550) and for the specific CSR plan variations.[4] See **5.5 Requirements for Cost-Sharing Reduction Plan Variations** for more details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.

- There must be a per-person amount and per-group amount entered for MOOP; the issuer may not enter **Not Applicable** for all these cells in all **Family** fields. The only exception is if a given plan is available to consumers only as self-only coverage.

4.13 Maximum Out of Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in **Figure 2D-15**.

Figure 2D-15. MOOP Fields

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

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

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

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[4] See the final annual *Notice of Benefit and Payment Parameters for the 2021 benefit year (final 2021 Payment Notice)*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2021*.

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

4.14 Maximum Out of Pocket for Drug EHB Benefits

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

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

4.15 Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)

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

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

4.16 Medical EHB Deductible

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

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

Medical EHB Deductible	Steps
Out of Network—Family	If the deductibles are *not* integrated, enter the per-person and per-group dollar amount for **Out of Network Family Medical EHB Deductible**.
Combined In/Out Network—Individual^#	If the deductibles are *not* integrated, enter the dollar amount for **Combined In/Out of Network Individual Medical EHB Deductible**.
Combined In/Out Network—Family#	If the deductibles are *not* integrated, enter the per-person and per-group dollar amount for **Combined In/Out of Network Family Medical EHB Deductible**.

4.17 Drug EHB Deductible

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

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

4.18 Combined Medical and Drug EHB Deductible

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

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

4.19 Maximum Out of Pocket for Dental EHB Benefits

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

MOOP Dental EHB Benefits	Steps
In Network—Individual*^#	Enter the dollar amount for **Dental In Network Individual MOOP for EHB Benefits**.
In Network—Family*#	Enter the per-person and per-group dollar amount for **Dental In Network Family MOOP for EHB Benefits**.

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

4.20 Dental EHB Deductible

This section is used for inputting deductible values for dental EHBs. The deductible value may not be higher than the MOOP value. Using the dropdown menus, enter the appropriate values for the individual and family deductibles for EHBs in the following areas on the template.

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

4.21 Other Deductible

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

Other Deductible	Steps
In Network—Individual*^#	If the deductibles are *not* integrated, enter the dollar amount for **In Network Individual Other Deductible**.

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

4.22 Health Savings Account (HSA)/Health Reimbursement Account (HRA) Detail

HSA/HRA Detail	Steps
HSA-Eligible^#	Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following: ◆ **Yes**—if the plan meets all HSA requirements. ◆ **No**—if the plan does *not* meet all HSA requirements.
HSA/HRA Employer Contribution^	(Required for small group only; must be left blank for individual market.) Indicate whether the employer contributes to an HSA/HRA. Choose from the following: ◆ **Yes**—if the plan has an HSA/HRA employer contribution. ◆ **No**—if the plan does *not* have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount^	(Required if **Yes** is entered for HSA/HRA Employer Contribution; must be left blank for individual market.) Enter a numerical value representing the employer contribution amount to the HSA/HRA. The template does not permit an individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 *Federal Register* 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

4.23 AV Calculator Additional Benefit Design

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

AV Calculator Additional Benefit Design	Steps
Maximum Coinsurance for Specialty Drugs^	Indicate whether the per-script coinsurance amount for specialty drugs is capped at a set amount. Enter the maximum coinsurance payments allowed for specialty prescription drugs. If no maximum coinsurance exists, leave the field blank.
Maximum Number of Days for Charging an Inpatient Copay?^	Indicate whether there is a limit on the number of days that a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day. Enter the maximum number of days allowed (1–10). If this option does not apply, leave the field blank.

AV Calculator Additional Benefit Design	Steps
Begin Primary Care Cost Sharing After a Set Number of Visits?^	Indicate whether primary care cost sharing begins after a certain number of fully covered visits. Enter the maximum number of fully covered visits (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?^	Indicate whether primary care visits are subject to the deductible and/or coinsurance after a certain number of primary care visits with copay have occurred. Enter the maximum number of copay visits (1–10) that can occur before visits become subject to the deductible and/or coinsurance. If this option does not apply, leave the field blank.

4.24 Covered Benefits

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

Fill in information for each of the benefits as follows:

1. If the issuer has plans that do not have out-of-network benefits for a given covered benefit, enter **Not Applicable** for the out-of-network copay fields and **100%** for the out-of-network coinsurance fields.

2. There is a drop-down option of **Not Applicable** for all cost-sharing fields. This value should be used in the following scenarios:

   a. If the issuer charges only a copay or a coinsurance for a benefit, enter **Not Applicable** for the other. For example, if an issuer wishes to charge a $20 copay for a benefit, enter **$20** for the copay and **Not Applicable** for the coinsurance. Please note that **No Charge** was used for this scenario in past years, but **Not Applicable** is the correct option in the 2021 template.

   b. If the issuer has multiple in-network tiers, enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance for any benefit category that does not have tiers. For example, if the issuer has only multiple in-network tiers for its inpatient hospital covered benefits, it would enter Tier 2 cost sharing as described below. For other covered benefits without multiple in-network tiers, issuers should enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance.

3. For further instructions on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see **5.8 Suggested Coordination of Drug Data between Templates**.

4. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, please see **Appendix A**.

5. There are many cost-sharing requirements for the CSR silver plan variations and the zero and limited cost-sharing plan variations (see **5.5 Requirements for Cost-Sharing Reduction Plan Variations**).

6. If cost sharing varies based on place of service or provider type, ensure that no benefit already specifically applies to the place of service or provider type. If there is not one available, fill out the copay and/or coinsurance most typical for most enrollees (such as the highest used); in the **Benefit Explanation** field, add appropriate and brief detail to communicate the cost-sharing exceptions for the scenarios that do not follow the most common structure entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) should also clearly communicate any cost-sharing information that may vary based on place of service or provider type.

Figure 2D-16 shows an example of how the fields for each benefit are laid out.

Figure 2D-16. Benefit Information Fields

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

Covered Benefits	Steps
Copay—In Network (Tier 1)*^#	If an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter **Not Applicable**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 2)*^#	If the plan has multiple in-network tiers and an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter **Not Applicable**. For any benefit category that does not have tiers, enter **Not Applicable** for this field and the **Coinsurance—In Network (Tier 2)** field. This field may be grayed out depending on answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance, or there are not multiple tiers for this benefit. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

| Covered Benefits	Steps
Copay—Out of Network*#	If an out-of-network copayment is charged, enter the amount in this field. If no copayment is charged, enter **Not Applicable**. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network	The following options are the only available benefits for Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure that all variations follow the same "per day" or "per stay" cost-sharing structure. If no copayment is charged, enter **Not Applicable**. The benefits Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services include these options as well as those described in the Copay—In Network (Tier 1) section above. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copay is charged (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Day**—the consumer pays a copayment per day (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay per Stay**—the consumer pays a copayment per stay (this indicates that this benefit is *not* subject to the deductible). ◆ **$X Copay per Day after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Stay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Day with deductible**—the consumer first pays the copay per day, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Stay with deductible**—the consumer first pays the copay for the stay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit. For Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility covered benefits, *do not* copy and paste cost-sharing values entered for other benefits (e.g., $25 copay). The entered values should have the "per day" or "per stay" qualifiers.

Covered Benefits	Steps
	Copying and pasting any other cost-sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.
Coinsurance—In Network (Tier 1)*^#	If an in-network coinsurance is charged, enter the percentage the consumer will pay in this field. If no coinsurance is charged, enter **Not Applicable**, unless the plan has a Tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **Not Applicable**—the consumer only pays a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—In Network (Tier 2)*^#	If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay in this field. If no coinsurance is charged, enter **Not Applicable**, unless the plan has a Tier 2 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. For any benefit category that does not have tiers, enter **Not Applicable** for this field, as well as for the **Copay—In Network (Tier 2)** field. This field may be grayed out depending on answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network*#	If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If no coinsurance is charged, enter **Not Applicable**, unless the plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. If this benefit is not covered out of network, enter **100%**. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is *not* subject to the deductible). *Note:* Use **Not Applicable**, not **No Charge**, if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible).

Covered Benefits	Steps
	◆ **X%**—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is *not* subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is *not* subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.25 Completed Plans & Benefits Template

Once the entire template, including all Benefits Package and Cost Share Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans & Benefits** ribbon. If there are validation errors, a Validation Report (**Figure 2D-17**) will appear showing the data element and cell location of each error. The issuer must correct these errors for its Plans & Benefits Template to be accepted.

Figure 2D-17. Validation Report
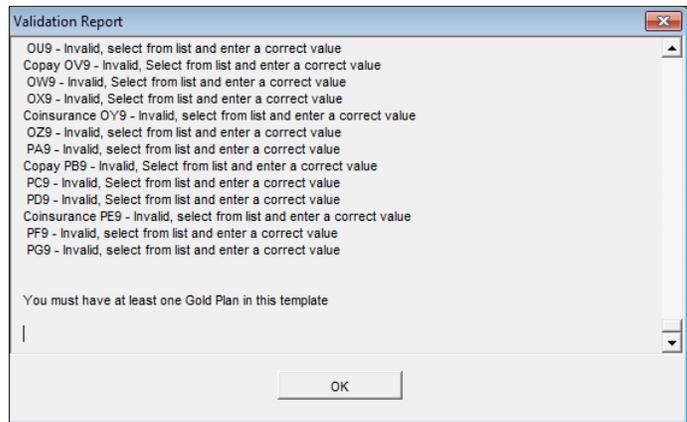
Once errors are corrected and the validation is successful, click the **Finalize** button on the menu bar under the **Plans & Benefits** ribbon (**Figure 2D-18**) to save the template as an XML file. Upload the saved file in the Benefits and Service Area Module. Before closing the template, save an XLSM version of the Excel file for future reference.

Figure 2D-18. Finalize Button
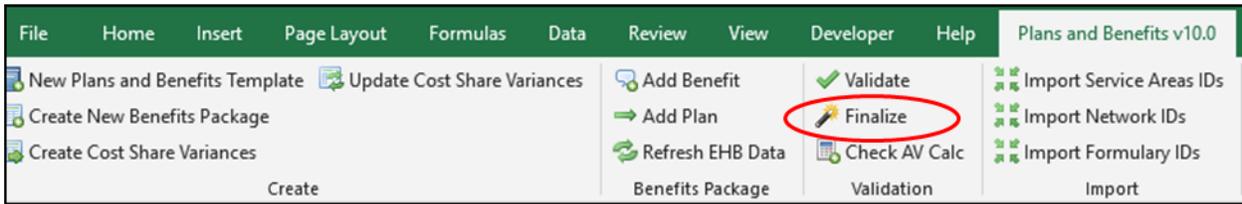
5. Key Requirements and Application Guidance

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

5.1 MOOP and Deductible Guidance

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

1. Annual Limitation on Cost Sharing.[5] When entering the MOOP values, ensure that the following limits are met for the in-network EHB MOOP. (See the final annual *Notice of Benefit and Payment Parameters for the 2021 benefit year [final 2021 Payment Notice]* for more details on the annual limit values.)

    a. If the plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.

    b. The standard plan's in-network EHB MOOP values must be less than or equal to $8,550 for an individual (self-only) or $17,100 for a family (other than self-only).

    c. For the 73 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to $6,800 for an individual (self-only) or $13,600 for a family (other than self-only).

    d. For the 87 percent and 94 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to $2,850 for an individual (self-only) or $5,700 for a family (other than self-only).

    e. For the zero cost-sharing plan variations, the in- and out-of-network MOOP and deductible values for EHBs must be $0. These fields auto-populate and should not be changed for EHBs.

    f. For the limited cost-sharing plan variations, the MOOP and deductible values must be the same as the associated standard plan's EHB MOOP value. These fields auto-populate whenever a value is entered for a standard plan and should not be changed.

2. Family MOOP Requirements. When entering the MOOP values, ensure that the following limits are taken into consideration. (See the *final 2021 Payment Notice*.)

    a. Plans that allow multi-member enrollment (family plans) must have a numeric value for either in-network or combined in- and out-of-network MOOP for both per group and per person. These plans are subject to the annual limitation on cost sharing for other than self-only coverage ($17,100) discussed above, as well as the annual limitation on cost sharing for self-only coverage.

    b. For these plans, the per-person amount for family coverage needs to be less than or equal to the annual limitation on cost sharing for self-only coverage for the standard plan ($8,550) and for the specific CSR plan variations as detailed in the annual limitation on cost sharing discussion immediately above.[6]

    c. For plans that allow only self-only coverage (individual plans), all family MOOP values may be entered as **Not Applicable**. However, this self-only coverage must be reflected on the Business Rules Template when indicating the relationship types allowed. (See the Business Rules Template instructions for more details on offering self-only coverage and eligible dependent relationships.)

3. Definition of **Not Applicable** and **$0** for Deductible and MOOP.

    a. Do *not* enter **Not Applicable** if there is a zero-dollar deductible or MOOP; **$0** is the appropriate data entry. For example, if a plan has a separate medical and drug deductible, and if there is no drug deductible, issuers must enter **$0** as opposed to **Not Applicable**.

    b. **Not Applicable** should be used in the In Network MOOP or deductible field only to imply that in-network service costs accumulate toward the entered Combined In/Out of Network MOOP or deductible.

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[5] See the *final 2021 Payment Notice.* Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2021*.

[6] See the *final 2021 Payment Notice*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2021*.

c. If the **Individual In Network** and **Individual Combined In/Out of Network** deductible fields are equal to **Not Applicable**, the template returns an error when calculating the plan's AV using the AVC.

4. To include multiple children in child-only plans, use the "family" MOOP and deductible fields to capture the data.

5. The following explains how the values for various MOOP and deductible fields are related. Complete the fields as follows:

   a. Some plans may have only combined in-network and out-of-network deductibles or MOOPs, rather than separate in-network and out-of-network deductibles or MOOPs. Other plans may have a mixture of in-network, out-of-network, and combined in-network and out-of-network deductibles or MOOPs. When defining deductibles and MOOPs, issuers must adhere to the guidelines.

   b. If the plan does *not* have multiple in-network tiers, the following apply:

      i. If the **In Network** field is equal to a dollar value ($X), the **Combined In/Out of Network** field can be either a dollar value or **Not Applicable**.

      ii. If the **In Network** field is **Not Applicable**, the **Combined In/Out of Network** field must contain a dollar value.

      iii. The **Out of Network** field has no restrictions; it can be either a dollar value or **Not Applicable**.

   c. If the plan has multiple in-network tiers, the following apply:

      i. If the **In Network** and **In Network (Tier 2)** fields are equal to dollar values, the **Combined In/Out of Network** field can be either a dollar value or **Not Applicable**.

      ii. If the **In Network** field is **Not Applicable**, the **In Network (Tier 2)** field must be **Not Applicable** and the **Combined In/Out of Network** field must contain a dollar value.

      iii. If the **In Network (Tier 2)** field is **Not Applicable**, the **In Network** field must be **Not Applicable** and the **Combined In/Out of Network** field must contain a dollar value.

      iv. The **Out of Network** field has no restrictions; it can be either a dollar value or **Not Applicable**.

5.2 Catastrophic Plan Instructions

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

1. They can be offered only in the individual market.

2. They are permitted, but not required, to cover multi-person enrollment (families) when all members meet eligibility requirements for this type of plan.

3. They do not have multiple in-network tiers for EHBs.

4. They have integrated medical and drug deductibles.

5. They have integrated medical and drug MOOPs.

6. They have an in-network deductible and in-network MOOP equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the PPACA and in the *final 2021 Payment Notice*. For PY2021, this limit is $8,550 for individuals (self-only) and $17,100 for families (other than self-only).

7. They have an out-of-network deductible and out-of-network MOOP greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.

8. If they have an in-network deductible and in-network MOOP, and a combined in/out-of-network deductible and combined in- and out-of-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.

9. If they have a combined in- and out-of-network deductible and in- and out-of-network MOOP but no specific in-network deductible or in-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be equal to the annual limitation on cost sharing.

10. They have in-network cost sharing equal to no charge after the deductible for all EHBs, excluding primary care and preventive health services. (See **5.10 Plan Compare Cost-Sharing Display Rules** for direction on completing the copay and coinsurance fields to have this cost-sharing value displayed to the consumer.)

11. All benefits except primary care visits and coverage of preventive health services—in accordance with Section 2713 of the PHS Act—are subject to the in-network deductible. Issuers must provide benefits for at least three primary care visits and coverage of preventive health services (in accordance with Section 2713 of the PHS Act) prior to the consumer reaching the deductible.

12. Coverage of preventive health services (in accordance with Section 2713 of the PHS Act) is not subject to the in-network deductible and does not impose any other cost-sharing requirement.

5.3 Actuarial Value Details

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

1. A de minimis variation of −4/+2 percentage points is used for standard plans.

   a. The AV for a bronze plan must be between 56 percent and 62 percent.

   b. The AV for an expanded bronze plan must be between 56 percent and 65 percent.

   c. The AV for a silver plan must be between 66 percent and 72 percent.

   d. The AV for a gold plan must be between 76 percent and 82 percent.

   e. The AV for a platinum plan must be between 86 percent and 92 percent.

