

Qualified Health Plan Issuer Application Instructions

Plan Year 2024

04/2023

PY2024 QHP Instructions: Revisions

Changes made after initial document posting are listed by section.

Section	Change

Terminology Guide

Abbreviation	Term
AAAHHC	Accreditation Association for Ambulatory Health Care
API	application programming interface
AV	actuarial value
AVC	Actuarial Value Calculator
BPCK	brand name pack
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	<i>Code of Federal Regulations</i>
CMS	Centers for Medicare & Medicaid Services
COA	certificate of authority
COB	coordination of benefits
CSR	cost-sharing reduction
DCR	data change request
DDS	doctor of dental surgery
DMD	doctor of dental medicine
DO	doctor of osteopathy
DOS	date of service
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECP	essential community provider
EHB	Essential Health Benefit
EOB	explanation of benefits
EPO	exclusive provider organization
FF-SHOP	Federally-facilitated Small Business Health Options Program
FFE	Federally-facilitated Exchange
FIPS	Federal Information Processing Standards
FTE	full-time equivalent
GPCK	generic pack
HDHP	High Deductible Health Plan
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HMO	health maintenance organization
HPSA	health professional shortage area
HRA	health reimbursement arrangement
HSA	health savings account
ICD	International Classification of Disease
IP	in patient

Abbreviation	Term
IRO	independent review organization
ISS	Interactive Survey System
MD	medical doctor
MOOP	maximum out-of-pocket
MPMS	Marketplace Plan Management System
MSP	multi-state plan
NA	network adequacy
N/A	not applicable
NADP	National Association of Dental Plans
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NP	nurse practitioner
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
PA	physician assistant
PHS	Public Health Service (Act)
PM	plan management
POC	point of contact
POS	point of service
PPACA	Patient Protection and Affordable Care Act
PPO	preferred provider organization
PY	plan year
QHP	qualified health plan
QIS	quality improvement strategy
RBIS	Rate & Benefits Information System
RXCUI	RxNorm Concept Unique Identifiers
SADP	stand-alone dental plan
SBC	summary of benefits and coverage
SBD	semantic branded drug
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SCD	semantic clinical drug
SERFF	System for Electronic Rates & Forms Filing
SHOP	Small Business Health Options Program
TTY	term types
UMLS	Unified Medical Language System
URR	Unified Rate Review
URRT	Unified Rate Review Template
U.S.C.	<i>United States Code</i>
USP	United States Pharmacopeia

Contents

Qualified Health Plan Issuer Application Instructions.....	i
PY2024 QHP Instructions: Revisions.....	ii
Introduction: Qualified Health Plans for PY2024.....	1
Overview of the QHP Certification Process.....	1
QHP Application Submission Process.....	1
QHP Application Sections, Associated Templates, and Supporting Documentation.....	3
Review Periods, Revision Process, and Certification.....	4
New for PY2024.....	5
Review Tools.....	6
Using This Document.....	6
1. Using the Marketplace Plan Management System Module.....	1-1
1.1 SERFF Issuers and MPMS.....	1-2
2. Completing the QHP Application.....	2-1
Section 2A: Administrative.....	2A-1
Section 2B: Interoperability.....	2B-1
Section 2C: Program Attestations.....	2C-1
Section 2D: Business Rules.....	2D-1
Section 2E: Essential Community Providers/Network Adequacy.....	2E-1
Section 2F: Network ID.....	2F-1
Section 2G: Plans & Benefits.....	2G-1
Section 2H: Prescription Drug.....	2H-1
Section 2I: Service Area.....	2I-1
Section 2J: Accreditation.....	2J-1
Section 2K: Transparency in Coverage.....	2K-1
Section 2L: Rates Table.....	2L-1
Section 2M: URL Collection.....	2M-1
Appendices	
Appendix A: Actuarial Value Calculator	
Appendix B: Plan ID Crosswalk	
Appendix C: Supporting Documentation	
Appendix D: Review Tools	
Appendix E: Understanding Issuer Types	
Appendix F: Network Adequacy Standards	
Appendix G: Standardized Plan Option Requirements	

Introduction: Qualified Health Plans for PY2024

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 to display for consumers selecting insurance plans on [HealthCare.gov](https://www.healthcare.gov). This document is addressed to issuers who intend to submit a completed QHP Application for plan year (PY) 2024 certification.

Overview of the QHP Certification Process

You must complete and submit a QHP Application that includes all plans you intend to offer on the Federally-facilitated Exchange (FFE) each year. During the annual application and certification process, you ensure the plans you submit comply with the PPACA and all applicable regulations. We recommend reading all applicable published guidance, including the following items that can be found on the [Center for Consumer Information and Insurance Oversight \(CCIIO\) website](https://www.cciio.gov):

- The yearly “Letter to Issuers” provides guidance on offering QHPs, including stand-alone dental plans (SADPs), in the FFEs and in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs).
- The annual Notice of Benefit and Payment Parameters (Payment Notice) sets new standards to improve consumers’ Exchange experience.
- The Market Stabilization Final Rule of 2017, the PPACA Exchange and Insurance Market Standards for 2015, and Beyond Final Rule of 2014 provide additional relevant guidance and regulations.
- The *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year* guidance sets payment parameters.

