Qualified Health Plan
Issuer Application Instructions

2022

Extracted section:
Section 2E: Transparency in Coverage

[02/2021]

Section 2E: Transparency in Coverage

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix E for additional information.

1. Introduction

This document provides instructions for QHP issuers submitting Transparency in Coverage data (transparency data) for PY2022.[1]

If you are submitting a QHP certification application for PY2022, you must make accurate and timely disclosures of transparency reporting[2] information to the appropriate Exchange, the Secretary of HHS, and the state insurance commissioner, and make the information available to the public.[3] These instructions apply to issuers applying for QHP certification in FFEs in PY2022, including issuers in FFEs where states perform plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs). This includes:

- On-Exchange Certified Medical QHPs
- On-Exchange Certified SADPs
- Off-Exchange-only Certified SADPs
- SHOP QHPs.

Note: If you're an issuer in an SBE state not on the federal platform, you are not required to submit Transparency in Coverage data at this time.

Exchange Type	Transparency in Coverage Reporting Required?
FFE	Yes
FFE with state performing plan management functions	Yes
SBE using own IT platform	No
SBE-FP (using federal IT platform)	Yes

2. Data Requirements

To complete this section, you will need the following:

- Information on whether the issuer was on the Exchange in 2020
- HIOS Issuer IDs and all PY2022 plan IDs
- Number of PY2020 claims and denials
- Number of PY2020 appeals
- Claims Payment Policy and Other Information URL ("Transparency in Coverage URL").

To apply for PY2022 QHP certification, you must submit a Transparency in Coverage Template that includes all PY2022 plan IDs. You cannot submit your QHP Application without this template. However, only on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2020, through December 31, 2020. Other issuers, including on-Exchange issuers not on the Exchange in PY2020, should complete the template indicating reporting requirements are not applicable.

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[1] Office of Management and Budget Control Number CMS-10572.

[2] Section 2715A of the PHS Act extends the transparency reporting provisions under Section 1311(e)(3) to non-grandfathered groups and issuers offering group or individual coverage, except for a plan not offered on an Exchange.

[3] The implementation of the transparency reporting requirements under Section 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into Section 715(a)(1) of the Employee Retirement Income Security Act and Section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

The Transparency in Coverage Template must include all PY2022 plan IDs submitted in the Plans & Benefits Template. If you have more than one HIOS Issuer ID in a state, you must submit a Transparency in Coverage Template for each unique HIOS Issuer ID. Only report claims data for plan IDs that were offered on the Exchange in PY2020 and will be offered again in PY2022. If a PY2022 plan ID was not offered on the Exchange in PY2020, include it in the template but indicate that PY2020 claims data is not applicable for that plan ID. See Table 2E-1 for a summary of Transparency in Coverage reporting requirements.

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

Table 2E-1. Summary of Transparency in Coverage Reporting Requirements

Plan Type	Transparency in Coverage Template Required?	Transparency in Coverage Claims Data Required?	Transparency in Coverage URL Required?
On-Exchange QHP that was offered in PY2020	Yes	Yes. Do not include or count claims data for off-Exchange QHP enrollment.	Yes
On-Exchange SADP that was offered in PY2020	Yes	Yes. Do not include claims data for off-Exchange SADP enrollment.	Yes
Off-Exchange SADP that was offered in PY2020	Yes	No. Do not include or count off-Exchange plan IDs or claims data.	No
On-Exchange QHP that was **NOT** offered in PY2020	Yes	No. Note as N/A in the template.	Yes
On-Exchange SADP that was **NOT** offered in PY2020	Yes	No. Note as N/A in the template.	Yes
Off-Exchange SADP that was **NOT** offered in PY2020	Yes	No. Do not include or count off-Exchange plan IDs or claims data.	No

3. Quick Reference

Key Changes for 2022

- The deadline for submitting Transparency in Coverage data and the Claims Payment Policies and Other Information URL is now aligned with QHP certification and will be due on June 16, 2021.
- The template includes a new validation for SADP-only issuers. Please select **Yes** from the dropdown box on the issuer-level tab if you are an SADP-only issuer. If you are not an SADP-only issuer, you must select **No**.
- The instructions for entering data into the Issuer and Plan Level tabs of the Transparency in Coverage Template now include information regarding expected values for specific columns.
- Off-Exchange-only plan IDs are no longer required to be entered in the Plan Level tab of the Transparency in Coverage Template.
- **PLEASE NOTE: CMS has clarified definitions and expectations for reporting claims received, claims denied, and reasons for denied claims data. The instructions now contain examples to help illustrate these clarifications.**