2. A de minimis variation of ±1 percentage point is used for silver plan variations.

   a. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent.

   b. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.

   c. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.

3. The AV of a standard silver plan and the AV of the associated 73 percent silver plan variation must differ by at least 2 percentage points.

4. The AV of the zero cost-sharing plan variations must be 100 percent.

5. The AV of the limited cost-sharing plan variations must be equal to the associated standard plan's AV.

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

5.4 Editing the Template

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

1. If a benefit is mistakenly added as an additional benefit, it cannot be manually deleted, but issuers may do one of the following:

   a. Select **Not Covered** under the "Is this Benefit Covered?" column. When the Cost Share Variances worksheet is generated, this benefit will not appear on that worksheet.

   b. Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but also removes any other data entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.

   c. Additional steps need to be taken if the issuer has already created the Cost Share Variances worksheet. See below.

2. If an issuer changes whether a benefit is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, the benefits will *not* update on the Cost Share Variances worksheet even if the issuer selects the **Update Cost Share Variances** button. Instead the issuer must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon and generate a new worksheet.

3. To add a new plan or delete a plan after the Cost Share Variances worksheet has already been created, do the following:

   a. After adding a new plan to the Benefits Package worksheet, click the **Update Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon. This adds the new plan to the Cost Share Variances worksheet.

   b. To delete a plan on the Benefits Package worksheet, delete all data for that plan's row. If any plans are below that row, cut and paste the data from these rows into the empty row (see below). If the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below the blank row and their corresponding data are deleted from the Cost Share Variances worksheet.

   Example: To delete Plan 2 (**Figure 2D-19**), delete all data from the plan's row, cut and paste Plan 3 from Row 11 to Row 10, and then cut and paste Plan 4 from Row 12 to Row 11. Once those steps are completed, click the **Update Cost Share Variances** button. Plan 2 will be removed from the Cost Share Variances worksheet but Plans 3 and 4 will remain.

Figure 2D-19. Deleting a Plan

   c. If the issuer changes any benefits package data on a specific plan that already exists, only the following changes will be reflected on the Cost Share Variances worksheet when the issuer clicks the **Update Cost Share Variances**:

      i. Plan Marketing Names will be updated.

      ii. Plans added to the Benefits Package worksheet will be added to the Cost Share Variances worksheet.

      iii. Plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet.

   d. If there is a need to update the information for an existing plan, the issuer must first delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button. All previously entered information for this plan on the Cost Share Variances worksheet will be deleted. Reenter the plan and associated data on the Benefits Package worksheet, and click the **Update Cost Share Variances** button to add the plan back to the Cost Share Variances worksheet.

5.5 Requirements for Cost-Sharing Reduction Plan Variations

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

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

an Indian health care provider or from another provider if they have a referral from an Indian health care provider.

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

Each variation type has several requirements.

1. The requirements for zero cost-sharing plan variations are as follows:

   a. The template automatically generates a zero cost-sharing plan variation for all metal-level plans (except catastrophic) on the individual market.

   b. The AV of the plan variation must be 100 percent.

   c. All In Network MOOP values must be **$0**. Out of Network and Combined In/Out Network MOOP values should be **$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.

   d. All In Network deductible values must be **$0**. Out of Network and Combined In/Out Network deductible values should be **$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.

   e. All EHBs must have cost-sharing values of **$0**, **0%**, or **No Charge** for both in- and out-of-network services.[7] However, if the associated standard plan does not cover out-of-network services, the zero cost-sharing plan variation is not required to cover out-of-network services either. (See **5.6 EHB Variance Reason and EHB Designation** for details on indicating whether a benefit is an EHB.)

   f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated limited cost-sharing plan variation. If the associated standard plan is a silver plan, the cost sharing also must follow successive cost sharing with the associated 94 percent AV silver plan variation. (See **5.7 Successive Cost Sharing Guidance** for further explanation and examples of successive cost sharing.)

   g. Tier utilization must be the same as the associated standard plan.

2. The requirements for limited cost-sharing plan variations are as follows:

   a. The template automatically generates a limited cost-sharing plan variation for all metal-level plans (except catastrophic) on the individual market.

   b. The AV of the limited cost-sharing plan variation must be greater than or equal to the associated standard plan's AV.

   c. All MOOP values for EHBs must be the same as the associated standard plan's MOOP values for EHBs.

   d. All deductible values must be the same as the associated standard plan's values.

   e. All EHBs must have the same cost-sharing values as the associated standard plan's values (see **5.6 EHB Variance Reason and EHB Designation**).

   f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see **5.7 Successive Cost Sharing Guidance**).

   g. Tier utilization must be the same as the associated standard plan's tier utilization.

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

3. The requirements for silver plan variations are as follows:

   a. Each silver plan offered on the individual market must have 73 percent AV, 87 percent AV, and 94 percent AV silver plan variations.

   b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and it must also be at least 2 percentage points greater than the associated standard plan's AV.

   c. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.

   d. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.

   e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to $6,800 for an individual (self-only) or $13,600 for a family (other than self-only).

   f. For the 87 percent and 94 percent AV silver plan variations, the MOOP must be less than or equal to $2,850 for an individual (self-only) or $5,700 for a family (other than self-only).

   g. All MOOP values must follow successive cost sharing for all plan variations (see **5.7 Successive Cost Sharing Guidance**).

   h. All deductible values must follow successive cost sharing for all plan variations.

   i. The copay and coinsurance for all benefits must follow successive cost sharing for all plan variations.

   j. Tier utilization must be the same as the associated standard plan's tier utilization.

5.6 EHB Variance Reason and EHB Designation

As explained in **5.5 Requirements for Cost-Sharing Reduction Plan Variations**, benefits in the plan variations have specific requirements, depending on whether a benefit is considered an EHB. A benefit's EHB designation is based on the **EHB** and **EHB Variance Reason** fields for the benefit on the Benefits Package worksheet as outlined in **4.9 Out of Pocket Exceptions**. **Table 2D-1** explains when a benefit is considered an EHB based on different inputs.

Table 2D-1. EHB Designation

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

5.7 Successive Cost Sharing Guidance

As explained in **5.5 Requirements for Cost-Sharing Reduction Plan Variations**, successive cost sharing is required to be reviewed for multiple plan variations and data fields. The purpose of successive cost sharing is to ensure that a specific element in a given plan variation always has an equal or more generous cost-sharing value for the consumer compared with a standard plan or plan variation.

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

1. A standard silver plan and its associated silver plan variations must follow successive cost sharing for the MOOP, deductible, copay, and coinsurance fields. This includes EHBs and non-EHBs. All of the following must be true:

   a. The cost sharing value of the 73 percent AV silver plan variation must be less than or equal to that of the associated standard plan.

b. The value of the 87 percent AV silver plan variation must be less than or equal to that of the 73 percent AV silver plan variation.

c. The value of the 94 percent AV silver plan variation must be less than or equal to that of the 87 percent AV silver plan variation.

2. A zero cost-sharing plan variation must follow successive cost-sharing with the associated limited cost-sharing plan variation for the copay and coinsurance fields for non-EHBs. This means that the value of the zero cost-sharing plan variation must be less than or equal to that of the limited cost-sharing plan variation.

3. A zero cost-sharing plan variation for a standard silver plan must follow successive cost sharing with the associated 94 percent AV silver plan variation for the copay and coinsurance fields for non-EHBs. This means the value of the zero cost-sharing plan variation must be less than or equal to that of the 94 percent AV silver plan variation.

4. A limited cost-sharing plan variation must follow successive cost sharing with the associated standard plan for the copay and coinsurance fields for non-EHBs. This means the value of the limited cost-sharing plan variation must be less than or equal to that of the standard plan. The MOOP, deductible, and EHB cost-sharing fields should be equal to that of the associated standard plan.

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

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

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

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

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

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

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

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

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

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

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

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

Plan	Coinsurance	Compliance
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	30%	

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

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

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

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
$X Copay Per Day	$Y Copay Per Day (when $Y \leq $X) $Y Copay Per Stay (when $Y \leq $X) - No Charge - Not Applicable	$Y Copay Per Day (when $Y > $X) $Y Copay Per Stay (when $Y > $X) $Y Copay Per Day With Deductible (all values) $Y Copay Per Day After Deductible (all values) $Y Copay Per Stay With Deductible (all values) $Y Copay Per Stay After Deductible (all values) - No Charge After Deductible $Y Copay (all values) $Y Copay After Deductible (all values) $Y Copay With Deductible (all values)
$X Copay Per Stay	$Y Copay Per Stay (when $Y \leq $X) $0 Copay Per Day - No Charge - Not Applicable	$Y Copay Per Stay (when $Y > $X) $Y Copay Per Day (when greater than 0) $Y Copay Per Day After Deductible (all values) $Y Copay Per Stay With Deductible (all values) $Y Copay Per Stay After Deductible (all values) - No Charge After Deductible $Y Copay (all values) $Y Copay After Deductible (all values) $Y Copay With Deductible (all values)
$X Copay Per Day With Deductible	$Y Copay Per Day With Deductible (when $Y < $X) $Y Copay Per Stay With Deductible (when $Y < $X) - No Charge - No Charge After Deductible $0 Copay Per Day $0 Copay Per Stay - Not Applicable	$Y Copay Per Day With Deductible (when $Y > $X) $Y Copay Per Day (when greater than 0) $Y Copay Per Day After Deductible (all values) $Y Copay Per Stay With Deductible (when $Y > $X) $Y Copay Per Stay After Deductible (all values) $Y Copay Per Stay (when greater than 0) $Y Copay (all values) $Y Copay After Deductible (all values) $Y Copay With Deductible (all values)
$X Copay Per Stay With Deductible	$Y Copay Per Stay With Deductible (when $Y < $X) $Y Copay Per Day With Deductible (when $Y < $X) - No Charge - No Charge After Deductible $0 Copay Per Stay $0 Copay Per Day - Not Applicable	$Y Copay Per Stay With Deductible (when $Y > $X) $Y Copay Per Stay (when greater than 0) $Y Copay Per Stay After Deductible (all values) $Y Copay Per Day With Deductible (all values) $Y Copay Per Day After Deductible (all values) $Y Copay Per Day (when greater than 0) $Y Copay (all values) $Y Copay After Deductible (all values) $Y Copay With Deductible (all values)
$X Copay Per Day After Deductible	$Y Copay Per Day After Deductible ($Y < $X) $Y Copay Per Stay After Deductible ($Y < $X) $Y Copay Per Day ($Y < $X) $Y Copay Per Stay ($Y < $X) - No Charge	$Y Copay Per Day With Deductible (all values) $Y Copay Per Day After Deductible (when $Y > $X) $Y Copay Per Day (when $Y > $X) $Y Copay Per Stay With Deductible (all values) $Y Copay Per Stay After Deductible (when $Y > $X) $Y Copay Per Stay (when $Y > $X) $Y Copay (all values)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
	◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Stay After Deductible	◆ $Y Copay Per Stay After Deductible ($Y < $X) ◆ $Y Copay Per Stay ($Y < $X) ◆ $0 Copay Per Day After Deductible ◆ $0 Copay Per Day ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (when $Y > $X) ◆ $Y Copay Per Stay (when $Y > $X) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (when greater than 0) ◆ $Y Copay Per Day (when greater than 0) ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
No Charge After Deductible	◆ No Charge After Deductible ◆ No Charge ◆ $0 Per Day ◆ $0 Per Stay ◆ $0 Copay Per Day After Deductible ◆ $0 Copay Per Stay After Deductible ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (when greater than 0) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (when greater than 0) ◆ $Y Copay Per Day (when greater than 0) ◆ Not Applicable ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
No Charge	◆ No Charge ◆ $0 Per Day ◆ $0 Per Stay ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (all values) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Day (when greater than 0) ◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)

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

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

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

5.8 Suggested Coordination of Drug Data between Templates

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

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

1. Enter the cost-sharing data for the tier in the Prescription Drug Template with the highest generic drug utilization into the Generic Drugs benefit category in the Plans & Benefits Template.

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

3. Enter the cost-sharing data for the tier in the Prescription Drug Template with the most specialty drug utilization into the Specialty Drugs benefit category in the Plans & Benefits Template.

Cost-sharing data should reflect the following:

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

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

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

1. Preferred pharmacy cost sharing corresponds to **In Network (Tier 1)**.

2. Nonpreferred pharmacy cost sharing corresponds to **In Network (Tier 2)**.

3. Issuers without multiple in-network tiers for their medical benefits do not need to represent nonpreferred pharmacy cost sharing under the Tier 2 fields on the Plans & Benefits Template.

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

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

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

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

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

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

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

Plan Compare Label Name	Template Value	Data Source
Deductibles and Maximum Out of Pocket Rules	◆ If medical and drug amounts are integrated, the combined amount will display. ◆ If medical and drug amounts are not integrated, only the medical amount will display on the Plan Summary page. (The drug amount will display in the Prescription Drug Details section.) ◆ If there is only one person in the enrollment group, the Individual Per Person amount will display. ◆ If there is more than one person in the enrollment group, the Family Per Group amount will display. The dollar amount will display followed by "Per Group." ◆ If there is more than one person in the enrollment group and the plan design does not have a per-group deductible, then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by "Per Person."	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template
	Combined Medical & Drug EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template
Maximum Out of Pocket	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
Metal Level	Level of Coverage	Plans & Benefits Template
Provider Directory	Network URL	Network ID Template
Insurance Company + Plan Marketing Name + Plan Type *Issuer Legal Name (as recorded in HIOS) will display if Issuer Marketplace Marketing Name is null*	Issuer Marketplace Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template

Plan Compare Label Name	Template Value	Data Source
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care—Adult Major Dental Care—Adult *Note:* All three must be available to show Adult Dental Included	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child *Note:* All three must be available to show Pediatric Dental Included	Plans & Benefits Template
National Provider Network Offered/National Network	National Network	Plans & Benefits Template
Health Care Costs	Derived from **Level of Coverage**	Plans & Benefits Template
Reduced Costs	Indicates whether the plan is a CSR variant	Based on Consumer Eligibility information

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

Plan Compare Label Name	Template Value	Template Source
Benefit Data Rules These data display for each covered benefit below when the **Is This Benefit Covered?** value is **Yes**	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit "Limits and Exclusions Apply" hyperlink displays when Explanation or Exclusions is not null	Plans & Benefits Template
Medical Care Coverage		
Visit to a Primary Care Provider	Primary Care Visit to Treat an Injury or Illness	Plans & Benefits Template
Visit to a Specialist	Specialist Visit	Plans & Benefits Template
X-Rays and Diagnostic Imaging	X-Rays and Diagnostic Imaging	Plans & Benefits Template
Laboratory and Outpatient Professional Services	Laboratory Outpatient and Professional Services	Plans & Benefits Template
Hearing Aids	Hearing Aids	Plans & Benefits Template
Routine Eye Exam for Adults	Routine Eye Exam for Adults	Plans & Benefits Template
Routine Eye Exam for Children	Routine Eye Exam for Children	Plans & Benefits Template
Eyeglasses for Children	Eyeglasses for Children	Plans & Benefits Template
Heath Savings Account Eligible Plan	HSA-Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template
3 Month In-Network Mail Order Pharmacy Benefit Offered?	3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug Template

Plan Compare Label Name	Template Value	Template Source
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When the **Medical & Drug Deductibles Integrated?** value is **Yes**, "Included with Medical" displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out of Pocket: In-Network—Individual Drug EHB Maximum Out of Pocket: In-Network—Family (When the **Medical & Drug MOOP Integrated?** value is **Yes**, "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral Required to See a Specialist	Plans & Benefits Template
Hospital-Based Services		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., hospital stay)	Inpatient Hospital Services (e.g., hospital stay)	Plans & Benefits Template
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
Coverage Examples		
Total Cost of Having a Baby	SBC Scenario—Having a Baby. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
Total Cost of Treating a Simple Fracture	SBC Scenario—Treatment of a Simple Fracture. Sum of the following data elements: ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit	Plans & Benefits Template
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template

Plan Compare Label Name	Template Value	Template Source
Orthodontia	Orthodontia—Adult	Plans & Benefits Template
Pediatric Dental Coverage		
Check-Up	Dental Check-Up for Children	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Child	Plans & Benefits Template
Major Dental Care	Major Dental Care—Child	Plans & Benefits Template
Orthodontia	Orthodontia—Child	Plans & Benefits Template
Medical Management Programs		
Asthma	Disease Management Programs Offered	Plans & Benefits Template
Heart Disease	Disease Management Programs Offered	Plans & Benefits Template
Depression	Disease Management Programs Offered	Plans & Benefits Template
Diabetes	Disease Management Programs Offered	Plans & Benefits Template
High Blood Pressure & Cholesterol	Disease Management Programs Offered	Plans & Benefits Template
Low Back Pain	Disease Management Programs Offered	Plans & Benefits Template
Pain Management	Disease Management Programs Offered	Plans & Benefits Template
Pregnancy	Disease Management Programs Offered	Plans & Benefits Template
Weight Loss Program	Disease Management Programs Offered	Plans & Benefits Template
Other Benefits		
Acupuncture	Acupuncture	Plans & Benefits Template
Chiropractic Care	Chiropractic Care	Plans & Benefits Template
Infertility Treatment	Infertility Treatment	Plans & Benefits Template
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health Outpatient Services	Plans & Benefits Template
Mental/Behavioral Health Inpatient Services	Mental/Behavioral Health Inpatient Services	Plans & Benefits Template
Habilitative Services	Habilitative Services	Plans & Benefits Template
Bariatric Surgery	Bariatric Surgery	Plans & Benefits Template
Outpatient Rehabilitative Services	Outpatient Rehabilitation Services	Plans & Benefits Template
Skilled Nursing Facility	Skilled Nursing Facility	Plans & Benefits Template
Private-Duty Nursing	Private-Duty Nursing	Plans & Benefits Template

5.10 Plan Compare Cost-Sharing Display Rules

The anticipated display logic follows for the deductible, MOOP, copay, and coinsurance cost sharing for Plan Compare for individual market coverage effective starting January 1, 2021. It covers the majority of situations but is not exhaustive. This should not be viewed as the final display logic for Plan Compare, and CMS may make changes after these instructions are published. It is provided here as a reference for issuers before submitting QHP Applications.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug amounts are integrated, then the total amount for the medical and drug data element will display on the Plan Summary page. "Included with Medical" will display on the Plan Details page under the drug amounts.