You can also visit the [QHP certification website](https://www.cciio.gov) for these and other resources. The CCIIO website also has general guidance on the [Health Insurance Market Reforms](https://www.healthinsurance.gov) and on the [Health Insurance Marketplaces](https://www.healthinsurance.gov).

QHP Application Submission Process

You will submit templates, supporting documentation, and justifications for all plans you intend to have certified as part of your QHP Application, and make all necessary revisions to your QHP Application before the deadline.

In PY2024, the deadline for submitting the QHP Application Rates Table Template is later than the general QHP Application initial submission deadline. You will submit a complete QHP Application—except for the QHP Rates Table Template and On-Exchange Marketing URLs (Summary of Benefits and Coverage [SBC], Plan Brochure, Payment, Network, Formulary)—by the initial submission deadline. You may submit the QHP Rates Table Template by the initial submission deadline, but no later than the secondary deadline. You can find all deadlines in the [PY2024 QHP Data Submission and Certification Timeline bulletin](https://www.cciio.gov).

We rely on systems that automate the data collection and validation process. The systems you will use to submit your QHP Application materials depend on the Exchange model your state uses. Review our list of [Submission Systems](https://www.cciio.gov) for information on which system you should use to file your QHP Applications and supporting data.

If you are applying for QHP certification in a state that does not perform plan management functions, you must submit your QHP Applications in the Health Insurance Oversight System (HIOS).

Some FFE states that do not perform plan management functions may choose to collect plan data, which may include copies of the QHP templates, in both HIOS and in the National Association of Insurance Commissioners’ (NAIC’s) System for Electronic Rates & Forms Filing (SERFF). If your state collects some plan data via SERFF, you must also submit your complete QHP Application in HIOS. The Centers for Medicare & Medicaid Services (CMS) does not receive your plan data from SERFF for FFE states.

If your state performs plan management functions, you should submit QHP Applications in SERFF in accordance with state and CMS review deadlines. Your state will transfer all QHP Application data as specified in state guidance.

No matter your state, you must submit the Unified Rate Review Template (URRT) to CMS (see [Rate Review Bulletin](#) for deadlines). Issuers in states without an Effective Rate Review Program or states that do not use the SERFF system (currently OK, WY, and FL) submit rate filings directly in the HIOS Unified Rate Review (URR) Module. Issuers in all other states submit rate filings in SERFF. Dental issuers do not need to submit rate filings.

SADP Issuers

You may offer SADPs if you participate in the dental market as a dental-only issuer or in the medical and dental markets as a dual-product issuer. Certain sections of the QHP Application do not apply to and are not required for dental-only issuers.

SADP or dual issuers must offer the pediatric dental EHBs in the individual and small group markets. Medical QHPs are not required to offer pediatric dental EHBs on the Exchange in states where pediatric dental EHBs are covered by an SADP on the Exchange.

Use HIOS or SERFF as applicable to your state to complete the relevant application sections and templates.

HIOS

You must register in HIOS to obtain a HIOS Issuer Identifier (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. Within HIOS there are several modules used to submit and review application data.

- The Marketplace Plan Management System (MPMS) is a new web application replacing most previous HIOS QHP Modules. It is where FFE issuers submit plan benefit, rating, and business data to CMS. All QHP applicants, including issuers in states performing plan management functions and State-based Exchange on the Federal Platform (SBE-FP) states, will access the Plan Validation Workspace in MPMS and also submit URL and Interoperability data to this module. MPMS consists of the following components:
 - **Home Page:** This is where you can access announcements pertaining to applications and metrics about any applications started.
 - **Plan Validation Workspace:** This is where you can upload QHP templates for validation and receive validation results at any time, including before submitting a QHP Application. Issuers in states performing plan management functions and SBE-FP states have access to the workspace to validate data before submitting a QHP Application in SERFF.
 - **QHP Applications:** This is where you can create new QHP Applications, update Applications, submit Applications to CMS for review, receive review results for several Application areas, and make corrections as needed throughout the certification process.
 - **Issuer Details (available in a future MPMS release):** This is where you can maintain cross plan year data, including updating machine readable (MR) URLs.
 - **Plan Preview (available in a future MPMS release):** This is where you view PY2024 plan and issuer data as it will display in Plan Compare on [HealthCare.gov](#) if you plan to offer QHPs or on-Exchange SADPs.
- **Plan Finder Product Data Collection Module:** This is where you submit, review, and modify administrative data. Refer to the [HIOS Plan Finder – Issuer User Manual](#) for detailed instructions.
- **QHP Plan Preview Module:** This is where you view PY2023 plan data and issuer data as it will display in Plan Compare on [HealthCare.gov](#) for your PY2023 QHPs or on-Exchange SADPs. Refer to the [Plan Preview User Guide](#) for more information.

- **Unified Rate Review System Module:** This is where you submit the URRT if you are an issuer in a state without an Effective Rate Review Program or in a state that does not have access to SERFF (currently OK, WY, and FL). Refer to the [Unified Rate Review System Module User Guide](#) for detailed instructions. A rate filing in SERFF automatically uploaded to the Unified Rate Review System Module of HIOS is considered as filed with CMS.