Tips for the Transparency Section
◆ If you are applying to offer QHPs for PY2022 but did not offer QHPs in 2020, you must still submit a Transparency in Coverage Template. ◆ **Do not include off-Exchange-only plans in the Plan Level tab of the Transparency in Coverage template.** ◆ Required data elements are identified by an asterisk (*) next to the field name. Complete a separate template for each unique HIOS Issuer ID. ◆ Use only the tabs provided in the Transparency in Coverage Template. Do not add additional tabs, rows, or columns. Separate templates should be submitted for each unique HIOS Issuer ID. ◆ Enter all on-Exchange 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 templates for completeness and data validity before you submit by clicking **Validate** on the Issuer Level Data tab. ◆ The Claims Payment Policies and Other Information URL will be collected in the Supplemental Submission Module (SSM) in HIOS and must be active and compliant with URL requirements at the time of initial submission. ◆ If you are submitting via HIOS, you must upload the completed template to the Benefits and Service Area Module of HIOS by the required deadline. ◆ If you are submitting via SERFF, submit one identical Transparency in Coverage Template containing all plan IDs in each submission binder. For example, if you submit an Individual market binder and a SHOP binder, include both the Individual market plan IDs and the SHOP market plan IDs in one Transparency in Coverage Template and submit it in each binder.

Additional Resources
◆ There are supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

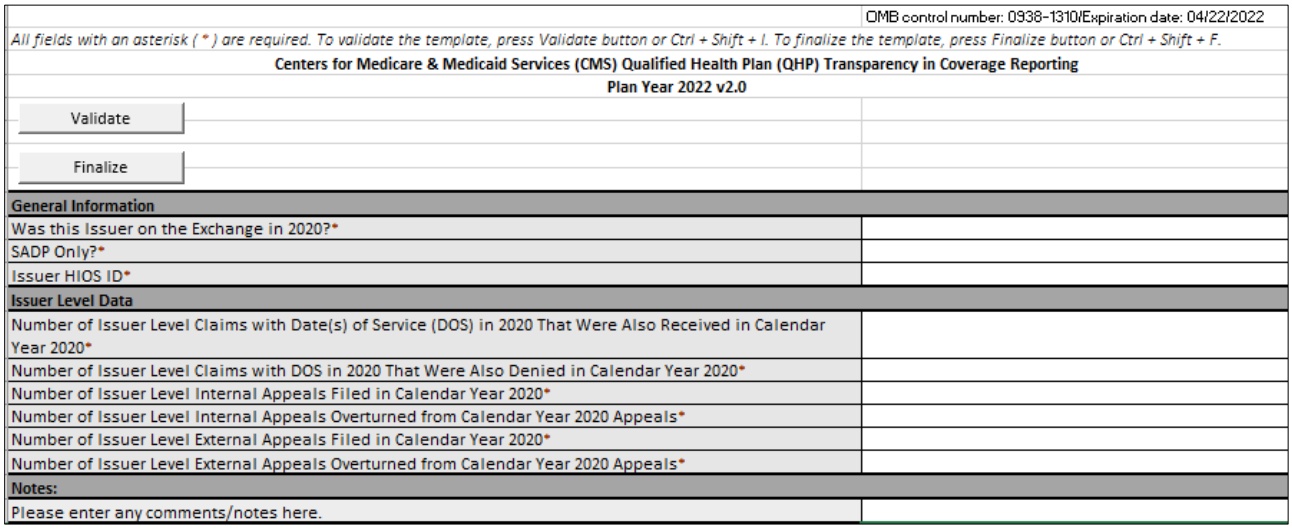
4. Transparency in Coverage Template

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

Note if you are submitting via SERFF: You must include all plan IDs you wish to offer in one Transparency in Coverage Template and submit that template in all binders. The HIOS system allows only one template submission. If you submit two 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 last template your state transfers from SERFF to HIOS will be retained; the information submitted in previous templates will be overwritten. Adding all plan IDs associated with a HIOS Issuer ID to a single template and using it for all binders associated with that HIOS Issuer ID will help you avoid problems related to SERFF overwrite rules.