- If medical and drug amounts are not integrated, only the medical amount will display on the Plan Summary page. The drug amount will display in the Prescription Drug Details section on the Plan Details page.

- If there is only one person in the enrollment group, the individual MOOP and deductible amounts will display on the Plan Summary and Plan Details pages.

- On the Plan Summary page, if more than one person is in the enrollment group, the Family Per Group MOOP amount will display. The dollar amount will display followed by "Per Group."

- On the Plan Summary page, if there is more than one person in the enrollment group, and if the issuer entered either $0 or a positive dollar amount for the **Family Per Group** data field, the Family Per Group deductible amount will display. The dollar amount will display followed by "Per Group." If there is more than one person in the enrollment group and the plan design does not have a per-group deductible (i.e., the Family Per Group Deductible is **Not Applicable**), then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by "Per Person."

- On the Plan Details page, the Family Per Group and the Family Per Person deductible and MOOP amounts will display.

- The out-of-network deductible and MOOP will not display on Plan Compare.

5.10.2 Covered Benefit Plan Compare Display Logic

- The Plan Compare display logic considers the entered values for both copay and coinsurance. For example, if the issuer enters **Not Applicable** for copay and **20%** for coinsurance for a specialist visit, "20%" will display on Plan Compare.

- When copay is **Not Applicable** and rounded coinsurance is greater than zero and less than 100 percent, the coinsurance value will display.

- When copay is greater than zero and coinsurance is **Not Applicable**, the entered copay value will display.

- If coinsurance is equal to **100%**, a benefit will display as "Not Covered."

- "No Charge After Deductible" will display if one of the following occurs:

  - The issuer entered **No Charge After Deductible** for copay and coinsurance.

  - The issuer entered **Not Applicable** for copay and **No Charge After Deductible** for coinsurance, or vice versa.

- "No Charge" will display when the combination of entered copay and coinsurance values include **0**, **No Charge**, or **Not Applicable**. Similarly, if any of the aforementioned values include copay or coinsurance qualifiers of **After Deductible**, then **No Charge After Deductible** will display.

- When copay and coinsurance are each greater than zero, both will display.

5.11 Troubleshooting the Plans & Benefits Add-In File

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

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for best results.

2. *Never* rename the Add-In file to a different name.

3. Ensure that only one copy of the Add-In file is on the computer; delete all extra copies. When downloading a new one, always "replace" the old version.

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

1. Open a blank sheet in Excel (no template or file). The Excel ribbon should not have a **Plans & Benefits** ribbon.

   a. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (**Figure 2D-20** through **Figure 2D-22**).

2. Verify that the **Plans & Benefits** ribbon is gone.

3. Open a Plans & Benefits Template.

4. The template should open the Add-In automatically after **Enable Macros** is clicked. This means the template successfully loaded the Add-In.

Figure 2D-20. Excel Options Window
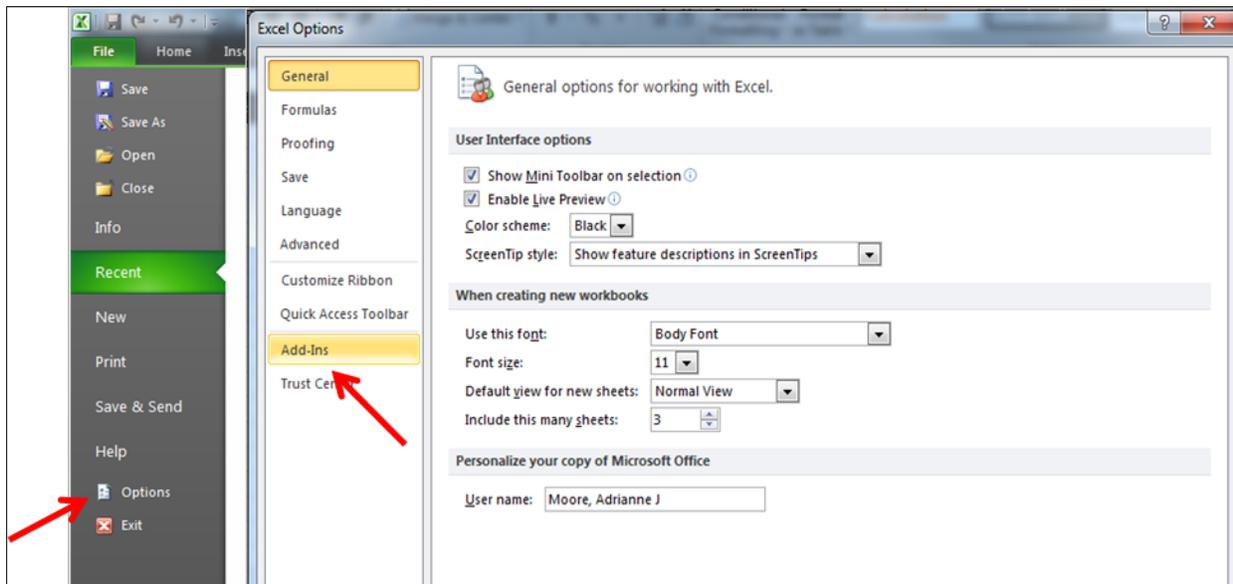
Figure 2D-21. Add-Ins Tab in Excel Options Window
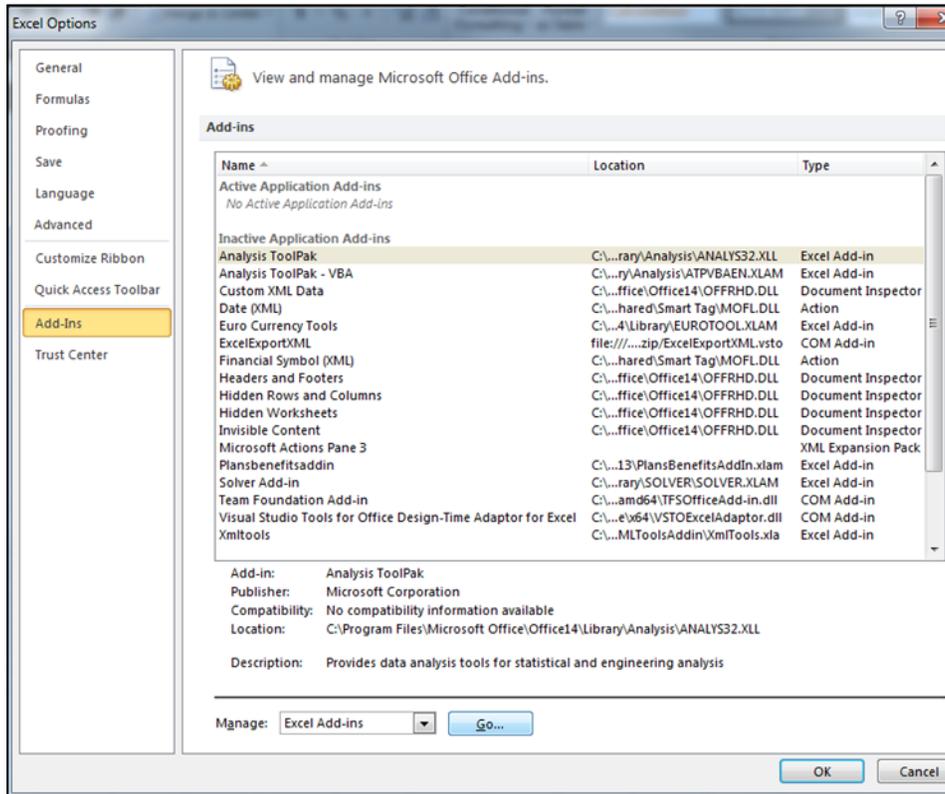
Figure 2D-22. Add-Ins Window
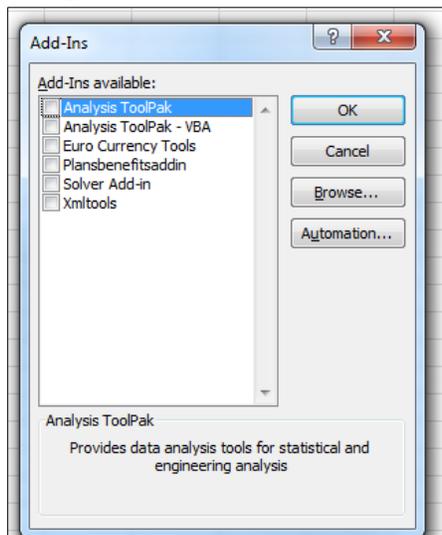
Section 2E. Transparency in Coverage Template

1. Introduction

This document provides instructions for QHP issuers submitting transparency in coverage data (transparency data) for PY2021.[8]

Issuers seeking certification of a QHP must make accurate and timely disclosures of transparency reporting[9] information to the appropriate Exchange, the Secretary of HHS, and the state insurance commissioner, and make the information available to the public.[10] These instructions apply to issuers applying for QHP certification in FFEs in PY2021, including issuers in FFEs where states perform plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs). This includes SADPs and SHOP QHPs. There are no requirements for SBE issuers not using the federal platform at this time.

2. Data Requirements

To complete this section, issuers will need the following:

- Information on whether the issuer was on the Exchange in 2019

- HIOS Issuer IDs and all PY2021 plan IDs

- Number of PY2019 claims and denials

- Number of PY2019 appeals

- Claims Payment Policy and Other Information URL ("Transparency in Coverage URL").

All issuers applying for PY2021 QHP certification, including off-Exchange SADPs, must submit a Transparency in Coverage Template with all PY2021 plan IDs. You will be unable to submit your application to CMS without this template. However, while the template is a required submission for all PY2021 issuers, only on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2019, through December 31, 2019. Other issuers, including off-Exchange SADPs and on-Exchange issuers not on the Marketplace in PY2019, should complete the template indicating reporting requirements are not applicable (see Section 4).

The Transparency in Coverage Template must include all PY2021 plan IDs submitted in the Plans & Benefits Template, including plan IDs for Exchange-certified stand-alone dental plans that are only offered off-Exchange. Issuers that have more than one HIOS Issuer ID in the same state must submit a Transparency in Coverage Template for each unique HIOS Issuer ID. Issuers should only report claims data for plan IDs that were offered on the Exchange in PY2019 and will be offered again in PY2021. If the PY2021 plan ID was not offered on the Exchange in PY2019, it should be included in the template, but the issuer should indicate that PY2019 claims data is not applicable for that plan ID.

If a QHP is available both on and off the Exchange, issuers are required to report claims data only for the on-Exchange enrollees.

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3. Quick Reference

Key Changes for 2021
◆ The Transparency in Coverage Template will be submitted in the Benefits and Service Area Module of HIOS. Issuers who submit via SERFF will submit their Transparency in Coverage Template in their SERFF binders.
◆ **Issuers must include all plan IDs that are present in their QHP Application (including off-Exchange SADPs and medical QHPs) in the Transparency in Coverage Template.**
◆ **The Claims Payment Policies and Other Information URL will be collected in the Supplemental Submission Module (SSM).**
◆ Issuers who submit via HIOS will need to submit their Transparency in Coverage Template into the Benefits & Service Area Module before submitting the Transparency URL via the SSM.
◆ For issuers who submit via SERFF, states will need to transfer submissions into HIOS before issuers will be able to access the SSM and submit Transparency in Coverage URL information.
◆ Transparency URLs must be active at the time of template submission. Specific dates can be found on https://www.qhpcertification.cms.gov/s/Timeline.

Tips for the Transparency Template
◆ **Issuers applying to offer QHPs for PY2021 that did not offer QHPs in 2019 must still submit a Transparency Coverage Template.**
◆ **Required data elements are identified by an asterisk (*) next to the field name. If a field is not required and does not apply to your organization, enter "N/A."**
◆ **Complete the template for each unique HIOS Issuer ID.**
◆ **Use only the tabs provided in the Transparency in Coverage Template and do not add additional tabs, rows, or columns. Separate templates should be submitted for each unique HIOS Issuer ID.**
◆ **Enter all Plan Level data in the Plan Level Data tab. One plan ID should be captured in each row. Each plan ID listed should be a distinct 14-character ID.**
◆ **Check the template(s) for completeness and data validity prior to submission by clicking the "Validate" button on the issuer level data tab.**
◆ **Once the template is completed, HIOS issuers must upload the template to the Benefits and Service Area Module of HIOS by the required deadline.**
◆ **Issuers submitting via SERFF should submit one identical template with all plan IDs in each of their submission binders.**
◆ **States who transfer data to CMS via SERFF will need to transfer issuer data before the issuer will be able to access the SSM in HIOS and submit the Claims Payment Policies and Other Information URL.**

4. Transparency in Coverage Template

Perform the following steps to complete the Transparency in Coverage Template (**Figure 2E-1**).

Note for Issuers submitting via System for Electronic Rate and Form Filing (SERFF): The HIOS system allows only one template submission. If an issuer submits two different templates in SERFF (for example, one in the Individual Market SERFF binder and one in the SHOP SERFF binder), each with different plan-level information, only the most recent template transferred by the state from SERFF into HIOS will be retained. The information submitted on the first template transferred will be overwritten by the information submitted on the second template transferred and so on. To avoid problems related to SERFF overwrite rules, all Transparency in Coverage Template submissions should be the same across binders for the same HIOS Issuer ID. Failure to submit identical templates with all plan IDs may cause template transfers to be overwritten.

In addition, issuers submitting via SERFF will need to have their issuer data transferred by the state before the issuer will be able to access the SSM to submit their Transparency in Coverage URL information. Because of this, states should be mindful of transferring issuer data in a timely manner to avoid submission delays.

Figure 2E-1. Transparency in Coverage Template

	OMB control number: 0938-1310/Expiration date: 04/22/2022

*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2021 v1.0

Validate	
Finalize	

General Information	
Was this Issuer on the Exchange in 2019?*	
Issuer HIOS ID*	

Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	

Notes:	
Please enter any comments/notes here.	

Note: If the issuer was not on the Exchange in 2019 or if the issuer offers off-Exchange SADPs for 2021, please mark N/A for the claims data fields.

4.1 Issuer Level Data Tab

General Information	**Steps**
Was this issuer on the Exchange in 2019?*	Enter **Yes** or **No** to indicate whether or not this issuer was on the Exchange in 2019. ◆ If **Yes**, the issuer must fill out claims and appeals data. ◆ If **No**, the issuer must enter "N/A" to the claims and appeals data fields. ◆ If the issuer offers only off-Exchange SADPs, enter **No.**
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID. If the issuer has more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID.

Issuer Level Data	**Steps**
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	Enter the number of issuer level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an **in-network** health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value. ◆ A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. ◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If the issuer has more than one HIOS Issuer ID, it should submit a separate spreadsheet for each HIOS Issuer ID. ◆ Do not include claims that were pended or denied for additional information and subsequently paid more than once.[11] ◆ Do not include out-of-network claims. The total issuer level claims received data must include in-network claims for **all** QHPs in 2019, including QHPs not offered in 2021. Therefore, the plan level claims reported elsewhere in the template may not total the issuer level claims reported here.