SERFF

If your state performs plan management functions or operates an SBE-FP, you will submit your QHP Application via SERFF and HIOS MPMS (see Section 1.1 [SERFF Issuers and MPMS] for additional detail on how SERFF issuers will use MPMS). If your state has an Effective Rate Review Program, submit your rate filing (including the URRT) via SERFF. Contact your state regulator 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, contact the relevant state.

Plan Management Community

Issuers use the Plan Management (PM) Community to review QHP Application data submitted to CMS and complete QHP certification-related activities. Issuers that are required to submit Plan ID Crosswalk data to CMS (i.e., on-Exchange issuers certified in the previous plan year), submit those templates in the “Plan ID Crosswalk” tab of the PM Community. Issuers also retrieve and submit their essential community provider (ECP) and Network Adequacy justification documentation in the “ECP/NA Justifications” tab of the PM Community. The PM Community is also used to view results of certain reviews.

Refer to the [PM Community webpage](#) of the QHP certification website for more information on using this system.

QHP Application Sections, Associated Templates, and Supporting Documentation

The QHP Application consists of Excel templates and supporting documents that issuers must complete with issuer and plan data. Table 1 lists materials required for the HIOS submission process.

Note: Not all QHP Application sections require the submission of supporting documentation or justifications. Table 1 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 issuers should use when naming the supporting documentation or justification.

Table 1. Required Materials

MPMS Group	Application Area	Required Materials
Issuer Attestations and Administrative Information	Administrative	◆ <i>Marketplace General Information</i> fields in the HIOS Plan Finder Module ^a
Issuer Attestations and Administrative Information	Interoperability	◆ Interoperability Attestations in MPMS (not required for SADP-only, FF-SHOP, and SBE-FP issuers) ◆ Interoperability Justification ◆ Interoperability URL(s)
Issuer Attestations and Administrative Information	Program Attestations	◆ Attestation responses in MPMS (FFE issuers) ^a ◆ State Partnership Exchange Issuer Program Attestation Response Form in SERFF (SBE-FP issuers should follow state guidance)
Plan Business Rules	Business Rules	◆ Business Rules Template ^a

MPMS Group	Application Area	Required Materials
Plan Attributes	Plans & Benefits	<ul style="list-style-type: none"> ◆ Plans & Benefits Template^a ◆ Plans & Benefits Add-In^a ◆ Plans & Benefits Add-In Change Log ◆ Standardized Plan Options Add-In ◆ Actuarial Value (AV) Calculator Screenshot ◆ Discrimination—Cost-Sharing Outlier: Supporting Documentation and Justification ◆ EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification ◆ Unique Plan Design—Supporting Documentation and Justification
Plan Attributes	Prescription Drugs	<ul style="list-style-type: none"> ◆ Prescription Drug Template ◆ Combined Prescription Drug Supporting Documentation and Justification ◆ Discrimination—Treatment Protocol Supporting Documentation and Justification ◆ Adverse Tiering Supporting Documentation and Justification^c
Plan Attributes	Service Area	<ul style="list-style-type: none"> ◆ Service Area Template^a ◆ Service Area Partial County Supplemental Response ◆ Evidence of state approval of the partial county (FFE issuers)
Plan Attributes	ECP/Network Adequacy (NA) & Network ID	<ul style="list-style-type: none"> ◆ ECP/NA Template^a ◆ Network ID Template^a ◆ ECP Justification Form (received and submitted via PM Community)^a ◆ NA Justification Form (received and submitted via PM Community)^a ◆ ECP Write-in Worksheet^a
Issuer Accreditation	Accreditation	<ul style="list-style-type: none"> ◆ Responses to terms and conditions ◆ Quality Improvement Strategy (QIS) ◆ Accreditation Certificate
Transparency Data	Transparency in Coverage	<ul style="list-style-type: none"> ◆ Transparency in Coverage Template ◆ Transparency in Coverage URL
Plan Rates	Rates Table	<ul style="list-style-type: none"> ◆ Rates Table Template^a
Issuer URLs	URL	<ul style="list-style-type: none"> ◆ URLs for plan information^a
HIOS Module	Application Area	Required Materials
Unified Rate Review Module	Unified Rate Review	<ul style="list-style-type: none"> ◆ Unified Rate Review Template
PM Community	Application Area	Required Materials
Plan ID Crosswalk tab	Plan ID Crosswalk	<ul style="list-style-type: none"> ◆ Plan ID Crosswalk Template^b

^a Applicable to SADP issuers.

^b Applicable to returning issuers.

^c Available for upload in a future MPMS release

Review Periods, Revision Process, and Certification

QHP certification involves data submission, data review, and data revision (as necessary). We provide several opportunities for data submission. You must submit your materials by each QHP Application submission deadline so that we can review them for compliance with market-wide standards and other regulations.

For the PY2024 QHP Application submission process, CMS will release review results to issuers in MPMS and the PM Community. These review results include required corrections that issuers need to make to their applications, a description of how to correct the errors, and the affected review area.