Example of Successful SERFF Issuer Submission: If you have an Individual market SERFF binder with 3 plan IDs and a SHOP SERFF binder with 7 plan IDs, you should submit identical Transparency in Coverage Templates containing all 10 plan IDs in both binders. Although the first Transparency in Coverage Template will be overwritten by the second, because you have entered all 10 plan IDs in both templates, you will not lose any information and you will submit successfully.

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 2022 v2.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2020?*	
SADP Only?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	
Notes:	
Please enter any comments/notes here.	

Note: If you were not on the Exchange in 2020 or will offer off-Exchange SADPs for 2022, please mark **N/A** for all claims data fields.

4.1 Issuer Level Data Tab

General Information	Steps
Was this issuer on the Exchange in 2020?*	Enter **Yes** or **No** to indicate whether or not this issuer was on the Exchange in 2020. ◆ If **Yes**, the issuer must fill out claims and appeals data. ◆ If **No**, the issuer must enter **N/A** in the claims and appeals data fields. ◆ If the issuer offers only off-Exchange SADPs, enter **No**.
Issuer HIOS ID*	Enter your five-digit HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID.
SADP Only?	Select **Yes** or **No** from the drop-down menu to indicate whether you offer only SADPs.

Issuer Level Data	Steps
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	Enter the number of issuer-level claims you received that asked 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 your network (such as an HMO or PPO). Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value. ◆ A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims). ◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID. ◆ **Claims that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim:** ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason.

Issuer Level Data	Steps
	Do not include out-of-network claims. The value you submit in this field must include in-network claims for all QHPs in 2020, including QHPs not offered in 2022. Therefore, the plan-level claims reported elsewhere in the template may not add to the issuer-level claims reported here.
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Enter the number of issuer-level claims you received that asked 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 your network (such as an HMO or PPO) that you subsequently denied. ◆ A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims). ◆ Include claims for all QHPs that fall under the reporting HIOS Issuer ID. If you have more than one HIOS Issuer ID, submit a separate template for each HIOS Issuer ID. ◆ **Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:** ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2020, including: ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. ◆ **Do not include out-of-network claims.** **The value you submit in this field must include in-network denied claims for all QHPs in 2020, including QHPs not returning to the Exchange in 2022**. Therefore, the sum of plan-level denied claims reported elsewhere in the template may be less than the issuer-level denied claims reported here.
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	Enter the number of requests for internal appeals involving adverse determinations you received from consumers pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage. Include appeals regarding services with DOS in 2020 that you received, fully adjudicated, and completed in 2020. Do not include appeals that were subsequently withdrawn. CMS expects the number of issuer-level internal appeals reported here to be less than the Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for internal review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage.

Issuer Level Data	Steps
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	Enter the number of requests for external appeals of final adverse determinations consumers sent to an external review organization pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals regarding services with DOS in 2020 that you received, fully adjudicated, and completed in 2020. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for external review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

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 2022									
Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020*	Notes: (Please enter any comments/notes here.)

You must include all on-Exchange plan IDs that are present in your PY2022 QHP Application in the Transparency in Coverage Template. If you were not on the Exchange in 2020, enter **N/A** in the claims data fields.

Note: Report all reasons a claim is denied. A claim can be denied for more than one reason. Therefore, the sum of the reasons why claims were denied may either be equal to or greater than the *Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*.

4.2 Plan Level Data Tab

PY2022 Plan Data	Steps
2022 On-Exchange Plan ID*	Enter the 14-character PY2022 On-Exchange plan ID on the Plan Level Data tab. The plan ID is composed of the five-digit HIOS Issuer ID, the two-character state abbreviation, and the seven unique digits for the plan (e.g., 12345AZ1234567). If there is more than one PY2022 plan ID to report for a single HIOS Issuer ID, add each plan 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. For example: ◆ Reported claims for 12345AZ1234567 would include claims that fall under this plan ID from members on all associated plan variants: ▪ 12345AZ1234567-01: 100 claims ▪ 12345AZ1234567-02: 500 claims ▪ 12345AZ1234567-03: 200 claims ▪ 12345AZ1234567-04: 50 claims. Reporting for plan ID 12345AZ1234567 should be entered as one plan ID in one row of the template with a total of 850 claims (100 + 500+ 200+ 50) for the applicable data field.
Number of Plan Level Claims with DOSs in 2020 That Were Also Received in Calendar Year 2020*	Enter the number of in-network plan-level claims you received that asked 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 your network (such as an HMO or PPO). Include pediatric dental and vision claims. Count claims by DOS and report claims data

PY2022 Plan Data	Steps
	with a single numerical value. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. ◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ 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 for any reason, as shown in Footnote 4 should only be counted once. For example, the following each count as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer-level claims received data may include plans not offered in 2022. Therefore, the plan-level claims total may not total the issuer-level claims.
Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020[4] (Plan Level Claims Denied)*	Enter the number of plan-level claims you received that asked 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 you subsequently denied. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. ◆ A claim is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ Include claims for all QHPs that fall under the reporting plan ID. ◆ **Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:** ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately.