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[11] For example, if an issuer were to have a total of 10,000 claims, of which
- 8,000 were paid immediately;
- 1,000 were pended or denied and resubmitted, of which,
  - 700 were subsequently paid and
  - 300 were subsequently denied at some point in the plan year; and
- 1,000 were denied immediately;

Issuer Level Data	Steps
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Enter the number of issuer level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an **in-network** health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. ◆ A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. ◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If the issuer has more than one HIOS Issuer ID, it should submit a separate spreadsheet for each HIOS Issuer ID. ◆ Do not include claims that were pended or denied for additional information and subsequently paid. ◆ Do not include out-of-network claims. ◆ If a claim is denied for more than one reason, it must only be counted as one claim. ◆ Include *all* denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to: ▪ pediatric vision and dental denials, including SADPs; ▪ denials due to ineligibility; ▪ denials due to incorrect submission; ▪ denials for incorrect billing; and ▪ duplicate claims.
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	Enter the number of requests by the insured for internal appeals involving adverse determinations pursuant to 45 CFR 147.136. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer. Include appeals that the issuer received in 2019 for DOS in 2019 that were fully adjudicated and completed in 2019. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	Enter the number of final determinations adverse to the insured that are overturned on request for internal review **in whole or in part** pursuant to 45 CFR 147.136. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer.
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	Enter the number of requests by the insured for external appeals of final adverse determinations to an external review organization pursuant to 45 CFR 147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals that the issuer received in 2019 for DOS in 2019 that were fully adjudicated and completed in 2019. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	Enter the number of final adverse determinations overturned on request for external review, **in whole or in part** pursuant to 45 CFR 147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

then the total number of claims to be reported is 10,000, and the total number of claims denied to be reported is 1,300 (1,000 immediate denials and 300 subsequent denials at some point in the plan year).

Figure 2E-2. Transparency in Coverage Template—Plan Level Tab

	Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting									
	Plan Year 2021									
	Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019*	Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, *excluding* Behavioral Health in Calendar Year 2019*	Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health *only*, in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019*	Notes: (Please enter any comments/notes here.)

Note: If the issuer was not on the Exchange in 2019, please mark N/A for the claims data fields. Issuers must include all plan IDs that are present in their PY2021 QHP Application (including off-Exchange SADPs) in the Transparency in Coverage Template.

4.2 Plan Level Data Tab

PY2021 Plan Data	Steps
2021 Plan ID*	Enter the 14-character PY2021 Plan ID on the Plan Level Data tab. The plan ID is composed of the five-digit Issuer HIOS Issuer ID, the two-character state abbreviation, and the seven-digit unique digits for the plan. If there is more than one PY2021 Plan ID to report for a single HIOS Issuer ID, this information should be added line by line in the Plan Level Data tab. ***All plan variants should be rolled up to one plan ID or line in the template.*** Sample plan level claims reporting: ◆ Reported claims for XXXXXXXXXXXX56 would include claims that fall under this plan ID from Members on all associated plan variants: ▪ XXXXXXXXXXXX56-01: 100 claims ▪ XXXXXXXXXXXX56-02: 500 claims ▪ XXXXXXXXXXXX56-03: 200 claims ▪ XXXXXXXXXXXX56-04: 50 claims Reporting Plan ID XXXXXXXXXXXX56 should be entered as **one** plan ID in **one** row of the template with a total of 850 claims for the applicable data field.
Number of Plan Level Claims with DOSs in 2019 That Were Also Received in Calendar Year 2019*	Enter the number of **in-network plan level** claims received by an issuer that ask for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value. **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** ◆ A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. ◆ Include claims for all QHPs that fall under the reporting plan ID. ◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12** should only be counted once. ◆ Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2021. Therefore, the plan level claims total may not total the issuer level claims.

PY2021 Plan Data	Steps

Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019[12]
 	
(Plan Level Claims Denied)*
	Enter the number of **plan level** claims received by an issuer that ask for a payment or reimbursement by or on behalf of an **in-network** health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.**
	
	◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.
	◆ Include claims for all QHPs that fall under the reporting plan ID.
	◆ If a claim is denied for more than one reason, only count it as one denied claim.
	◆ Include all denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to:
	  ▪ pediatric vision and dental denials, including for SADPs;
	  ▪ denials due to ineligibility;
	  ▪ denials due to incorrect submission;
	  ▪ denials for incorrect billing; and
	  ▪ duplicate claims.
	◆ Do not include the following claims:
	  ▪ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	  ▪ Out-of-network claims.
	
	The total number of Plan Level Claims Denied in the specified calendar year should also be accounted for in the six "Plan Level Claims Denial" categories. Note, however, that the totals from the "Plan Level Claims Denial" categories will not add up to the total number of Plan Level Claims Denied.

Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 *(Plan Level Claims Denied)**	Enter the number of in-network **plan level** denials for non-emergency-related claims for service that required prior or preauthorization, referral, prior approval, or precertification; in this instance, the claim was denied for plans that require a prior or preauthorization, referral, prior approval, or precertification. **Issuers may also enter N/A in this field for PPOs or if a plan did not exist in PY2019. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** Issuers should include the following claims (individual claim line of service item): ◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification has been denied.

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[12] For example: # of Plan Level Claims Received: Plan has a total of 20,000 claims.
   # of Plan Level Claims Denied: Plan denies 3,000 of those claims for various reasons.
   The issuer would further report the reasons for the 3,000 claims denied in one or more of six denial categories:
   1. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019.
   2. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019.
   3. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019.
   4. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2019.
   5. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2019.
   6. Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019.
   In this example, an issuer could report denial *reasons* greater than 3,000 in the six reporting categories if claims were denied for more than one reason, but the number of plan level claims denied is 3,000.

PY2021 Plan Data	Steps
	◆ Total number of claims denied for services or supplies when an enrollee is required to receive prior or preauthorization, referral, prior approval, or precertification, but fails to.
	◆ A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.
	◆ Health services obtained without a referral when a referral is necessary.
	◆ Include claims for all QHPs that fall under the reporting plan ID. Do not include the following claims:
	▪ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	▪ Out-of-network claims.
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019 **(Plan Level Claims Denied)***	Enter the number of **plan level** denial of claims for services from outside of the plan's network of health care providers when the plan has a closed network. ***Issuers may enter N/A in this field for PPO plans or if a plan did not exist in PY2019. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.***
	Issuers should include the following claims (individual claim line of service item):
	◆ Total number of claims denied for point of service benefit provided by someone (example: health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plans (HMO or closed network plans) network.
	◆ A claim means any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.
	Do not include the following claims:
	◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	◆ In-network claims.
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019 **(Plan Level Claims Denied)***	Enter the number of in-network **plan level** denial of claims for services excluded or non- covered services. **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.**
	Issuers should include (individual claim line of service item):
	◆ Total number of claims denied due to limitations or exclusions of certain services, test, treatment, admissions, supplies, etc., that are excluded, not covered, or limited under the plan, including claims denied as a result of a drug not being on the formulary.
	◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.
	Do not include the following claims:
	◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	◆ Out-of-network claims.
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health in Calendar Year 2019</u> **(Plan Level Claims Denied)***	Enter the number of in-network **plan level** denial of claims for health care services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item):
	◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales.
	◆ Issuers should use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health:
	▪ Analgesics

PY2021 Plan Data	Steps
	▪ Anesthetics
	▪ Antibacterials
	▪ Anticonvulsants
	▪ Antidementia Agents
	▪ Antiemetics
	▪ Antifungals
	▪ Antigout
	▪ Anti-Inflammatory
	▪ Antimigraine Agents
	▪ Antimyasthenic Agents
	▪ Antimycobacterials
	▪ Antineoplastics
	▪ Anti-Obesity Agents
	▪ Antiparasitics
	▪ Antiparkinson Agents
	▪ Antipasticity Agents
	▪ Antivirals
	▪ Blood Glucose Regulators
	▪ Blood Products/Modifiers/Volume Expanders
	▪ Cardiovascular Agents
	▪ Central Nervous System Agents
	▪ Contraceptives
	▪ Dental and Oral Agents
	▪ Dermatological Agents
	▪ Electrolytes/Minerals/Metals/Vitamins
	▪ Gastrointestinal Agents
	▪ Genetic, Enzyme, or Protein Disorder: Replacement, Modifiers, Treatment
	▪ Genitourinary Agents
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers)
	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)
	▪ Hormonal Agents, Suppressant (Adrenal)
	▪ Hormonal Agents, Suppressant (Pituitary)
	▪ Hormonal Agents, Suppressant (Thyroid)
	▪ Immunological Agents
	▪ Infertility Agents
	▪ Inflammatory Bowel Disease Agents
	▪ Metabolic Bone Disease Agents
	▪ Ophthalmic Agents
	▪ Otic Agents
	▪ Respiratory Tract/Pulmonary Agents
	▪ Sexual Disorder Agents
	▪ Skeletal Muscle Relaxants
	▪ Sleep Disorder Agents.

PY2021 Plan Data	Steps
	Do not include the following claims:
	◆ Behavioral or mental health claims or payment for services.
	▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.
	▪ Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the most current version of the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.
	▪ Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD.
	◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	◆ Out-of-network claims.
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, _Behavioral Health only_, in Calendar Year 2019 **(Plan Level Claims Denied)**	Enter the number of in-network **plan level** denial of claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat an illness, injury, condition disease, or its symptoms, related to behavioral/mental health. **If a plan did not exist in PY2019 or is an SADP, please enter N/A. Otherwise, all on-Exchange plans must enter a value in this field; 0 is acceptable.** Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item):
	◆ Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health.
	▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.
	▪ Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.
	▪ Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM and the most current version of the ICD and federal or state guidelines.
	◆ Issuers should use the following USP drug categories to count pharmacy claims including behavioral health:
	▪ Anti-addiction/substance abuse treatment agents
	▪ Antidepressants
	▪ Antipsychotics
	▪ Anxiolytics
	▪ Bipolar agents.
	Do not include the following claims:
	◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales.
	◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**.
	◆ Out-of-network claims.

PY2021 Plan Data	Steps
Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019 (***Plan Level Claims Denied***)	Enter the number of in-network **plan level** denial of claims rejected for a variety of reasons. **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** Issuers should include (individual claim line of service item): ◆ incorrect bill coding; ◆ patient not insured by the plan; ◆ coverage terminated; ◆ duplicate claims; ◆ coordination of benefits issues/failures; ◆ untimely claims filings based on an issuers time frame for filing a claim; ◆ denial because a procedure is considered experimental, cosmetic, or investigational; and ◆ **any other claim denied for any services not appropriate for the previous plan level categories.** Do not include out-of-network claims.

4.3 Transparency in Coverage Template Submission for Issuers Not Subject to Reporting Requirements, Including Issuers Using Extended Submission Deadlines

All issuers applying for PY2021 QHP certification are required to submit a Transparency in Coverage Template as part of their application. You will be unable to submit your QHP certification application to CMS without this template. However, your issuer may not be required to submit Transparency in Coverage data as described earlier in this section, either because the reporting requirement does not apply to your issuer (for example, issuers new to the Marketplace, or off-Exchange SADPs), or because CMS has authorized additional time to report your data for the year. This section will describe how to submit the Transparency in Coverage Template without reporting numerical transparency data.

To complete the template in this way, you will need the HIOS Issuer IDs and all PY2021 plan IDs.

CMS has validation checks built into the submission system to verify that all expected values are present. Therefore, you will need to enter placeholder, or dummy, data into the template (see Figure 2E-3 and Figure 2E-4).

For **issuers with plan offerings that are not required to submit data (e.g., off-Exchange SADPs)**, enter the HIOS Issuer ID in the **Issuer Level Data** tab and all plan IDs in the **Plan Level Data** tab. N/A must be entered in all data fields as indicated below.

For **issuers subject to Transparency in Coverage reporting requirements** who wish to take advantage of the extended submission deadline, enter the values below for the HIOS Issuer ID in the **Issuer Level Data** tab and for all plan IDs in the **Plan Level Data** tabs in the Transparency in Coverage Template. This includes indicating in the notes section of both Issuer Level and Plan Level data tabs that the template contains dummy data. These values will indicate to CMS that the data submitted is not true reportable Transparency in Coverage data. You may still receive review results indicating that this data requires correction. All issuers subject to Transparency in Coverage reporting requirements must submit complete and accurate data by the submission deadlines set by CMS.

4.3.1 Dummy Data—Issuer Level Data Tab

General Information	Expected Value
Was this issuer on the Exchange in 2019?*	No
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID.

Issuer Level Data	Expected Value
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	N/A
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	N/A

Notes	Expected Value
Please enter any comments/notes here.	This is dummy data.[13]

Figure 2E-3. Sample Dummy Data Template—Issuer Level Tab

	OMB control number: 0938-1310/Expiration date: 04/22/2022
*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*	
Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2021 v1.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2019?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	N/A
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	This is dummy data.

4.3.2 Dummy Data—Plan Level Data Tab

Plan Level Data	Expected Value
2021 Plan ID*	Enter the 14-character PY2021 Plan ID on the Plan Level Data tab. Issuers must include all Plan IDs present in their QHP application (including off-Exchange SADPs) on the Plan Level Data tab.
Number of Plan Level Claims with DOSs in 2019 That Were Also Received in Calendar Year 2019*	N/A

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[13] Only issuers subject to Transparency in Coverage reporting requirements seeking to take advantage of the extended submission deadline should note dummy data in their Transparency Template.

Plan Level Data	Expected Value
Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019 *(Plan Level Claims Denied)**	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 *(Plan Level Claims Denied)**	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019 *(Plan Level Claims Denied)**	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019 *(Plan Level Claims Denied)**	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health in Calendar Year 2019</u> *(Plan Level Claims Denied)**	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, <u>*Behavioral Health only*, in Calendar Year 2019</u> *(Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019 *(Plan Level Claims Denied)*	N/A

Notes	Expected Value
Please enter any comments/notes here.	This is dummy data.[14]

Figure 2E-4. Sample Dummy Data Template—Plan Level Tab

	All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.									
	All plan IDs submitted via Plans & Benefits Template(s) must be included in this template.									
	Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting									
	Plan Year 2021									
	Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, *excluding* Behavioral Health in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health *only*, in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019*	Notes: (Please enter any comments/notes here.)
11111VA1111111	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	This is dummy data.
11111VA2222222	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	This is dummy data.

5. Claims Payment Policy and Other Information URL

All issuers applying for PY2021 QHP certification, including those with off-Exchange SADP offerings, must enter a Transparency in Coverage URL in the SSM. You will be unable to submit your network URLs without including the Transparency in Coverage URL. However, if you are submitting before the final submission deadline,

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[14] Only Issuers subject to Transparency in Coverage Reporting Requirements seeking to take advantage of the extended submission deadline should note dummy data in their Transparency Template.

instead of submitting your final active URL leading to the webpage with your claims payment policies, you can submit a dummy URL. QHP issuers who do not yet have a valid URL may submit the dummy URL, "http://temporary.url", until the final Transparency submission deadline.

Please note that while a URL submission is required for all PY2021 issuers, only those with on-Exchange QHP and SADP offerings are required to submit an active URL that directs to a claims payment policy website. Other issuers, such as those with only off-Exchange SADP offerings, should complete the SSM with the dummy URL, "http://temporary.url". See the table below.

Issuer Type	Acceptable URL Submission
QHP issuer	Active URL directing to claims payment policies
QHP issuer prior to Transparency submission deadline	http://temporary.url
Other issuers (e.g., issuers with only off-Exchange SADP offerings)	http://temporary.url

The Claims Payment Policy and Other Information URL will be collected in the SSM in HIOS. Please refer to the SSM user guide for instructions on how to submit the URL. The information below provides an overview of the type of information that needs to be included on the Transparency in Coverage URL.

Note that issuers submitting via SERFF will need to have their issuer data transferred by the state before the issuer will be able to access the SSM to submit their Transparency in Coverage URL information. Because of this, states should be mindful of transferring issuer data promptly to avoid submission delays.