We will again offer an optional “Early Bird” review round. If you submit complete QHP Applications by the Early Bird submission deadline, we will review your applications and post review results in MPMS and the PM Community before the initial submission deadline.

Between the initial submission deadline and the final submission deadline, you may make necessary changes to your QHP Application, including any changes mandated in our review, and upload and submit revised QHP data templates. After the close of the final submission deadline, issuers in FFE states and states performing plan management functions must submit a data change request (DCR) to make data changes to QHP data templates. DCRs are generally not required for issuers to submit CMS-identified corrections. Issuers in SBE-FPs do not submit DCRs to CMS, and should work with their state to make changes. All data submitted may be subject to compliance action, including issuer- and state-requested changes. All data submitted may be subject to compliance action, including issuer- and state-requested changes. All CMS-identified data errors and corrections must be addressed before the affected QHPs may be certified or displayed on [HealthCare.gov](https://www.healthcare.gov).

We certify plans based on the information contained in the application. After final submission, you must notify CMS and your state regulator if you intend to alter a QHP Application. We reserve the right to revisit the certification of any plan. We also reserve the right to decertify a plan during the plan year if we determine information in the relevant QHP Application is inaccurate, is incomplete, or does not meet certification standards or program requirements.

We will routinely monitor ongoing compliance with certification standards and other program requirements. These standards and requirements remain in place throughout the entire plan year.

We certify each plan’s compliance with QHP standards based on our review of the application and any information we receive from the applicable state regulator, including appropriate state approvals. Regardless of our determinations, you must comply with all applicable state and federal requirements.

New for PY2024

- The MPMS Module is the new system used for completing the QHP Application submission process. Refer to the [MPMS User Guide](#) for details on how to access the system and submit templates and other data needed for the QHP Application.
- There is new guidance for plan variant marketing names to ensure compliance with requirements at 45 CFR 156.225(c). See the Plans & Benefits Section 4.10.1 for additional detail.
- There are new Prescription Drug Template requirements for standardized plan options. Within the Prescription Drug Template, for Standardized Plan Options, you should enter zero cost share preventive drugs for tier one, generic drugs for tier two, preferred brand drugs for tier three, non-preferred brand drugs for tier four, specialty drugs for tier five, and medical service drugs for tier six, if applicable.
- There is new Plan Compare logic for display of separate Rx deductible. Refer to Section 5.9 and 5.10 of the Plans & Benefits instructions for detail.
- Per the Final HHS Notice of Benefit and Payment Parameters for 2024, SADP issuers must use an enrollee’s age at the time of policy issuance or renewal (referred to as age on effective date) as the sole method to calculate an enrollee’s age for rating and eligibility purposes. SADP issuers must also submit guaranteed rates beginning with Exchange certification for PY2024.
- All issuers must use a provider network to operate on the Marketplace and submit their provider network data within the ECP/NA Template.
- Instead of submitting supplemental documents for EHB Allocation and Actuarial Value (AV) as in prior years, issuers that offer SADPs will attest to requirements for SADPs in the Program Attestation section of the application.

- New Issuer Level and Plan Level data fields were added to the Transparency in Coverage template. See Transparency in Coverage instructions for additional detail.
- In the PY2024 AVC, copays paid during the deductible phase for services that are not subject to deductible will no longer accrue toward the deductible and instead count toward the maximum out-of-pocket (MOOP).
- Two new supplemental documents are included:
 - Interoperability Justification: Previously collected in a webform, issuers must use this supplemental document to provide their justification responses in the Interoperability section.
 - Discrimination–Adverse Tiering Supporting Documentation and Justification: Issuers will use this supplemental document to address drug tier coverage corrections.

Review Tools

Review tools are provided to facilitate states' review of issuers' QHP Application data, and to help them identify errors that would require corrections. While all issuers may use the review tools, CMS requires that FFE issuers use the Plan Validation Workspace to validate their data and identify any errors that require correction before submission, as the Plan Validation Workspace performs additional validations that are not included in the public facing tools. For this reason, SERFF issuers are also required to use the Plan Validation Workspace prior to making their submission.

Appendix D: Review Tools provides a high-level description of each tool's functionality.

Using This Document

This document uses screenshots and written guidance to explain each step required to complete the PY2024 QHP Application. Hyperlinks throughout the document will direct you to external content that you may need to use to complete your application.

Bolded text indicates items and information that you will use, enter, or select from a drop-down menu, such as the option **Yes** to indicate that you agree to an attestation.

Italicized text indicates the names of fields into which you will enter information, such as your *HIOS Issuer ID*. *Italicized text* may also be used to indicate document titles, such as the *HHS Notice of Benefit and Payment Parameters for 2024*.

Underlined text is used for emphasis, such as to specify that you should not complete a certain step.

Hyperlinks are indicated with blue font and are underlined. Clicking a hyperlink will direct you to a location outside of this document to reference additional information.

The remainder of this document will serve as step-by-step instructions for completing the PY2024 QHP Application, navigating through MPMS, and identifying specific policy and submission criteria for each section.