[4] For example, if one of your plans were to receive 20,000 claims and deny 3,000 of those claims, you would further report the reasons for the 3,000 denials in one or more of six denial categories:

1. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020
2. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020
3. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020
4. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2020
5. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2020
6. Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020.

In this example, you could report more than 3,000 denial reasons in the six reporting categories if claims were denied for more than one reason, but would only report 3,000 plan-level claims were denied.

PY2022 Plan Data	Steps
	◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2020, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. ◆ Do not include 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 that CMS expects the sum of the six Plan Level Claims Denial categories to be greater than or equal to the Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020 because individual claims may be denied for more than one reason.*
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020 (Plan Level Claims Denied)*	**NOTE: The following claim denial reporting instructions for Columns D, E, F, G, H, and I of the plan-level tab are different than the instructions for claim denial reporting on the issuer-level tab and Column C of the plan-level tab. Rather than reporting denied claims based on their final adjudication, report each incidence of the following denials that occur throughout the life of a claim. For example:** ◆ **For the Issuer-Level tab and Column C of the plan-level tab:** ▪ **If a claim is denied for any reason, then resubmitted and denied again without further resubmission, it will count as one denied claim.** ◆ **For Columns D, E, F, G, H, and I:** ▪ **If a claim is denied for lacking a prior authorization and being an excluded service, then resubmitted and denied again for lacking a prior authorization and being an excluded service, it will count twice in Column D (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020), and twice in Column F (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020).** Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network <u>plan-level</u> denials you issued for non-emergency-related claims for service that required prior authorization, 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 beginning from when a claim was first received to its final adjudication. <u>If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable</u>. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied. ◆ Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification. ◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for requiring a prior authorization, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for requiring a prior authorization, resubmitted with the required documentation, and paid, it will count as one denial in this category. Include claims for all QHPs that fall under the reporting plan ID. Do not include out-of-network claims.

PY2022 Plan Data	Steps
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of plan-level denials you issued for claims for service from outside the plan's network of health care providers if the plan has a closed network beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for point of service benefits provided by someone (e.g., health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plan's (HMO or closed network plans) network. ◆ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for services from an out-of-network provider, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for services from an out-of-network provider, resubmitted with updated documentation, and paid, it will count as one denial in this category. ◆ **Do not include in-network claims.**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan-level denials you issued for claims for excluded or non-covered services. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because certain services, tests, treatments, admissions, supplies, etc., 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 is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied as an excluded service, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied as an excluded service, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health, in Calendar Year 2020 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan-level denials you issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Include the following 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. ◆ Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: ▪ Analgesics

PY2022 Plan Data	Steps
	▪ Anesthetics ▪ Antibacterials ▪ Anticonvulsants ▪ Antidementia Agents ▪ Antiemetics ▪ Antifungals ▪ Antigout ▪ Antimigraine Agents ▪ Antimyasthenic Agents ▪ Antimycobacterials ▪ Antineoplastics ▪ Antiparasitics ▪ Antiparkinson Agents ▪ Antipasticity Agents ▪ Antivirals ▪ Blood Glucose Regulators ▪ Blood Products and Modifiers ▪ Cardiovascular Agents ▪ Central Nervous System Agents ▪ Dental and Oral Agents ▪ Dermatological Agents ▪ Electrolytes/Minerals/Metals/Vitamins ▪ Gastrointestinal Agents ▪ Genetic or 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 ▪ Inflammatory Bowel Disease Agents ▪ Metabolic Bone Disease Agents ▪ Ophthalmic Agents ▪ Otic Agents ▪ Respiratory Tract/Pulmonary Agents ▪ Skeletal Muscle Relaxants ▪ Sleep Disorder Agents. Do not include the following claims: ◆ Behavioral or mental health claims or payment for services. ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Report claims as

PY2022 Plan Data	Steps
	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 for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD. ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied due to lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied due to lacking medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2020 (Plan Level Claims Denied)	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan-level denials you issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat illness, injury, condition disease, or the symptoms of these related to behavioral or mental health beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans must enter a value in this field; 0 is acceptable. If you responded **Yes** to *SADP Only* on the Issuer Level Data tab, no action is required. ◆ Issuers should include the following claims denials for lack of medical necessity (individual claim line of service items): 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 for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the DSM and 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 for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD as well as 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. ◆ **Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied due to lack of medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category. Do not include the following: ◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. ◆ Out-of-network claims.