PY2021 URL	Minimum Requirements
Claims Payment Policies & Other Information URL	Enter the active and easily accessible URL. A URL is easily accessible when ◆ it can be viewed on the plan's public website via a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number and ◆ when an individual can easily discern which information applies to each plan the issuer offers. The URL is the web address on the issuer website that consumers use to view pertinent information about the issuer's practices. All URLs should be live, with one URL for a landing page or a single page with a link providing the information indicated below. Issuers that have unique HIOS Issuer IDs in the same state may submit the same URL, if the Transparency in Coverage information is the same across the HIOS Issuer IDs. *Note*: If the URL or website content refers to the plan year, it should refer to the plan year of the current application submission, not the plan year of the claims data.
Out-of-network liability and balance billing	**Description**: ◆ Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or any amounts that may remain on a deductible. **Provide**: ◆ Information regarding whether an enrollee may have financial liability for out-of-network services. ◆ Any exceptions to out-of-network liability, such as for emergency services. ◆ Information regarding whether an enrollee may be balance billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing. **Example of Acceptable Language:** *Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing.*

PY2021 URL	Minimum Requirements
Enrollee claim submission	**Description**: ◆ An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received. **Provide**: ◆ General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, this should be indicated as well. ◆ A time limit to submit a claim, if applicable. ◆ Links to any applicable forms. ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. **Example of Acceptable Language:** *A claim is a request to an insurance company for payment of health care services. As a member, you may need to submit a claim yourself, especially if you see a provider or use a pharmacy outside of the network. In most cases, the time limit for a member to submit a claim is XXX days, but this can vary depending on the group. Please contact customer service at XXX-XXX-XXXX to determine the specific time limit for submitting your claim.* *To file a claim, follow these steps:* *1. Complete a claim form [Claim Form Link].* *2. Attach an itemized bill from the provider for the covered service.* *3. Make a copy for your records.* *4. Mail your claim to the address on the claim form.*
Grace periods and claims pending	**Description**: ◆ A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90-day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d). **Provide**: ◆ An explanation of what a grace period is. ◆ An explanation of what claims pending is. ◆ An explanation that the issuer will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. **Example of Acceptable Language:** *You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in [state], we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period.* *If you are enrolled in an individual health care plan offered on the Health Insurance Marketplace and you receive an advance premium tax credit, you will get a three-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the three-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the three-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.*

PY2021 URL	Minimum Requirements
Retroactive denials	**Description**: ◆ A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment. **Provide**: ◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable. ◆ Ways to prevent retroactive denials when possible, such as paying premiums on time. **Example of Acceptable Language:** *A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include a claim that was paid during the second or third month of a grace period or a claim paid for a service for which you were not eligible.* *You can avoid retroactive denials by paying your premiums on time and in full, and making sure you talk to your provider about whether the service performed is a covered benefit.* *You can also avoid retroactive denials by obtaining your medical services from an in-network provider.*
Recoupment of overpayments	**Description**: ◆ Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to overbilling by the issuer. **Provide**: ◆ Instructions to enrollees on obtaining a refund of premium overpayment. **Example of Acceptable Language:** *If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.*
Medical necessity and prior authorization time frames and enrollee responsibilities	**Description**: ◆ Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. ◆ Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit. **Provide**: ◆ An explanation that some services may require prior authorization and may be subject to review for medical necessity. ◆ Any ramifications should the enrollee not follow proper prior authorization procedures. ◆ A timeframe for the prior authorization requests. **Example of Acceptable Language:** *We must approve some services before you can get them. This is called prior authorization or preservice review. If you need a service that we must first approve, your in-network doctor will call us for the authorization. An example of a service needing prior authorization is any kind of inpatient hospital care (except maternity care). If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll.* *A decision on a request for prior authorization for medical services will typically be made within 72 hours of us receiving the request for urgent cases or 15 days for non-urgent cases.*

PY2021 URL	Minimum Requirements

Drug exception timeframes and enrollee responsibilities (not required for SADPs)	**Description**:
	◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).
	Provide:
	◆ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.
	◆ The timeframe for a decision based on a standard review or expedited review due to exigent circumstances.
	◆ Instructions on how to complete the application.
	Example of Acceptable Language:
	Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form [link provided here]. If the drug is denied, you have the right to an external review.
	If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision.
	An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:
	  [Request Form Link]
	  [Address]
	  [Phone]
	  [Fax].
	For standard exception review of medical requests where the request was denied, the timeframe for review is 72 hours from when we receive the request.
	For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when we receive the request.
	To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.

Explanation of benefits (EOB)	**Description**: ◆ An EOB is a statement an issuer sends the enrollee to explain what medical treatments or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy. **Provide**: ◆ An explanation of what an EOB is. ◆ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. **Example of Acceptable Language:** *Each time we process a claim submitted by you or your health care provider, we explain how we processed it in the form of an Explanation of Benefits (EOB).* *The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.*

PY2021 URL	Minimum Requirements
Coordination of benefits	**Description**: ◆ Coordination of benefits exists when an enrollee is covered by more than one plan and determines which plan pays first. **Provide**: ◆ An explanation of what coordination of benefits means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). **Example of Acceptable Language:** *Coordination of benefits, or COB, is when you are covered under one or more other group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about Coordination of Benefits can be found in your benefit booklet.*

Once the template is completed, issuers must submit their templates in the Benefits and Service Area Module of HIOS as well as their URL in the Supplemental Submission Module of HIOS by the required deadline. Issuers who submit via SERFF will submit their Transparency in Coverage Template in their SERFF binders. Issuers who need to resubmit or correct any errors must follow the resubmission steps in these instructions.

Issuers may find the Transparency in Coverage Checklist (**Figure 2E-5**) to be a useful resource to ensure that all transparency data requirements are met. This document is not required for submission, but rather is a useful guide to ensure issuers complete all sections of the template for each unique HIOS Issuer ID and test each URL to ensure proper functioning prior to the data submission.

If issuers have questions about the transparency data submission process, contact the CMS Marketplace Service Desk at 855-CMS-1515 or via email at CMS_FEPS@cms.hhs.gov. Issuers will receive a response to their inquiry within two business days.

Transparency in Coverage Checklist

Introduction

This checklist is a resource for issuers that are submitting transparency in coverage data to ensure that all transparency data requirements have been met. Issuers must complete all sections of the template for each unique HIOS Issuer ID and test the URL(s) to ensure proper function prior to submission.

___*Note*___: This document is not for submission.

Checklist

1. URL Information:
   - ☐ URL is live upon Transparency submission.
   - ☐ URL is accessible on the plan's public website without requiring an individual to create or access an account or enter a policy number.
   - ☐ One URL for a single landing page.

Claims Payment Policies and Practices URL Data Display Elements:

2. Out-of-network liability and balance billing, including the following:
   - ☐ Information regarding whether an enrollee may have financial liability for out-of-network services.
   - ☐ Information regarding any exceptions to out-of-network liability, such as for emergency services.
   - ☐ Information regarding whether an enrollee may be balance-billed.

3. Enrollee claim submission, including the following:
   - ☐ General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.
   - ☐ A time limit to submit a claim, if applicable.
   - ☐ Links to download any applicable claim forms.
   - ☐ A physical mailing address to mail claims documents.

4. Grace periods and claims pending, including the following:
   - ☐ An explanation of what a grace period is.
   - ☐ An explanation of what claims pending is.
   - ☐ An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

5. Retroactive denials, including the following:
   - ☐ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
   - ☐ Ways to prevent retroactive denials when possible, for example paying premiums on time.

6. Recoupment of overpayments, including the following:
   - ☐ Instructions to enrollees on obtaining a refund of premium overpayment.

7. Medical necessity and prior authorization timeframes and enrollee responsibilities, including the following:
   - ☐ An explanation that some services may require prior authorization and/or be subject to review for medical necessity.
   - ☐ Any ramifications should the enrollee not follow proper prior authorization procedures.
   - ☐ A timeframe for the prior authorization requests.

8. Drug exception timeframes and enrollee responsibilities (not required for SADPs), including the following:
   - ☐ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.
   - ☐ The timeframe for a decision based on a standard review or expedited review due to exigent circumstances.
   - ☐ How to complete the application.

9. Explanation of benefits (EOB), including the following:
   - ☐ An explanation of what an EOB is.
   - ☐ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).
   - ☐ How a consumer should read and understand the EOB.

10. Coordination of benefits, including the following:
    - ☐ An explanation of what coordination of benefits is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

3. Rating Module

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

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

Figure 3-1. Three Module Tabs

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

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

Figure 3-2. Upload/Download Data Submitter Page

Figure 3-3. Data Validator Page

Figure 3-4. Final Submission Page

Section 3A: Rates Table

1. Introduction

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

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2021
◆ Federal TIN is removed from the template.
◆ Issuers can assign the same set of rates to multiple Rating Areas within a template worksheet.

Tips for the Table Rates Section
◆ **SADPs should be entered on a separate Rates Table Template from QHPs.**
◆ **Issuers are encouraged to use separate sheets for individual market plans and Small Business Health Option Program (SHOP) plans.**
◆ **For individual market plans, the rate effective date must be January 1, 2021.**
◆ **For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, or October 1). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect.**

4. Detailed Section Instructions

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Rate Effective Date	Enter the rate effective date as mm/dd/yyyy. For individual market plans, the rate effective date must be January 1, 2021. ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet in the Rates Table Template is bound to a separate effective date range. An issuer submitting SHOP trended quarterly rates should submit a separate worksheet for each date range that a set of rates will be in effect. ◆ An issuer submitting a SHOP quarterly rate change should submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable quarterly rate change submission window. An issuer may submit rate changes that would apply for the next quarter or any subsequent quarter in the remaining plan year. An issuer should not change or delete rates from the template for any current or previous quarter during the submission window. For example, during the submission for updated second-quarter SHOP rates, the first-quarter rates should match the original submission that contained the rates offered during the first quarter. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding Unified Rate Review Template (URRT).
Rate Expiration Date	Enter the rate expiration date as mm/dd/yyyy. ◆ For individual market plans, the rate expiration date must be December 31, 2021. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (March 31, June 30, September 30, or December 31).

Rates Table Template	Steps
Rating Method	Select whether the plans on the worksheet use age-based rates or family-tier rates. *Note:* Only issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers or issuers entering rates for SADPs are eligible to select "Family-Tier Rates." A list of states that use family-tier rating is available here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html.
Add Sheets	Use the **Add Sheet** button to add additional worksheets for the following: ◆ If the issuer has SHOP plans with different rates effective and expiration dates. All plans on a single worksheet *must* have the same effective and expiration dates. ◆ To separate individual market plans and SHOP plans. ◆ To separate plans that use age-based rating and family-tier rating. ◆ To separate by rating area.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (xxxxxAAxxxxxxx) that identifies the plan associated with the rates in that row.
Rating Area	Select the rating area from the list. The rating area is the geographic area where the rates in the row are valid. Rating areas are defined by each state. A list of rating areas for each state is available here: http://cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-gra.html. If a set of rates are allowed to be offered in more than one Rating Area, issuers can elect to assign the set of rates to multiple Rating Areas within a template worksheet.
Tobacco	If using age-based rates, select from the following options in the drop-down menu to indicate whether rates vary based on tobacco use: ◆ **Tobacco User/Non-Tobacco User**—if rates are different for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require QHP tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.[15] *Note:* QHPs rating by tobacco use may not apply tobacco rating to individuals age 0–20, whom the sale and use of tobacco products is prohibited under federal law. For each underage tobacco age band (0–14, 15, 16, 17, 18, 19, and 20), enter the same rate values under the Individual (non-tobacco) Rate column and the Individual Tobacco Rate column. This entry will prevent application of unique tobacco rating to an underage enrollee. *Note:* Small-group market medical plans (including SHOP QHPs) with tobacco rating must offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the Public Health Service (PHS) Act and indicate the wellness program on their Plans & Benefits Template. If the plan does not offer such a wellness program, the plan cannot rate for tobacco use. *Note:* For the Federally-facilitated Small Business Health Options Program (FF-SHOP), if an enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate should be charged. ◆ **No Preference**—if the rate applies to tobacco and non-tobacco users. No separate rates should be submitted for tobacco and non-tobacco users.
Age	If using age-banded rates, the template will automatically generate a row for each age band 0–14 through 64 and over. ◆ If the issuer elects to rate by tobacco use, then tobacco rates for the child age bands of 0–14, 15, 16, and 17 will be auto-populated with the non-tobacco rates of the corresponding child age bands if the non-tobacco rates are first entered in the template. The issuer has the option to edit the auto-populated non-tobacco rates. ◆ For dental plans only: SADPs that meet the definition of excepted benefits are not subject to the market rating rules. These plans may adjust for rating age bands that are not present in this template. In the Plan Attributes section of the Plans & Benefits Template, SADP issuers have the option to elect by plan ID whether they are voluntarily complying with the rating rules in this template (**Guaranteed**), or if the issuer

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[15] 42 U.S.C. 300gg—Fair Health Insurance Premiums.

Rates Table Template	Steps
	reserves the right to make further premium adjustments (**Estimated**). The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. ◆ If the issuer is in a state that does not permit rating for age or tobacco use and establishes uniform family tiers (and corresponding multipliers) or is entering rates for an SADP using "Family-Tier Rates" as the rating method, skip to Family Tier.
Individual Rate	◆ Enter the individual rate that applies to that row. Market rules require individual rates to vary based on age by not more than three times the 21-age rate. In addition, QHPs may not have a 0–20 age rate higher than the 21-age rate and must follow the federal age-rating curve, or state age-rating curve for issuers in states with state age-rating curves within the 1:3 market rule. A list of states using state-specific age curve variations is available here: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html. *Note:* QHPs and SADPs must enter a value above $0.00 for all age bands under the Individual Rate column unless the QHP or SADP has a value of "Allows Child-Only" under the Child-only Offering column of the Plans & Benefits Template. QHP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19, and 20 age bands and are allowed to enter a value of $0.00 for adult age bands 21 through 64 and over. SADP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, and 18 age bands and are allowed to enter a value of $0.00 for adult age bands 19 through 64 and over. ◆ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under the Individual Tobacco Rate column for age bands 21 through 64 and over. For the 0 through 20 age bands, QHPs must enter the same value as the non-tobacco rate under the Individual Tobacco Rate column in order to prevent the application of unique tobacco rating to underage enrollees. For QHPs, tobacco rating cannot be applied to individuals age 0–20, whom the sale and use of tobacco products is prohibited under federal law.
Family Tier	Issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers and individual market SADP issuers that selected "Family-Tier Rates" in the rating method field, will enter the individual rate in the individual rate field. Selecting "Family-Tier Rates" will also generate the following family tier columns: ◆ **Individual Rate** (required): Enter the rate of an individual non-tobacco or no preference enrollee on a plan. ◆ **Couple** (required): Enter the rate for a couple. A couple is defined as a primary subscriber and his or her spouse. A couple may also be a domestic partnership if Life Partner is allowed by the issuer in the Business Rules Template. ◆ **Primary Subscriber and One Dependent** (required): Enter the rate for a primary subscriber with one dependent. ◆ **Primary Subscriber and Two Dependents** (required): Enter the rate for a primary subscriber with two dependents. ◆ **Primary Subscriber and Three or More Dependents** (required): Enter the rate for a primary subscriber with three or more dependents. ◆ **Couple and One Dependent** (required): Enter the rate for a couple with one dependent. ◆ **Couple and Two Dependents** (required): Enter the rate for a couple with two dependents. ◆ **Couple and Three or More Dependents** (required): Enter the rate for a couple with three or more dependents. In the family tier option defined above, a dependent is defined as any dependent relationship allowed by the issuer that falls under the maximum age of a dependent as defined in the Business Rules Template. If any member of the enrollment group is determined to be ineligible, no rate will be returned for that plan.

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

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

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

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

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

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

Section 3B: Business Rules

1. Introduction

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

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2021
◆ New field added for "Medical, Dental, or Both?" Issuers indicate whether they are entering rating business rules for medical plans only, dental plans only, or both medical and dental plans.
◆ New field added for "Medical or Dental Rule?" Issuers may enter different allowed values for template fields based on whether a rule is Medical or Dental.
◆ New field added for "What is the maximum number of rated underage dependents on this policy?"
◆ Following fields are removed from the template: TIN; How are rates for contracts covering two or more enrollees calculated?; What are the maximum number of under age (under 21) dependents used to quote a two parent family?; What are the maximum number of under age (under 21) dependents used to quote a single parent family?; What are the maximum number of children used to quote a children-only contract?; Are domestic partners treated the same as secondary subscribers?; and Are same-sex partners treated the same as secondary subscribers?
◆ Following dependent relationship options are removed from the template: Father or Mother; Grandfather or Grandmother; Uncle or Aunt; Cousin; Adopted Child; Son-in-Law or Daughter-in-Law; Brother-in-Law or Sister-in-Law; Father-in-Law or Mother-in-Law; Stepparent; Dependent of a Minor Dependent; Guardian; Court Appointed Guardian; Annuitant; and Trustee.

Tips for the Business Rules Section
◆ **Enter values for HIOS Issuer ID and "Medical, Dental, or Both?" before entering data for the rest of the template fields, which are locked until "Medical, Dental, or Both?" is populated.**
◆ **For a SERFF-submitting dual issuer who is submitting multiple Business Rules Templates through multiple SERFF binders, a value of "Both" must be entered for all submitted templates.**
◆ **An Issuer ID must enter all rating business rules associated with all Plan IDs that are being submitted for QHP certification into one Business Rules Template. This includes all rules associated with QHPs, on-exchange SADPs, off-exchange SADPs, individual market plans, and SHOP market plans.**
◆ **For SERFF-submitting issuers submitting multiple Business Rules Templates through multiple SERFF binders, the issuer must submit an identical template containing all rules in all submitted SERFF binders.**
◆ **The first row of rules (Row 10) is the base set of issuer business rules, which must have blank values for the product ID and plan ID and must have data entered for all subsequent columns. This row applies to all products and plans associated with the HIOS Issuer ID, including individual, SHOP, QHP, and SADP products and plans. Products or plans with rules that differ from the base set of issuer business rules are defined at the product or plan level in the subsequent rows.**

4. Detailed Section Instructions

Note for Issuers submitting via System for Electronic Rate and Form Filing (SERFF): CMS is requiring SERFF-submitting issuers to enter all rating business rules associated with all Plan IDs that are being submitted for QHP certification into one Business Rules Template. This includes all rules associated with QHPs, on-exchange SADPs, off-exchange SADPs, individual market plans, and SHOP market plans. For SERFF-submitting issuers submitting multiple Business Rules Templates through multiple SERFF binders, the issuer must submit an

identical template containing all their rules in all submitted SERFF binders. This requirement prevents an issuer's submitted rules from being overwritten at the issuer, product, and plan levels. An issuer's business rules may be overwritten when one version of the template from one SERFF binder is completely or partially erased by rules received in a different version of the template from a different SERFF binder.