1. Using the Marketplace Plan Management System Module

The process for completing templates is the same as that of prior plan years; however, the steps for submission have changed. Rather than submitting templates and supporting documents in the Issuer, Benefits & Service Area, Rating, and Supplemental Submission Modules, you will submit them in the relevant section of the MPMS Module. You will not submit the following templates and documents in MPMS: the Plan ID Crosswalk Template is submitted in the PM Community, the ECP and NA Justifications are retrieved from and submitted in the PM Community, and the URRT is submitted in SERFF (or in the URR Module if you are an issuer in a state without an Effective Rate Review Program or in a state that does not have access to SERFF).

The QHP Application is divided into sections and groupings within MPMS. These instructions are ordered according to how sections are grouped in the QHP Application. Refer to Table 1 for detail regarding group names, corresponding sections, and materials required to complete each section. Note that the sections displayed will depend on your product and market type, as indicated by the issuer in its application. For example, SADP-only issuers will not see the Interoperability section because SADP-only issuers are not required to submit Interoperability data.

After populating your templates and creating .XML versions, you will upload the .XML files to the Plan Validation Workspace to validate and cross validate each of your templates. Once a template is found to have no errors, it can be linked to the appropriate section of the application.

After you have linked the validated templates to the corresponding application section, you can then submit any necessary supporting documents. Once each section in a grouping is completed, you may submit that application grouping to CMS for review.

Application sections will display one of the following statuses:

- *In Progress*: Application section has been started but a valid template or supplemental documentation is missing. A section may also be *In Progress* if an attestation is completed but other data is needed.
- *Ready to Submit*: All necessary components of the section, including (as applicable) linked templates, uploaded supporting documentation, and responses to questions have been completed.

Each application grouping will display one of the following statuses:

- *Not Started*: None of the application sections within the grouping has been started.
- *In Progress*: One or more application sections within the grouping has been started.
- *Submitted – Under Review*: All application sections within the group were submitted for CMS review. While the group is in this status, no changes can be made to any section within the group.
- *Corrections Required*: Reviews were completed for all applicable application sections in the group and required corrections were identified for one or more sections. Make the required changes to your application and resubmit the group for review.
- *No Action Required*: Reviews were completed for all application sections in the group and no corrections were required. While the group is in this status, changes can be made to any section within the group.

Once all groupings are in a status of *No Action Required* the QHP Application is complete and no further revisions are required. However, data and supporting documents may be updated if changes are desired and are made before the applicable deadline.

Detailed instructions on how to use the Plan Validation Workspace, complete the sections of an application, and submit the application can be found in the [MPMS User Guide](#).

1.1 SERFF Issuers and MPMS

SERFF issuers will submit the majority of their data through SERFF, but will use MPMS directly to do the following:

- Use the Plan Validation Workspace
- Create a QHP Application
- Review and verify Administrative data
- Submit Interoperability Attestations, Interoperability URL, and Interoperability Justification, if necessary
- Submit Transparency in Coverage URL
- Submit On-Exchange Marketing URLs.

SERFF issuers are required to use the Plan Validation Workspace in MPMS to validate templates before submitting them to SERFF. The Plan Validation Workspace will identify validation errors and allow the issuer to correct data before SERFF submission, perform cross validations on their data, and provide validation warnings regarding data issues that will not prevent submission, but that may need additional attention from issuers to resolve. While SERFF Validate & Transform has been enhanced for PY2024, it will identify only validation errors. Thus, issuers are required to use the Plan Validation Workspace to ensure receipt and review of their validation warnings.

SERFF issuers are strongly encouraged to log in to MPMS to create a new QHP Application before their state transfers data from SERFF to MPMS. This approach will allow MPMS to customize the application appropriately to display only the sections that are required for the issuer to complete. This approach also allows the issuer to review and submit data that are not dependent on the state transfer of data from SERFF, including Administrative data, Transparency in Coverage URLs, and Interoperability data.

Note that successful transfer of data to HIOS from a SERFF state does not complete submission of the application to CMS. Additionally, SERFF issuers will be required to submit the Plan Rates group of the application before the secondary submission deadline, which will allow MPMS to perform and return cross validation results against the issuer's URR submission.

2. Completing the QHP Application

The following instructions sections provide additional detail about submitting required data for the QHP Application. This includes how to complete the QHP Application templates and submit them in the MPMS.

Section 2A: Administrative

1. Introduction

In the Administrative section, issuers provide company specific information that displays to consumers. Administrative information displayed on the [Healthcare.gov](https://www.healthcare.gov) website will be pulled from the *Issuer Marketplace Information* fields in the HIOS Plan Finder Module. This applies to all qualified health plan (QHP) and stand-alone dental plan (SADP) issuers, including those who file through the System for Electronic Rate & Form Filing (SERFF).

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

- QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To enter or update your Administrative data, you must have the Submitter role for the HIOS Plan Finder Module. Instructions on how to update fields in the HIOS Plan Finder Module are contained in Section 3.2 of the [HIOS Plan Finder—Issuer User Manual](#).

3. Quick Reference

Key Changes for 2024

- ◆ Issuers will need to review their Administrative data within the Marketplace Plan Management System (MPMS) to determine if required fields are missing.