PY2022 Plan Data	Steps
Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020 (Plan Level Claims Denied)	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan-level denials you issued for claims rejected for reasons other than those specified above beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter **N/A**. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service items): ◆ 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 timeframe for filing a claim ◆ Denial because a procedure is considered experimental, cosmetic, or investigational ◆ **Any other claim denied for any services not appropriate for the previous plan-level categories.** ◆ **Include all instances of a denial that falls in the "other" category throughout the life of a claim in the total reported for this column. For example:** ▪ If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted, and denied again for the same reasons, it will count as **four** denials in this category. ▪ If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted with updated documentation, and paid, it will count as **two** denials in this category. Do not include out-of-network claims.

Verify the following before submitting the PY2022 Transparency in Coverage template:

- Issuer-level claims received reported on the Issuer Level tab is greater than or equal to the sum of claims received across all plan IDs on the Plan Level tab.
- Issuer-level claims denied reported on the Issuer Level tab is greater than or equal to the sum of claims denied across all plan IDs on the Plan Level tab.
- Issuer-level claims denied reported on the Issuer Level tab is greater than or equal to the Number of Issuer Level Internal Appeals Filed in Calendar Year 2020.
- Sum of Plan Level reasons for denied claims (Columns D, E, F, G, H, and I) is greater than or equal to reported claims denied (Column C) for each plan ID.

4.3 Transparency in Coverage Template Submission for Issuers Not Subject to Reporting Requirements

To apply for PY2022 QHP certification, you must submit a Transparency in Coverage Template that includes all your PY2022 plan IDs. You cannot submit your QHP Application without this template. However, the following issuers are not required to submit Transparency in Coverage data as described in 4.1 Issuer Level Data Tab and 4.2 Plan Level Data Tab:

- Issuers that are new to the Exchange
- Off-exchange certified SADPs.

Off-Exchange-only issuers (non-QHP) that are not seeking certification are not required to submit a Transparency in Coverage Template and do not have a data reporting requirement at this time.

This section describes how to submit the Transparency in Coverage Template without reporting numerical transparency data. You will enter a **HIOS Issuer ID** in the Issuer Level Data tab (Figure 2E-3) and all PY2022 plan IDs in the Plan Level Data tab (Figure 2E-4). **N/A** must be entered in data fields as indicated below.

4.3.1 Issuers With no Data Reporting Requirement—Issuer Level Data Tab

General Information	Expected Value
Was this issuer on the Exchange in 2020?*	No
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID.

Issuer Level Data	Expected Value
Number of Issuer Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	**N/A**
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	**N/A**
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	**N/A**
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	**N/A**
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	**N/A**
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	**N/A**

Figure 2E-3. Sample Data Template With No Reporting Requirement—Issuer Level Tab

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2022 v2.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2020?*	No
SADP Only?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2020 That Were Also Received in Calendar Year 2020*	N/A
Number of Issuer Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2020*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2020 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2020*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2020 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	N/A

4.3.2 Issuers With no Reporting Requirement—Plan Level Data Tab

Plan Level Data	Expected Value
2022 On-Exchange Plan ID*	Enter the 14-character PY2022 plan ID on the Plan Level Data tab. You must include all on-Exchange plan IDs present in your QHP Application (do not include plan IDs for off-Exchange only plans) on the Plan Level Data tab.
Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	**N/A**

Plan Level Data	Expected Value
Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2020 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2020 (Plan Level Claims Denied)	**N/A**
Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020 (Plan Level Claims Denied)	**N/A**

Figure 2E-4. Sample Data Template With No Reporting Requirement—Plan Level Tab

Plan Year 2022									
Plan Level Data									
Plan ID*	Number of Plan Level Claims with DOS in 2020 That Were Also Received in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2020*	Number of Plan Level Claims with DOS in 2020 That Were Also Denied for "Other" Reasons in Calendar Year 2020*	Notes: (Please enter an comments/notes here.)
11111VA1111111	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

5. Claims Payment Policy and Other Information URL

To apply for PY2022 QHP certification, you must enter a Transparency in Coverage URL in the SSM, including those with off-Exchange SADP offerings. You cannot submit your network URLs without submitting the Transparency in Coverage URL at the same time as or before the network URLs.