For dual issuers submitting the Business Rules Template to CMS through multiple SERFF binders, the field of "Medical, Dental, or Both?" must be set to a value of "Both" in all submitted Business Rules Templates. For example, dual issuers may not enter a value of "Medical" for this field in one template version, and "Dental" for this field in another template version.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Medical, Dental, or Both?	Select one of the following options from the drop-down menu: ◆ **Medical**—if entering rating business rules for medical plans only. ◆ **Dental**—if entering rating business rules for dental plans only. ◆ **Both**—if entering rating business rules for medical and dental plans within the template. Issuers must enter a value for this field before proceeding to enter data for other template fields, which are locked until a value for "Medical, Dental, or Both?" is entered. *Note:* For dual issuers submitting the Business Rules Template to CMS through multiple SERFF binders, the field of "Medical, Dental, or Both?" must be set to a value of "Both" in all submitted Business Rules Templates. For example, dual issuers may not enter a value of "Medical" for this field in one template version, and "Dental" for this field in another template version.
Product ID	For products with rules that differ from those entered in Row 10, enter the 10-character (xxxxxAAxxx) HIOS-generated Product ID number that identifies the product that will be associated with the rules defined in that row. ◆ If a product ID is entered, the rules defined in that row will be applied to all plans associated with that product ID. All other products will use the rules associated with either the HIOS Issuer ID in Row 10 or a different product ID rule. ◆ If no product ID is entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products.
Plan ID	Enter the 14-character alphanumeric HIOS-generated Plan ID (xxxxxAAxxxxxxx) that identifies the plan that will be associated with the rules in that row. ◆ If a plan ID is entered, the rules defined in that row will be applied to that plan ID only. All other products and plans will use the rules associated with the HIOS Issuer ID rule, product ID rule, or a different plan ID rule. ◆ If no plan ID is entered, then the rules for the product ID associated with that plan ID will be used. If no product ID rules were entered, the rules associated with the HIOS Issuer ID in Row 10 will be used for all products and plans.
Medical or Dental Rule?	Select whether the business rule in the template row applies to medical or dental plans. The drop-down options are: ◆ **Medical** ◆ **Dental**. The allowed value for this field depends on the value that an issuer entered for "Medical, Dental, or Both?": ◆ If Medical, the issuer-level row (Row 10) for "Medical or Dental Rule?" defaults to Medical. Issuers may only enter Medical for any subsequent rule. ◆ If Dental, the issuer-level row for "Medical or Dental Rule?" defaults to Dental. Issuers may only enter Dental for any subsequent rule. ◆ If Both, the issuer-level row for "Medical or Dental Rule?" defaults to Medical. Issuers may enter Medical or Dental for any subsequent rule, and must have a default issuer-level medical rule and at least one dental product-level or plan-level business rule within the template for the template to validate.

Business Rules Template	Steps
What is the maximum number of rated underage dependents on this policy?	Select the maximum number of rated underage dependents from the drop-down menu. A rated underage dependent is defined as age 0–20 and is limited to the child dependent relationships of Child, Brother and Sister, Foster Child, and Stepson or Stepdaughter. A QHP cannot rate more than the three oldest covered children in determining the total family premium.[16] This rule does not apply to SADPs. If the value for "Medical or Dental Rule" is Medical, then the allowed options are: ◆ **1** ◆ **2** ◆ **3**. If the value for "Medical or Dental Rule" is Dental, then the allowed options are: ◆ **1** ◆ **2** ◆ **3** ◆ **Not Applicable**. *Note:* The option of "Not Applicable" means that a dental plan associated with the business rule has no maximum number of rated underage dependents on a policy. This option is not available to medical plans.
Is there a maximum age for a dependent?	Set the maximum age for a dependent for purposes of eligibility. The maximum age for a dependent applies only to the dependent relationships of Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter. Choose from the following options: ◆ **Yes**—if selected, a pop-up will appear allowing the issuer to enter the maximum age for a dependent. QHP issuers must enter a minimum value of 25 for a Medical business rule. SADP issuers must enter a minimum value of 18 for a Dental business rule. Please note that the age entered is inclusive *through* that age. For example, a value of 25 is through age 25, up to age 26. ◆ **Not Applicable**—if selected, then there is no maximum age and the dependent is allowed to enroll regardless of age as long as he or she meets the other eligibility rules. ◆ Market rules require QHP issuers that cover child dependents to make such coverage available for children until attainment of age 26.[17] *Note:* Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 18.

How is age determined for rating and eligibility purposes?	Select how age is defined to determine if a consumer is eligible for a plan rate. Choose from the following options:
	
	◆ **Age on effective date**—return the rate based on the consumer's age on the effective date.
	◆ **Age on January 1 of the effective date year**—return the rate based on the consumer's age on January 1 of the effective date.
	◆ **Age on insurance date (age on birthday nearest the effective date)**—return the rate based on the consumer's age closest to the effective date of the plan.
	◆ **Age on January 1 or July 1**—return the rate based on the following:
	  If the date of enrollment is before July 1, then use the age as of January 1.
	  If the date of enrollment is after July 1, then use the age as of July 1.
	
	Note: Market rules require QHP plans to select the first option, "Age on Effective Date," whereas dental plans may choose from any of the four options above.[18]

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[16] 45 CFR 147.102(c)(1).
[17] 45 Code of Federal Regulations (CFR) 147.120.
[18] 45 CFR 147.102(a)(l)(iii).

Business Rules Template	Steps
How is tobacco status returned for subscribers and dependents?	Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following options: ◆ **Applicable [x] months**—if selected, a pop-up will appear asking for the number of months used to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than 6 months. Dental issuers are not subject to the look-back period.[19] Rates will be tobacco or non-tobacco depending only on whether an enrollee indicates that he or she was an active tobacco user within the last [x] months (tobacco rate) or not an active tobacco user within the last [x] months (non-tobacco rate). In addition, if the enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used. ◆ **Not Applicable**—if selected, then there are no separate tobacco and non-tobacco use rates. ◆ If rates are calculated by adding up individual rates, then the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and the non-tobacco rate for individuals who qualify for the non-tobacco rate. For states that (1) do not permit rating for age or tobacco use and (2) establish uniform family tiers and corresponding multipliers, there are no separate tobacco rates for each family tier.
What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	◆ Select from the pop-up list the relationships that are allowed to be included when returning rates and if the dependent must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of either the primary subscriber or dependent. The list options are: ▪ Self (by default, selected) ▪ Spouse ▪ Child ▪ Stepson or Stepdaughter ▪ Grandson or Granddaughter ▪ Brother or Sister ▪ Life Partner ▪ Nephew or Niece ▪ Collateral Dependent ▪ Ex-Spouse ▪ Foster Child ▪ Ward ▪ Sponsored Dependent ▪ Other Relationship ▪ Other Relative. ◆ For each relationship selected, select **Yes** or **No** if the dependent is required to live in the same household: ▪ **Yes**—the dependent must live in the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ▪ **No**—the dependent may live in or outside the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ▪ Market rules require QHP issuers that cover child dependents to make such coverage available for children until attainment of age 26, regardless of support, residency, or dependency factors. ▪ QHP products and plans that cover children must select a value of **No** for whether the child dependent is required to live in the same household. This requirement applies for all child dependent relationships, including Child, Foster Child, and Stepson or Stepdaughter.

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[19] 45 CFR 147.102(a)(I)(iv).

Business Rules Template	Steps
	◆ Select the relationship "Life Partner" to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Please note that relationships are not differentiated by sex. If a plan covers spouses and life partners, same-sex and opposite-sex spouses and life partners are covered. *Note:* To cover a dependent relationship that is functionally equivalent to the removed relationship of "Adopted Child," select "Child." To cover a relationship that is functionally equivalent to the removed dependent relationship of "Dependent of a Minor Dependent," select "Grandson or Granddaughter."

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

Figure 3B-1. Sample Business Rules Template

2021 Business Rules Template v10.1			*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*					
Validate			*Enter the Issuer Rule on the first row (no Product ID or Plan ID).*					
			For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.					
Finalize			*For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule.*					
			Issuer level rule will apply only to plan type indicated in cell C10.					
HIOS Issuer ID*	12345							
Medical, Dental, or Both?*	Both							
Product ID	Plan ID (Standard Component)	Medical or Dental Rule?*	What is the maximum number of rated underage dependents on this policy?	Is there a maximum age for a dependent?	How is age determined for rating and eligibility purposes?	How is tobacco status determined for subscribers and dependents?	What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
		Medical	3	25	Age on effective date	6	Self, Yes; Spouse, Yes; Child, No
12345AA111		Dental	Not Applicable	18	Age on effective date	Not Applicable	Self, Yes; Spouse, Yes; Child, No

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

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

Appendices

The appendices contain information that affects the QHP Application.

Appendix A: Actuarial Value Calculator (AVC)

Appendix B: Plan ID Crosswalk

Appendix A: Actuarial Value Calculator (AVC)

1. Introduction

To satisfy the actuarial value (AV) requirements of 45 Code of Federal Regulations (CFR) 156.140 and 156.420, qualified health plan (QHP) issuers must use the AVC developed and made available by the Department of Health and Human Services (HHS) for the given benefit year unless the plan design is not compatible with the AVC (a unique plan design) (45 CFR 156.135). To assist with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. In addition, upon submission of a QHP Application, HHS recalculates this value to validate that an issuer's plan designs meet AV requirements.[20] This section describes how cost-sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AVC. This information is applicable to QHP issuers.

2. Data Requirements

To complete this section, issuers will need the following:

1. Completed Plans & Benefits Template
2. Final standalone AVC.

3. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for Using the AVC
◆ **Download the final 2021 standalone AVC, which is available at https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.**
◆ **If a user is having difficulty matching AVs from the Plans & Benefits Template to the standalone AVC, follow the instructions on troubleshooting in 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template.**
◆ **The AVC has an Additional Notes field that outputs error messages that can only be seen in the standalone AVC. These notes are intended to help AVC users understand the AVC's assumptions and provide some information on the AV calculation being run in the AVC. When an AV calculation is not returned because of an input error, check the Additional Notes field for an explanation of the error.[21]**
◆ **If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, rerun the procedure so that the AVs in the AV Calculator Output Number field are updated to reflect the changes.**
◆ **If unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).**

4. Detailed Section Instructions

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

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

[21] Examples of these notes include how the special cost-sharing provisions are being engaged in the calculations.

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

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

Check AV Calc	Steps	
The **Check AV Calc** procedure on the **Plans & Benefits** ribbon allows the user to calculate AVs for all applicable plans.	Step 1	Select the relevant Cost Share Variances worksheet and fill out all the cost-sharing information necessary to run the AVC.
	Step 2	Click the **Check AV Calc** button. The **Check AV Calc** procedure will prompt the user to select the file location of the standalone AVC. The AVC file selected should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the **Check AV Calc** procedure.
	Step 3	◆ A prompt will appear asking if the issuer would like to save the screenshots. ◆ Select **Yes** if the screenshots will be saved. Using the prompt, select the file name and location to save the output and create a copy of the AVC with worksheets that contain AV screenshots for each plan and plan variation. ◆ Select **No** if the screenshots will not be saved, and the **Check AV Calc** procedure will complete without creating any new files.
	Step 4	A validation message box will appear with the status/error messages from the AVC for each plan or plan variation. The **AV Calculator Output Number** field (Column F in the Cost Share Variances worksheet) is updated with the AV from the AVC. If an error prevented an AV from being calculated, the **AV Calculator Output Number** field is left blank.
	Step 5	If any changes are made to the Plans & Benefits Template after running the **Check AV Calc** procedure, the user must rerun the procedure so that the AVs in the AV Calculator Output Number field are updated to reflect the changes.
	Step 6	After the AVC is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template. The AVC file selected should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all messages to finish the **Check AV Calc** procedure.
For Unique Plan Designs: Upload screenshot into HIOS.[22]	Step 7—(Optional)	◆ Copy the screenshots into a Word document (the Health Insurance Oversight System [HIOS] does not allow Excel files as supporting documents). ◆ Upload as a supporting document a screenshot of the standalone AVC with the **Plan Name**, **Plan ID**, and **HIOS Issuer ID** fields filled in, and include the plan ID (standard component) and date in the file name.

4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the issuer application should include the Unique Plan Design—Supporting Documentation and Justification.[23] The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.[24] For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under

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[22] Issuers can use the standalone AVC to test plan designs, but they do not need to submit a completed standalone AVC or other supplemental documentation, such as a screenshot, except in scenarios described in **Section 4.1 Unique Plan Design**. Instead, they should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

[23] When submitting a plan with a Unique Plan Design, issuers should consult state guidance and complete the Unique Plan Design—Supporting Documentation and Justification in accordance with the applicable state processes.

[24] This supporting document, including the certification section, is available at https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.

45 CFR 156.135(b), issuers should first try to use the integrated version of the AVC for those plans before reverting to the use of the unique plan design option.

For plans compatible with the AVC, issuers must always use an actuarially justifiable process when inputting their plan designs into the AVC.[25] If the AV obtained from the template is not identical to the AV obtained from the standalone AVC, do the following:

1. Ensure the template has been filled out correctly per the instructions in this appendix.

2. Follow the steps in **Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template** on troubleshooting the AVC.

3. After following the troubleshooting steps, determine whether the user can replicate the results of the standalone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.

    a. If the user cannot replicate the standalone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the standalone AVC and through the Plans & Benefits Template *both* fall within the relevant de minimis range for the plan's metal level or CSR variation, the user does not need to designate the plan as a unique plan design. Instead, the user should set the **Unique Plan Design** field equal to **No**, leave the **Issuer Actuarial Value** field blank, and run the integrated AVC.

    b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the standalone AVC does, designate that particular plan as a unique plan design by setting the **Unique Plan Design** field equal to **Yes**. For this plan, complete the **Issuer Actuarial Value** field with the value from the standalone AVC. The AV from the standalone AVC must fall within the relevant de minimis range. Also, upload, as a supporting document, a screenshot of the standalone AVC with the **Plan Name**, **Plan ID**, and **HIOS Issuer ID** fields filled in, and include the plan ID (standard component) and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.

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

1. One or more benefits applies a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.[26]

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

4.2 Differences between Standalone AV Calculator and Plans & Benefits Template

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

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[25] For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on Actuarial Value, available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Final-Master-FAQs-5-16-14.pdf.
[26] For more information, please refer to the AVC User Guide located in the first tab of the AVC here: https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.

standalone AVC. This side-by-side comparison can be very helpful in determining if the cost-sharing structure has been entered and applied as intended.

Table A-2 describes the steps an issuer should take to compare the AV generated by the **Check AV Calc** procedure and the AV generated by the standalone AVC.

Table A-2. Comparing Plans & Benefits and Standalone AVC Screenshots

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

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

Figure A-1. Standalone AVC Screenshot

Click Here for Important Instructions	Tier 1			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00

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

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

Figure A-3. Screenshot Created by Check AV Calc

Click Here for Important Instructions	Tier 1			
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00

5. Field Mapping

This section describes how the **Check AV Calc** procedure maps data from the Plans & Benefits Template into the AVC. The user does not need to perform these mappings, which take place automatically. If any of the

required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error. The layout of the following instructions is intended to align with the order that the fields appear in the Plans & Benefits Template.

5.1 Metal Tier

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

Expanded Bronze Plans: The AVC includes an option for users to indicate that the user is running an expanded bronze plan as finalized in the *HHS Notice of Benefit and Payment Parameters for 2018*.[27] The expanded bronze plan option in the AVC allows the user to calculate the AV for bronze plans that meet certain requirements and, therefore, the user would be allowed to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2) as established in 45 CFR 156.140(c). The AVC does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. It is the responsibility of the issuer to ensure that its bronze plan meets the requirements under this policy in 45 CFR 156.140(c) if the issuer uses the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is −4 percentage points and +5 percentage points. Please see the AVC Methodology and the *HHS Notice of Benefit and Payment Parameters for 2018* for more information. For expanded bronze and silver plan CSR variations, the **Indicate if Plan Meets CSR or Expanded Bronze AV Standard?** checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, the Desired Metal Tier depends on the AV level of the variation. The Desired Metal Tier for silver plan variances is set equal to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation. The Desired Metal Tier must be set to **Bronze** for expanded bronze plans.

De Minimis Range: In April 2017, CMS released a final rule, *Patient Protection and Affordable Care Act; Market Stabilization,*[28] that amends 45 CFR 156.140(c), which establishes the de minimis variation range for the AV level of coverage. Specifically, for plan years beginning on or after January 1, 2018, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is −4 percentage points and +2 percentage points. An exception exists for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is −4 percentage points and +5 percentage points.

5.2 Health Savings/Reimbursement Account Options

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

Figure A-4 shows the health savings account (HSA)/health reimbursement account (HRA) input fields in the Plans & Benefits Template and **Figure A-5** shows the corresponding input fields in the AVC.

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[27] The *HHS Notice of Benefit and Payment Parameters for 2018* is available at https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018.