Tips for the Administrative Section

- ◆ Ensure you have the Submitter role in HIOS.
- ◆ Ensure you complete the *Issuer Marketplace Information* fields in HIOS (not the *Issuer General Information* fields).

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are no instructional videos for this section.
- ◆ There are no templates for this section.

4. Detailed Section Instructions

Once in MPMS, navigate to the Administrative section in your QHP application. The section will identify if you have missing fields and whether the missing fields are required (errors) or optional (warnings). You must make any required corrections within HIOS Plan Finder. Changes made to the HIOS Plan Finder will refresh and be displayed in MPMS.

All issuers, including issuers that submit via SERFF will need to review their Administrative data within MPMS to determine if required fields are missing.

This concludes the Administrative section of the QHP Application Instructions.

Section 2B: Interoperability

1. Introduction

In the Interoperability section of MPMS, you are required to provide responses to attestations related to interoperability requirements. This is required of Medical QHP issuers, including those that issue plans in a state performing plan management functions, to provide responses to attestations related to interoperability requirements. Attestations are used to evaluate issuer compliance with the requirements finalized in the Interoperability and Patient Access Final Rule published on May 1, 2020. The rule specified that by July 1, 2021, issuers must implement the requirements detailed in *45 Code of Federal Regulations* (CFR) 156.221. These requirements consist of the implementation and maintenance of a patient access application programming interface (API) and related documentation. If issuers cannot respond affirmatively to each attestation, they must provide a justification using the Interoperability Justification Form.

Issuers in State-based Exchanges on the Federal Platform or issuers that only offer SADPs or plans in the Federally-facilitated Small Business Health Options Programs are not required to complete these attestations and will not see the Interoperability section within their QHP Application in MPMS.

2. Data Requirements

To complete this section, you will need the following:

1. Interoperability Justification Form. Only required if you respond “No” to any attestation.

3. Quick Reference

Key Changes for 2024

- ◆ If you are applying to certify Medical QHPs, you must still respond to the Interoperability Attestations, however justifications will be submitted via the Interoperability Justification Form uploaded in MPMS rather than in a free text box as in PY2023.

Tips for the Interoperability Section

- ◆ Respond to all questions on the web-based form to attest to compliance with each requirement. If you respond “No” to any attestation, you must submit the Interoperability Justification Form. Verify that submitted URLs are live and active.
- ◆ Verify that sign-in or registration are not required to access API documentation to ensure submitted URLs meet the public accessibility requirements.

Additional Resources

- ◆ There are [supporting documents](#) for this section
- ◆ There are no instructional videos for this section.
- ◆ There are no templates for this section.

4. Detailed Section Instructions

Issuers must complete four Interoperability Attestations related to key provisions of the Interoperability and Patient Access Rule (45 CFR 156.221). The issuer must provide a “Yes” or “No” answer for each attestation. Issuers must also provide publicly accessible URL(s) which demonstrate compliance with the requirements specified at 45 CFR 156.221(d) and 45 CFR 156.221(g) for Attestation 3 and 4. Issuers will submit at least one URL for Attestations 3 and 4 and may choose to submit up to two if needed. Issuers should check that URLs are

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

- QHP
- See Appendix E for additional information.

live and active at the time of submission. URLs should not require any special effort to access, including requirements to sign in or create an account.

Issuers that answer “No” to any of the four attestations must use the Interoperability Justification Form to provide the following details:

- The date (a single date specifying month, day, and year) by which all referenced requirements in questions 1–4 will be fully implemented.
- A description of how the non-implemented requirements will impact enrollees until such time as they are fully implemented. Specifically, detail what functionality, data elements, or guidance will not be accessible to enrollees until full implementation is achieved. Also, describe how enrollees currently access all health information maintained by the issuer prior to full implementation.
- The root cause for implementation delay and issuer’s plan for completing implementation by stated date.

Additional details for each attestation are listed below:

Attestation 1: A secure API and its necessary features are detailed in full in 45 CFR 156.221(c). You may also read our [Best Practices for Payers and App Developers](#) document online, which includes implementation and testing guidance for payers.

Attestation 2: The information detailed in full in 45 CFR 156.221(b) includes the following:

- a. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are being appealed, and provider remittances and enrollee cost-sharing pertaining to such claims, no later than 1 business day after a claim is processed.
- b. Encounter data from capitated providers, no later than 1 business day after data concerning the encounter is received by the QHP issuer.
- c. Clinical data, including laboratory results, if the QHP issuer maintains any such data, no later than 1 business day after data is received by the issuer.

Attestation 3: The information to be included on the issuer’s website is detailed in full in 45 CFR 156.221(d) and includes the following:

- a. API syntax, function names, required/optional parameters and their data types, return variables and their types/structures, and exception and exception handling methods and their returns.
- b. Software components and configurations an application must use to interact with the API and process its response(s).
- c. Technical requirements for an application to be registered with any authorization server(s) deployed along with the API.