Although a URL submission is required to apply for PY2022 QHP certification, you are required to submit an active URL that directs to a compliant claims payment policy website only if you offer on-Exchange QHPs and SADPs. If you offer only off-Exchange SADP offerings, complete the SSM using **http://temporary.url**.

Issuer Type	Acceptable URL Submission
QHP issuer	Active URL directing to compliant claims payment policies
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 information you must include on the Transparency in Coverage URL's web page and examples of how you might explain it.

PY2022 URL Contents	Minimum Requirements
Claims Payment Policies & Other Information URL	Enter the active and easily accessible URL. Ensure it meets the following requirements: ◆ It can be viewed on the plan's public website via a clearly identifiable link or tab on the issuer's home or marketplace plan landing page without requiring an individual to create or access an account or enter a policy number ◆ 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 directs consumers to the page on your website they can use to view pertinent information about your practices. All URLs should be live and compliant when you submit them, with one URL for a landing page or a single page with one or more links providing the information indicated below. If you have unique HIOS Issuer IDs in the same state and the Transparency in Coverage information is the same across the HIOS Issuer IDs, you may submit the same URL for all 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 the amount remaining on a deductible. Provide: ◆ Information regarding whether a consumer may have financial liability for out-of-network services. ◆ Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act. ◆ Information regarding whether a consumer may be balance billed. You do not need to include specific dollar amounts for out-of-network liability or balance billing. Example of Acceptable Consumer-Facing 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. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.
Enrollee claim submission	Description: ◆ An enrollee submits a claim instead of the provider, requesting payment for services 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, indicate this here. ◆ A time limit to submit a claim, if applicable. ◆ Links to any applicable forms. All forms must be easily identifiable and publicly accessible. ◆ Describe how an enrollee can submit a claim if you do not require any forms. List any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission. ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. Example of Acceptable Consumer-Facing Language: A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. Please contact customer service at [phone number] to determine the specific time limit for submitting your claim.

PY2022 URL Contents	Minimum Requirements
	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 below. [Company Name] [P.O Box 1234] [City, State, ZIP Code] 5. Alternatively, you can send the information by email to [claims-submissions@companyname.com] or by fax to [123-456-7890].
Grace periods and claims pending	Description: ◆ If you are a QHP issuer, you 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, you 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 you 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 Consumer-Facing 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 3-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 3-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 3-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.
Retroactive denials	Description: ◆ A retroactive denial reverses a previously paid claim, making the enrollee 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 Consumer-Facing 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 having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible.

PY2022 URL Contents	Minimum Requirements
	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: ◆ If you overbill an enrollee for a premium, they may use recoupment of overpayments to obtain a refund. Provide: ◆ Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact. Example of Acceptable Consumer-Facing 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 timeframes 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 by which an issuer approves a request to access a covered benefit before the enrollee 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 issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable. Example of Acceptable Consumer-Facing Language: We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. 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. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.
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 exceptions process for people to obtain non-formulary drugs. ◆ An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or Independent Review Organization (IRO). ◆ Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. ◆ Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact. Example of Acceptable Consumer-Facing 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.

PY2022 URL Contents	Minimum Requirements
	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 you send an enrollee that lists the medical treatments or services you paid for on an enrollee’s behalf, what you paid, 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 (e.g., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. Example of Acceptable Consumer-Facing Language: Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It 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.
Coordination of benefits (COB)	Description: ◆ COB allows an enrollee who is covered by more than one plan to determine which plan pays first. Provide: ◆ An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). Example of Acceptable Consumer-Facing 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.

After you complete the template, submit it in the Benefits and Service Area Module of HIOS and submit your Transparency in Coverage URL in the SSM. If you are submitting via SERFF, submit your Transparency in Coverage Template in your SERFF binders. To resubmit or correct any data errors, follow the resubmission steps in these instructions. If you need to correct URL errors, you should update your live URL page.

After you have entered all data, click **Save** to ensure no data are lost. This completes the Instructions for the Benefits and Service Area Module of the PY2022 QHP Application. The next section of the Instructions for the PY2022 QHP Application is the Rating Module.