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

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

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

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

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$500.00

5.3 Tiered Network Options

The AVC can accommodate plans using a multi-tiered, in-network plan design with up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, maximum out-of-pocket (MOOP) costs, and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.[29]

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

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

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

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

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

Figure A-7. Multi-Tier Options in AVC

Tiered Network Option	
Tiered Network Plan?	☑
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the **Not Applicable** option, issuers can explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a **Copay—In Network (Tier 2)** and a **Coinsurance—In Network (Tier 2)** equal to **Not Applicable**, the **Check AV Calc** procedure assumes the benefit does not have tiered cost

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

sharing and uses the **Copay—In Network (Tier 1)** and **Coinsurance—In Network (Tier 1)** values when mapping to Tier 2 in the AVC. This exception to the Tier 2 mapping applies to all fields other than MOOP, default coinsurance, and deductibles, but for simplicity it will not be noted in the individual sections that follow.

5.4 MOOP and Deductible Values

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

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

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

1. If the **In Network** field is equal to a dollar value (**$X**), the **In Network** field is used for the AVC.

2. If the **In Network** field is equal to **Not Applicable** and the **Combined In/Out of Network** field is equal to a dollar value, the **Combined In/Out of Network** field is used for the AVC.

3. If the **In Network** and **Combined In/Out of Network** fields are equal to **Not Applicable**, the Plans & Benefits Template returns an error when attempting to calculate an AV.

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

1. If the **In Network** and **In Network (Tier 2)** fields are equal to dollar values, the **In Network** and **In Network (Tier 2)** fields are used for the AVC.

2. If the **In Network** and **In Network (Tier 2)** fields are equal to **Not Applicable**, and the **Combined In/ Out of Network** field is equal to a dollar value, the **Combined In/Out of Network** field is used for the AVC. In that case, the Combined In/Out of Network MOOP or deductible is mapped to the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AVC.

3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:

    a. The **In Network** field is equal to a dollar value, and the **In Network (Tier 2)** field is equal to **Not Applicable**.

    b. The **In Network** field is equal to **Not Applicable**, and the **In Network (Tier 2)** field is equal to a dollar value.

    c. The **In Network, In Network (Tier 2)**, and **Combined In/Out of Network** fields are equal to **Not Applicable**.

5.4.1 Maximum Out of Pocket

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

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

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

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

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

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

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

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

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

1. The **Maximum Out of Pocket for Medical EHB Benefits—In Network—Individual** *or* **Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 1 Medical MOOP** field in the AVC.

2. The **Maximum Out of Pocket for Drug EHB Benefits—In Network—Individual** *or* **Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 1 Drug MOOP** field in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

    a. The **Maximum Out of Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual** *or* **Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 2 Medical MOOP** in the AVC.

    b. The **Maximum Out of Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual** *or* **Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 2 Drug MOOP** in the AVC.

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

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

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

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

Figure A-11. Separate Deductible and MOOP in AVC

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

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds $8,700. Because the AVC can be available before the finalization of the annual limit on cost sharing for a given plan year, there is an estimated annual limit on cost sharing in the AVC to ensure that the final AVC does not contain an annual limit on cost sharing that is lower than the finalized one. For the 2021 AVC, the MOOP limit and related functions have been set at $8,700 to account for an estimated 2021 annual limitation on cost sharing. The final 2021 annual limitation on cost sharing was specified in the final annual *Notice of Benefit and Payment Parameters for 2021 Benefit Year (final 2021 Payment Notice)* and is $8,550 for self-only coverage and $17,100 for other than self-only coverage for 2021. Issuers that are required to meet AV standards must comply with the limit established in the regulation and may not use the projected estimates stated in the 2021 AVC when finalizing plan designs.

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

5.4.2 Deductibles

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

If **Medical & Drug Deductibles Integrated?** is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the **Use Integrated Medical and Drug Deductible?** checkbox in the AVC is checked.[30] The following applies to integrated deductibles:

1. The **Combined Medical & Drug EHB Deductible—In Network—Individual** *or* **Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 1 Combined Deductible** in the AVC.

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

Figure A-12 shows the integrated deductible fields in the Plans & Benefits Template. **Figure A-9** displays a corresponding example in the AVC.

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

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

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

1. The **Medical EHB Deductible—In Network—Individual** *or* **Medical EHB Deductible—Combined In/ Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 1 Medical Deductible** in the AVC.

2. The **Drug EHB Deductible—In Network—Individual** *or* **Drug EHB Deductible—Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 1 Drug Deductible** in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

   a. The **Medical EHB Deductible—In Network (Tier 2)—Individual** *or* **Medical EHB Deductible— Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 2 Medical Deductible** in the AVC.

   b. The **Drug EHB Deductible—In Network (Tier 2)—Individual** *or* **Drug EHB Deductible— Combined In/Out Network—Individual** value in the Plans & Benefits Template is mapped to the **Tier 2 Drug Deductible** in the AVC.

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

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

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

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

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

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

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

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

5.5 Default Coinsurance

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

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

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

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

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

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

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

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

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

2. One minus the **Drug EHB Deductible—In Network—Default Coinsurance** percent value in the Plans & Benefits Template is mapped to the default **Tier 1 Drug Coinsurance** in the AVC.

3. If the plan has multiple in-network tiers, the following applies:

   a. One minus the **Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance** percent value in the Plans & Benefits Template is mapped to the default **Tier 2 Medical Coinsurance** in the AVC (found in the Tier 2 Plan Benefit Design table).

   b. One minus the **Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance** percent value in the Plans & Benefits Template is mapped to the default **Tier 2 Drug Coinsurance** in the AVC.

5.6 Subject to Deductible?

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

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

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

Figure A-17. Benefit Categories in AVC

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

The header row over the checkbox columns reads "Tier 1", and the first cell reads "Click Here for Important Instructions".

Table A-4 shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AVC—including the **Subject to Deductible?** logic—for all benefits other than Mental/Behavioral Health and Substance Use Disorder benefits. For mental health and substance abuse benefits, see **Table A-6**. Section **5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services** describes the copay and coinsurance mappings in more detail.

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

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

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

5.7 Subject to Coinsurance?

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

5.8 Different Coinsurance Values

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

The AVC functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AVC User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.[31]

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

5.9 Copay Values

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

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

As discussed in the AVC Methodology and User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services; Imaging; Speech Therapy; Occupational Therapy and Physical

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

Therapy; and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient-Facility or Outpatient-Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility and Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AVC also allows the user to indicate the cost sharing for Primary Care and/or Specialist Office Visits and X-rays. The standalone AVC will indicate if the special cost sharing was engaged in the AV calculation in the **Additional Notes** field. For additional information on the operations of these features, review the AVC Methodology and User Guide.

5.10 Copay Applies Only After Deductible

For each benefit, if **Copay—In Network (Tier 1)** is equal to **$X after deductible**, **$X Copay per stay after deductible**, or **$X Copay per day after deductible** and **Coinsurance—In Network (Tier 1)** is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the **Tier 1 Copay applies only after the deductible?** checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. Although the standalone AVC returns an error if the **Copay applies only after the deductible?** checkbox is checked and the benefit is also subject to a coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

5.11 Benefit Categories[32]

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

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

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

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

Plans & Benefits Template Category Name	AVC Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., hospital stay)	All Inpatient Hospital Services (including MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (excluding Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy

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[32] The 2021 AVC uses new claims data from 2017 projected forward to 2021. For information about the considerations of the new claims data, please refer to the AVC Methodology at https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits and the AV Calculator User Guide.

Plans & Benefits Template Category Name	AVC Category Name
Preventive Care/Screening/Immunization[33]	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (high-cost)

5.11.1 Inpatient Hospital Services

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

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

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

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

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

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

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

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

Set a Maximum Number of Days for Charging an IP Copay?	☑
# Days (1-10):	5

Figure A-20. Apply IP Copay Checkbox in AVC

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☑
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver ▾

5.11.2 Skilled Nursing Facility

If the **Skilled Nursing Facility Copay—In Network (Tier 1)** in the Plans & Benefits Template is equal to **$X Copay per Day, $X Copay per day with deductible**, or **$X Copay per day after deductible**, then the **Apply Skilled Nursing Facility Copay per Day?** checkbox in the AVC is checked. If the skilled nursing facility copay is charged per day for Tier 1, the AVC automatically assumes that the skilled nursing facility copay is also charged per day for Tier 2, if applicable.

Users intending to charge a skilled nursing facility copay per day should ensure that they have selected the **Apply Skilled Nursing Facility Copay per Day?** checkbox while filling out the standalone AVC to ensure accuracy of AV calculations.

5.11.3 Primary Care

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

If **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** checkbox in the AVC is checked and the **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** field in the Plans & Benefits Template is mapped to **# Copays (1–10)** in the AVC. If the **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** field is blank in the Plans & Benefits Template, then the **Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?** checkbox in the AVC is unchecked and **# Copays (1–10)** in the AVC is left blank. Per the AV Calculator User Guide, the use of this option does not imply a benefit

design for primary care visits after the initial copays have occurred. The user must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under **Primary Care Visit to Treat an Injury or Illness**.

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

Figure A-21. Primary Care Options in AVC

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	☑
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
52	# Copays (1-10):	

5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services copay and coinsurance inputs are weighted averages of the **Mental/Behavioral Health Outpatient Services** and the **Substance Abuse Disorder Outpatient Services** cost-sharing fields in the Plans & Benefits Template. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the **Mental/Behavioral Health Outpatient Services** benefit in the Plans & Benefits Template when mapping to the **Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Subject to Deductible?**, **Subject to Coinsurance?**, and **Copay applies only after the deductible?** checkboxes in the AVC. The copay and coinsurance values for the Substance Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AVC checkboxes.

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

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

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

1. **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** is equal to **$X** or **$X with deductible** in the Plans & Benefits Template

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

If **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** is equal to **$X after deductible** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** is equal

to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the **Tier 1 Copay applies only after the deductible?** checkbox for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in **Table A-5**) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the Tier 2 copay and Tier 2 coinsurance are equal to **Not Applicable**. If **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2)** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2)** are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the **Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)** and **Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)** values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services in the AVC. If **Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2)** and **Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2)** are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the **Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)** and **Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)** values for Substance Abuse Disorder Outpatient Services when mapping to the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services Tier 2 fields in the AVC.

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

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

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

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

5.11.5 Drugs

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

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay, enter **No Charge**, **No Charge after the deductible**, or **Not Applicable** rather than **0%** or **0% Coinsurance after deductible** in the **Coinsurance—In Network (Tier 1)** or **Coinsurance—In Network (Tier 2)** fields in the Plans & Benefits Template to avoid an error from the AVC. Likewise, if a drug benefit has only a coinsurance, enter **No Charge**, **No Charge after the deductible**, or **Not Applicable** rather than **$0** or **$0 Copay after deductible** in the **Copay—In Network (Tier 1)** or **Copay—In Network (Tier 2)** fields in the Plans & Benefits Template.

5.11.5.1 Specialty Drugs

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

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

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

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$200

6. Zero Cost-Sharing and Limited Cost-Sharing Plan Variations

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

Appendix B: Plan ID Crosswalk

1. Introduction

The Plan ID Crosswalk Template crosswalks PY2020 qualified health plan (QHP) plan ID and service area combinations (e.g., plan ID and county combinations) to a PY2021 QHP plan ID. These data will facilitate 834 enrollment transactions from the Centers for Medicare & Medicaid Services (CMS) to the issuer for those enrollees in the individual market who have not actively selected a different QHP during Open Enrollment. These instructions apply to QHP and stand-alone dental plan (SADP) issuers that offered individual market plans on the Exchange during PY2020.

2. Data Requirements

To complete this section, issuers will need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer's state
3. Market coverage
4. Completed Plans & Benefits Template
5. Completed Service Area Template.

3. Quick Reference

Key Changes for 2021
◆ No changes for the 2021 QHP Application.

Tips for the Plan ID Crosswalk Section
◆ **First-time QHP issuers are not expected to submit a Plan ID Crosswalk Template.** ◆ **For PY2021, CMS has deferred the Federally-facilitated Small Business Health Option Program's (FF-SHOP's) ability to auto-renew employees. Therefore, issuers should not attempt to submit a Plan ID Crosswalk Template for FF-SHOP plans.** ◆ **Issuers need to submit the Plan ID Crosswalk Template through the Plan Management (PM) Community.** ◆ **Issuers must import only one Plans & Benefits Template and one Service Area Template. You must make separate submissions for SADPs.**

4. Detailed Section Instructions

Issuers are expected to submit evidence from the state, such as an email confirmation, that the issuer is authorized to submit its Plan ID Crosswalk Template. CMS will require issuers to submit this evidence no later than June 17, 2020. Issuers should provide evidence of state authorization through the PM Community.

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

CMS will not send Plan ID Crosswalk Templates to states. Issuers may be asked by their state regulators to provide this template in addition to their submission to CMS (as part of the National Association of Insurance Commissioners' [NAIC's] System for Electronic Rate and Form Filing [SERFF] binder, for example).

Issuers in direct enforcement states (Missouri, Oklahoma, Texas, and Wyoming) should submit the authorization form to their state's Department of Insurance and to CMS's Compliance and Enforcement Division (formfiling@cms.hhs.gov) to obtain the necessary authorization for submission.

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

To complete the information on the **2020 Plan Crosswalk** tab, follow the steps in the table below.

2020 Plan Crosswalk Tab	Steps
Import 2020 Plans & Benefits and Service Area Template	Click the **Import 2020 Plans & Benefits and Service Area Template** button. This action imports the completed templates.
	The template will prompt you to select your completed 2020 Plans & Benefits Template and 2020 Service Area Template. The Plans & Benefits and Service Area Templates must be selected at the same time; save both templates in the same folder prior to importing. To select both files, click on one template, and then press and hold the **Ctrl** button while clicking on the other template. Then click **Open**. You must select exactly one Plans & Benefits Template and one Service Area Template.
	The Plan ID Crosswalk Template will populate a list of PY2020 plan IDs and their associated service areas on the 2020 **Plan and Service Area Data** tab. Review this tab to ensure the data was accurately imported. After the PY2020 plan and service area data has been imported, the 2020 **Plan Crosswalk** tab will be populated with all applicable issuer information as well as a row for each PY2020 plan ID.
HIOS Issuer ID	Ensure the template has accurately populated the five-digit HIOS Issuer ID.
Issuer State	Ensure the template has accurately populated the state in which the issuer is offering coverage.
Market Coverage	Ensure the template has accurately populated the market coverage from the drop-down menu.
	The FF-SHOP Exchange will not allow auto-renewals for PY2021. Therefore, this field will be hard coded to *Individual*.
Dental Only	Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental-only plans. Choose from the following:
	◆ **Yes**—this template is for SADPs only.
	◆ **No**—this template is for QHPs.
Crosswalk Level	Select from the drop-down menu the level at which you would like to crosswalk each PY2020 plan. Choose from the following:
	◆ **Crosswalking to the Same Plan ID:** Select this option if you are crosswalking your PY2020 plan to the same plan ID for PY2021, and you have no service area changes.
	◆ **Crosswalking at the Plan ID Level:** Select this option if you have no service area changes but are using a different PY2021 plan ID to reflect the same plan.
	◆ **Crosswalking at the Plan ID and county coverage level:** Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2020 plan to two or more PY2021 plan IDs.
	Note: If your PY2020 plan covered the entire state, you will need to crosswalk the plan for every county in the state.
	◆ **Crosswalking at the ZIP level for one or more counties:** Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2020 plan to two or more PY2021 plan IDs for the same county. Selecting this option will require you to select the counties from the PY2020 plan's service area that will be crosswalked at the ZIP-code level. The remaining PY2020 service area will be crosswalked at the county level.
	Note: CMS discourages issuers from crosswalking at the ZIP level unless absolutely necessary.
	◆ **Discontinue with no crosswalk:** Select this option if you are discontinuing a PY2020 plan with no re-enrollment option for its enrollees.
	◆ **Plan withdrawn prior to certification:** Select this option if the PY2020 plan was withdrawn from the Exchange prior to certification and has no enrollment. Issuers should also select this option if the PY2020 plan ID listed on the template was not

2020 Plan Crosswalk Tab	Steps
	approved by the state or the Federally-facilitated Exchange (FFE) to be offered on the Exchange in PY2020.
Counties Crosswalked at ZIP Level	Select the counties in your PY2020 plan's service area that will be crosswalked at the ZIP-code level from the pop-up menu.

To complete the information on the **2021 Plan Crosswalk** tab, follow the steps in the table below.