Attestation 4: The information to be included on the issuer’s website for enrollees is detailed in full in 45 CFR 156.221(g) and includes the following:

- a. General information on steps the individual may consider taking to help protect the privacy and security of enrollee health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information.
- b. An overview of which types of organizations or individuals are and are not likely to be Health Insurance Portability and Accountability Act–covered entities, the oversight responsibilities of the Office for Civil Rights and the Federal Trade Commission, and how to submit a complaint to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights and the Federal Trade Commission as described in 45 CFR 156.221. You may find the following best practices resource on [Patient Privacy and Security Resources – Supporting Payers Educating their Patients](#) helpful.

Figure 2B-1 through **Figure 2B-5** display the Interoperability Attestations and Justification Form submission.

Figure 2B-1. Interoperability Attestation Question 1

Interoperability

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2024-01	2024	10333- Aetna Life Alaska	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

Interoperability
Introduction

Question 1

Question 2

Question 3

Question 4

Justification

1. Has the issuer fully implemented a secure API that both:
- Allows all enrollees to access their claims and encounter information through a third-party application of the enrollee's choice and
 - Meets the standards of Health 7® [HL7] Fast Healthcare Interoperability Resources® [FHIR] Release 4.0.1?

- Yes
 No, I will submit justifications at the end of this section

Back

Save

Save and Next

Figure 2B-2. Interoperability Attestation Question 2

Interoperability

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2024-01	2024	10333- Aetna Life Alaska	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

Interoperability
Introduction

Question 1

Question 2

Question 3

Question 4

Justification

2. Has the issuer ensured inclusion of all information detailed in 45 CFR 156.221(b) in the content made accessible via the API?

- Yes
 No, I will submit justifications at the end of this section

Back

Save

Save and Next

Figure 2B-3. Interoperability Attestation Question 3

Interoperability

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2024-01	2024	10333- Aetna Life Alaska	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

Interoperability Introduction
<input checked="" type="checkbox"/> Question 1
<input checked="" type="checkbox"/> Question 2
<input checked="" type="checkbox"/> Question 3
<input type="checkbox"/> Question 4
<input type="checkbox"/> Justification

3. Has the issuer published on an easily accessible website and/or through publicly accessible hyperlink(s) information to support third party application use of the API, as detailed in 45 CFR 156.221(d)?

- Yes
 No, I will submit justifications at the end of this section

Provide an active URL or URLs demonstrating compliance with Question 3.

URL 1

URL 2

[Back](#)

[Save](#)

[Save and Next](#)

Figure 2B-4. Interoperability Attestation Question 4

Interoperability

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2024-01	2024	10333- Aetna Life Alaska	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

Interoperability Introduction
<input checked="" type="checkbox"/> Question 1
<input checked="" type="checkbox"/> Question 2
<input checked="" type="checkbox"/> Question 3
<input checked="" type="checkbox"/> Question 4
<input type="checkbox"/> Justification

4. Has the issuer published educational resources about health information privacy and security, including the information detailed in 45 CFR 156.221(g), on a website easily accessible to enrollees?

- Yes
 No, I will submit justifications at the end of this section

[Back](#)

[Save](#)

[Save and Next](#)

Figure 2B-5. Interoperability Justification Form Submission

Interoperability

Application 28020TX-2024-09 **Plan Year** 2024 **Issuer** 28020 - TX - Time Insurance Company, LLC. **Product Offering** QHP & SADP **Market Coverage Type** Individual & SHOP

[← Return to Application Overview](#)

- Interoperability Introduction
- ✔ Question 1
- ✔ Question 2
- ✔ Question 3
- ✔ Question 4
- ✔ **Justification**

A justification is needed for answering "No" to Questions 1-4. Upload the Interoperability Justification form that contains the following information:

- The date (a single date specifying month, day, and year, by which all referenced requirements in questions 1-4 will be fully implemented.
- A description of how the non-implemented requirements will impact enrollees until such time as they are fully implemented. Specifically, detail what functionality, data elements, or guidance will not be accessible to enrollees until full implementation is achieved. Also, describe how enrollees currently access all health information maintained by the issuer until full implementation is achieved.
- Details of the root cause for implementation delay and the issuer's plan for completing implementation by the stated date.

Justification Documents

Document Type	File Name	Uploaded By
Interoperability Justification	SupportingDoc.pdf	PMMOD012 test last 03/14/2023 03:29PM

[Back](#)

[Return to Application Overview](#)

This concludes the Interoperability section of the QHP Application.

Section 2C: Program Attestations

1. Introduction

In the Program Attestations section of MPMS, issuers filing via HIOS attest to their intent to comply with Federally-facilitated Exchange (FFE) requirements (Figure 2C-1). It includes the following attestations:

- 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.

You must respond to all attestations.

If your state performs plan management functions, complete and submit the form via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF).

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

- QHP
- SADP

See Appendix E for additional information.

Figure 2C-1. Program Attestations Application Section

Program Attestations

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
16842FL-2024-09	2024	16842 - FL	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

- Program Attestations Introduction
- QHP & SADP Attestation**
- QHP Attestation
- SADP Attestation

1. Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 Code of Federal Regulation (CFR) Parts 153, 155, and 156.

This attestation applies to all QHPs and SADPs that an issuer is submitting for certification for the next plan year. All issuers who wish to offer either certified QHPs or SADPs on the FFEs are required to agree to the above attestation.