2021 Plan Crosswalk Tab	Steps
Create "2021 Crosswalk Tab"	Click the **Create "2021 Crosswalk Tab"** button. This action creates one **2021 Plan Crosswalk** tab. The first four columns, 2020 HIOS Plan ID, County Name, Service Area ZIP Codes, and Crosswalk Level, will be auto-populated based on your entries in the **2020 Plan Crosswalk** tab. If you decided to crosswalk at the plan ID-county level for one or more plans, a row will appear for each county that plan covered in PY2020. If the user decided to crosswalk at the ZIP level for specific counties covered by a PY2020 plan, a row for each Plan ID-County-ZIP code combination will appear. Only click the **Create "2021 Crosswalk Tab"** button when you are sure the **2020 Plan Crosswalk** tab is complete. If you want to make changes on this tab after the **2021 Plan Crosswalk** tab is created, you will need to click the **Create "2021 Crosswalk Tab"** button again and start over on the **2021 Plan Crosswalk** tab. Clicking the **Create "2021 Crosswalk Tab"** button will clear all data you have already entered on the **2021 Plan Crosswalk** tab, so copy and paste this information into a separate workbook if you want to save your previous work.
Crosswalk Reason	Choose the reason for the crosswalk from the drop-down menu. The list of options will depend upon the crosswalk level selected. **Table B-1** details crosswalk reason entries for each crosswalk level: ◆ **Renewing exact same product/plan combination (Same PY2020 Plan ID):** Select this option if you are crosswalking this plan ID/service area to the exact same HIOS Plan ID. Under this option, the template will auto-populate the **PY2021 Plan ID** field with your PY2020 plan ID. Issuers are expected to comply with the "same plan" standards as defined in 45 Code of Federal Regulations (CFR) 144.103. Issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2021 plan year. ◆ **Renewing exact same product/plan combination (Different 2021 Plan ID):** Select this option if you are crosswalking this plan ID/service area to the same product/plan combination but with a different PY2021 plan ID. Issuers are expected to comply with the "same plan" standards as defined in 45 CFR 144.103. As stated above, in most cases, issuers should use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming PY2021. ▪ In the limited cases where an issuer is continuing the same plan but has a need to crosswalk to a different HIOS Plan ID, the issuer should seek guidance and approval from their state regulatory authority prior to submitting their Plan ID Crosswalk Template to CMS. ◆ **Renewing product: renewal in a different plan within product:** Select this option if you are renewing this product, but crosswalking this plan ID/service area to a different plan within the product offered through the FFE. If you select this option, you must use the same product ID embedded in the plan's 2020 plan ID.

2021 Plan Crosswalk Tab	Steps
	◆ **Continuing product: no plan available in the particular service area under that product; enrollment in a different product:** Select this option if you are continuing this product in PY2021 but will no longer offer any plans in part of the service area covered by the product in PY2020 and are crosswalking to a plan within a different product offered through the FFE. Select this reason for that portion of the service area that you no longer offer any plans under that product. If you select this option, you must crosswalk to a PY2021 plan ID with a different product ID from the PY2020 plan ID. ◆ **Continuing product: no plan available in the particular service area under that product; no enrollment option:** Select this option if you are continuing a PY2020 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Issuers should not enroll pertinent plans into a plan offered outside the Exchange. Selecting this option will disable the 2021 HIOS Plan ID field. ◆ **Continuing product: no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product:** Select this option if there is no available silver plan within the enrollee's product in a particular service area and the enrollee is being enrolled in a silver plan within another product. ◆ **Discontinuing product: enrollment into a different product:** Select this option if this PY2020 product is discontinued for PY2021 and enrollees in this plan and associated service area will be re-enrolled in a plan under a different product offered through the FFE. Under this option, the entered PY2021 plan ID must have a different product ID and you may not enter the discontinued PY2020 product ID for any other row under the PY2021 plan ID. Issuers should crosswalk any discontinued PY2020 plan to an available plan in a different product, if one exists. If an issuer does not provide a crosswalk for a discontinued plan, but still offers products in the same service areas, CMS, in accordance with the hierarchy established in 45 CFR 155.355(j)(2), will crosswalk the discontinued plan to another product offered by the same issuer under the same HIOS Issuer ID. ◆ **Discontinuing product: no enrollment option:** Select this option if a PY2020 product is discontinued for PY2021 and there is no enrollment option through the FFE for PY2020 enrollees in this plan ID/service area combination. Issuers should not enroll pertinent plans into a plan offered outside the Exchange. Selecting this option will disable the **PY2021 Plan ID** field. Under this option, you may not enter the discontinued PY2020 product ID for any other row under the PY2021 plan ID. Issuers should crosswalk any discontinued PY2020 plan to an available plan in a different product, if one exists. If an issuer does not provide a crosswalk for a discontinued plan, but still offers products in the same service area, CMS, in accordance with the hierarchy established in 45 CFR 155.355(j)(2), will crosswalk the discontinued plan to another product offered by the same issuer under the same HIOS Issuer ID.
2021 HIOS Plan ID	Enter the PY2021 plan ID you would like to crosswalk your enrollees to for the row's PY2020 plan ID/service area. This field will be auto-populated when **Renewing exact same product/plan combination (Same 2020 Plan ID)** is chosen under the Crosswalk Reason. This field will be disabled when **Discontinuing product; no enrollment option**, **Continuing product; no plan available in the particular service area under that product; no enrollment option**, is chosen under the Crosswalk Reason. *Note:* Issuers should only input PY2021 plan IDs for plans that will be offered through the Exchange and are listed in the 2021 QHP Application. CMS will not accept any PY2021 plan IDs for plans only sold outside the Exchange.
Is this PY2021 Plan a Catastrophic or Child-Only Plan?	This field will default to **No**. Please select **Yes** for any catastrophic or child-only plan being crosswalked.
PY2021 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan	If selecting **Yes** in the previous data element, this field will allow you to enter a PY2021 plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2021 plan ID entered in this field.

2021 Plan Crosswalk Tab	Steps
Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s)	CMS has included the following optional data fields to be completed if requested by an issuer's state regulator: ◆ **PY2020 Plan ID**—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s). ◆ **PY2021 Plan ID**—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s). ◆ **PY2021/20 Plan ID** (catastrophic or child-only)—Associated Policy Form Number(s) and NAIC SERFF Tracking Number(s) for Form Filing(s).

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

Figure B-1. Sample Plan ID Crosswalk Template

Table B-1 lists the crosswalk reason and PY2021 plan ID entry options for each crosswalk level.

Table B-1. Crosswalk Level, Reason for Crosswalk, and PY2021 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2021 HIOS Plan ID
Crosswalking to same Plan ID	Renewing exact same product/plan combination. (Same PY2020 Plan ID.) *(auto-populated)*	Template populates field with PY2020 Plan ID. *(auto-populated)*
Crosswalking at the Plan ID Level	Renewing exact same product/plan combination. (Different PY2021 Plan ID.)	Different plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same product ID as PY2020 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different product ID from PY2020 Plan ID.
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2021 Plan ID.
	Discontinuing product; enrollment into a different product.	Plan ID with different product ID from PY2020 Plan ID.
Crosswalking at the Plan ID and county coverage level	Renewing exact same product/plan combination. (Same PY2020 Plan ID.)	Template populates field with PY2020 Plan ID. *(auto-populated)*

Crosswalk Level	Crosswalk Reason	2021 HIOS Plan ID
	Renewing exact same product/plan combination. (Different PY2021 Plan ID.)	Different Plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same product ID as PY2020 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different product ID from PY2020 Plan ID.
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2021 Plan ID.
	Continuing product; no plan available in the particular service area under that product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
	Discontinuing product; enrollment into a different product.	Plan ID with different product ID from PY2020 Plan ID.
	Discontinuing product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
Crosswalking at the ZIP level for one or more counties	Renewing exact same product/plan combination. (Same PY2020 Plan ID.)	Template populates field with PY2020 Plan ID. *(auto-populated)*
	Renewing exact same product/plan combination. (Different PY2021 Plan ID.)	Different plan ID.
	Renewing product; renewal in a different plan within product.	Plan ID with same product ID as PY2020 Plan ID.
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product.	Plan ID with different product ID from PY2020 Plan ID.
	Continuing product; no plan available in the particular service area under that product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product.	Plan ID with different product ID from PY2021 Plan ID.
	Discontinuing product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
	Discontinuing product; enrollment into a different product.	Plan ID with different product ID from PY2020 Plan ID.
Discontinue with no crosswalk	Discontinuing product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
	Continuing product; no plan available in the particular service area under that product; no enrollment option.	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*
Plan Withdrawn Prior to Certification	Plan Withdrawn Prior to Certification. No enrollment option. *(auto-populated)*	**PY2021 HIOS Plan ID** field is disabled. *(auto-populated)*

Once the Plan ID Crosswalk Template is completed, issuers must validate, finalize, and upload the files to the PM Community.

Template Validation	Steps
Validate Template	Click the **Validate** button on the **2020 Plan Crosswalk** tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.

Template Validation	Steps
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the data element and cell location of each error. Correct any identified errors, and click **Validate** again. Continue this process until all errors are resolved.
Finalize Template	Click the **Finalize** button on the **2020 Plan Crosswalk** tab. The Finalize function creates the .XML file of the template.
Save Template	**Save** the XML Template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file.
Upload Template	**Upload** the finalized template to the PM Community with the subject title "2020 Plan ID Crosswalk." *Note:* If the .XML file name is modified after finalization, CMS cannot process the template. Also, CMS cannot review the uploaded templates until the **Submit Template** button is clicked.

5. Submitting Plan ID Crosswalk Documents

Issuers are required to submit their Plan ID Crosswalk Templates and associated documents through the PM Community.

The following details the steps issuers should follow to upload and submit the XML version of the Plan ID Crosswalk Template (completed above), their required state authorization, and any justifications, if applicable.

1. Issuers should log in to the PM Community and select "Plan ID Crosswalk Submission" from the top bar, as shown in **Figure B-2**.

Figure B-2. PM Community Home Screen

2. On the **Plan ID Crosswalk Submission** tab, issuers will see the screen depicted in **Figure B-3.** To upload files, issuers should click the "New" button on the right of this screen.

Figure B-3. Plan ID Crosswalk Submission Page
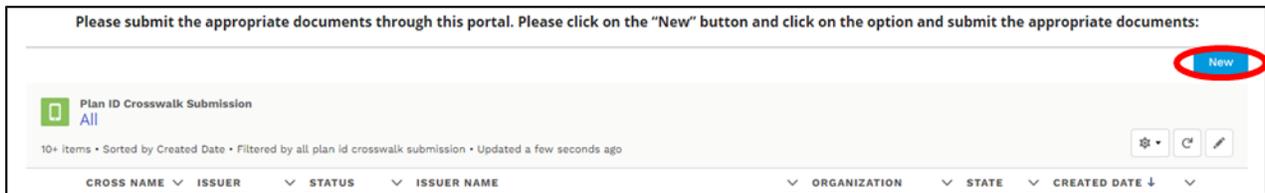
3. After selecting "New," the following screen will pop up. Issuers should use the drop-down in the search bar to select the specific HIOS Issuer ID and the plan year for which they are uploading a crosswalk. For example, for HIOS Issuer ID "12345" and plan year "2021," an issuer would select "12345-2021." A parent organization must complete this process for each HIOS Issuer ID for which a Plan ID Crosswalk Template is being submitted. After the issuer selects a specific HIOS Issuer ID, the box that says "Next" on the right of the screen (**Figure B-4**) will turn blue and the issuer should click it.

Figure B-4. Create Crosswalk Template Issuer Selection Window
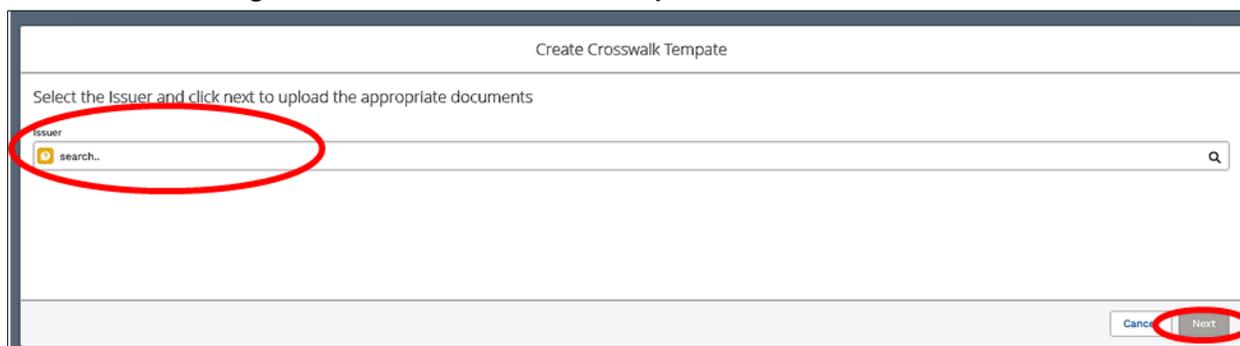
This will take issuers to the screen shown in **Figure B-5**. This is where the issuer can upload the following three files:

a. **Crosswalk Template.** This template must be submitted during the certification window in XML format. No other file formats will be accepted. This file is created after an issuer finalizes and validates the Excel-based Plan ID Crosswalk Template.

b. **State Authorization.** This file must be submitted during the certification window in Word or PDF format. The file allows states to attest that they have seen and approved of an issuer's proposed plan crosswalks.

c. **Justification.** This file is optional for issuers and it may be submitted in Word or PDF format. If an issuer has data issues or variances from the required regulations in their template, they may upload a justification file explaining why they believe their crosswalk is in compliance.

Figure B-5. Create Crosswalk Template File Upload Window
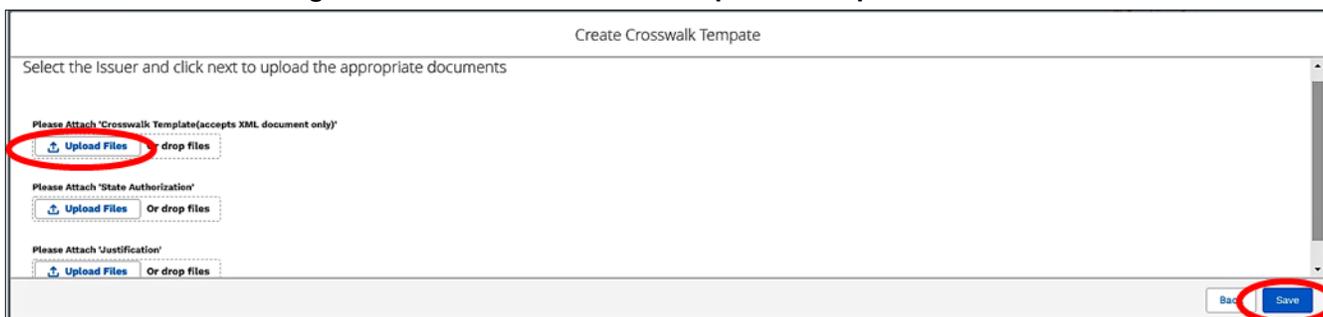
Issuers should select the "Upload Files" button for each of the file types which they wish to upload and then navigate to the desired file. Once a file is chosen and has been successfully uploaded, issuers will see the Upload Files screen shown in **Figure B-6**, and should select "Done" to continue.

Figure B-6. Upload Files Confirmation
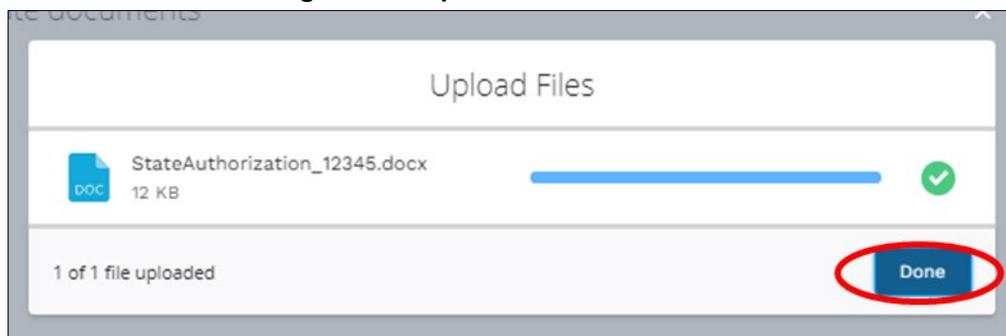
4. Next, the uploaded file names will appear on the Create Crosswalk Template window, as shown in **Figure B-7**. If an issuer has multiple templates, state authorizations, or justifications for a single HIOS Issuer ID, they may all be uploaded at one time.

Figure B-7. Create Crosswalk Template File Upload Window after Upload

5. After they have uploaded all of the files they wish to submit for that submission, the issuer should select the "Save" button in the bottom right of the window, as shown in **Figure B-5.** Issuers must complete additional steps after saving the files to complete the submission process.

6. After hitting save, the issuer will be brought to a screen as shown in **Figure B-8**. They should select the "Submit Templates" button in the top right of the screen to submit their templates to CMS. **IMPORTANT:** If files are uploaded or saved, but the "Submit Templates" button has not been selected, **CMS will not receive the files.**

Figure B-8. Plan ID Crosswalk Submission Window

7. **Figure B-8a** shows a closer view of the left side of the screen above. The status says "New," indicating that the files have not yet been submitted. After the issuer selects "Submit Templates," the status will change to "Submitted," as shown in **Figure B-8b**. This indicates that all files have been transferred to CMS and the crosswalk upload process is complete.

**Figure B-8a. Screen before
"Submit Templates" Is Clicked**

**Figure B-8b. Screen after
"Submit Templates" Is Clicked**

To update their Plan ID Crosswalk Template or State Authorization or submit a new justification document, issuers should repeat this plan ID crosswalk submission process.