I agree the issuer will comply with the above statement.

[Back](#) [Save](#) [Save and Next](#)

2. Data Requirements

To complete this section, you will need the following:

1. State Partnership Exchange Issuer Program Attestation Response Form: Only required if your state performs plan management functions and you are submitting in SERFF. Save the form using the naming convention in Table C-1.

3. Quick Reference

Key Changes for 2024

- ◆ For HIOS submitting issuers, only those attestations that are applicable for your plan types will be displayed (e.g., if you only offer Medical QHPs for certification, only those attestations relevant for Medical QHPs will be displayed).
- ◆ The attestation for Medical QHP issuers has been revised to remove the “segregation of funds for abortion services” language.
- ◆ The Optional Attestations and the requirement to submit an organizational chart and compliance plan (and cover sheet) have been removed.

Tips for the Program Attestations Section

- ◆ “Dual Issuer” refers to an issuer that offers both a Medical QHP and a Stand-alone Dental Plan (SADP) under the same HIOS issuer ID.
- ◆ You must respond to all attestations.
- ◆ For HIOS submitting issuers, you must agree with each attestation displayed.
- ◆ For issuers in states performing plan management functions:
 - Use the State Partnership Exchange Issuer Program Attestation Response Form.
 - If you only offer Medical QHPs for certification, respond Not Applicable to the attestations required in the SADP-only issuers subsection.
 - If you only offer SADPs for certification, respond Not Applicable to the attestations required in the Medical QHP-only issuers subsection.

Additional Resources

- ◆ There is a [supporting document](#) for this section (for issuers in states performing plan management functions).
- ◆ There are no instructional videos for this section.
- ◆ There are no templates for this section.

4. Detailed Section Instructions

To participate in the FFE, you must respond to the following:

Attestation Area	Steps
Attestations required of both Medical QHP and SADP issuers	All issuers must agree with this attestation to offer certified Medical QHPs or SADPs: <ul style="list-style-type: none"> ◆ All HIOS submitting issuers must check the box agreeing to comply. ◆ All issuers in states performing plan management functions must respond Yes.
Attestations required of Medical QHP issuers only	Issuers applying for certification of Medical QHPs must agree with this attestation to offer certified Medical QHPs: <ul style="list-style-type: none"> ◆ HIOS submitting issuers offering Medical QHPs must check the box agreeing to comply. ◆ Issuers in states performing plan management functions offering Medical QHPs must respond Yes. If you are not applying to offer Medical QHPs, select Not Applicable.
Attestations required of SADP issuers only	Issuers applying for certification of SADPs must agree with these attestations to offer certified SADPs: <ul style="list-style-type: none"> ◆ HIOS submitting issuers offering SADPs must check the boxes agreeing to comply. ◆ Issuers in states performing plan management functions offering SADPs must respond Yes to each attestation. If you are not applying to offer SADPs, select Not Applicable.

The specific attestations 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 <i>Code of Federal Regulations</i> (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.
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.

This concludes the Program Attestations section of the QHP Application Instructions.

Section 2D: Business Rules

1. Introduction

In the Business Rules section of the Marketplace Plan Management System (MPMS), you will enter information that is used to calculate rates and determine enrollee eligibility for coverage under a plan.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2024

- ◆ The template requires a data entry of **Age on effective date** for the field *How is age determined for rating and eligibility purposes?* for all Medical and Dental business rules. The template will auto-populate this value for the issuer-level business rule, and any product or plan-level rule. You will no longer be able to enter any of the following field values: Age on January 1 of the effective date year, Age on insurance date (age on birthday nearest the effective date), or Age on January 1 or July 1.

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. All other fields are locked until you respond to *Medical, Dental, or Both?*
- ◆ All rules associated with Individual Market and SHOP Market plans must be entered in a single Business Rules Template.
- ◆ The first row of rules (row 10) is the base set of issuer business rules. Leave the product ID and plan ID fields blank in this row, but enter data 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. Define how product or plan rules differ from the base set of issuer business rules in the subsequent rows, as applicable.

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Note if you are submitting via SERFF: You must include all rating business rules associated with all plan IDs for QHPs, on-Exchange SADPs, off-Exchange SADPs, Individual Market plans, and SHOP Market plans that you are submitting for QHP certification in one Business Rules Template and submit that template in all SERFF binders. If you submit more than one template through multiple different SERFF binders, each with different business rules, only the last template that your state transfers from SERFF to HIOS will be retained; business rules data from all other binders within the same SERFF transmission will be overwritten. The Centers for Medicare & Medicaid Services (CMS) requires submission of one single identical Business Rules Template in all binders to avoid data overwrite issues.

If you are a dual-product issuer submitting the Business Rules Template via multiple SERFF binders, set *Medical, Dental, or Both?* to **Both** in all submitted Business Rules Templates. You may not enter **Medical** for this field in one template version and **Dental** for this field in another template version.

Complete the Business Rules Template using the steps outlined below. You cannot validate this template until all required fields are completed.

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

- QHP
- SADP

See Appendix E for additional information.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Medical, Dental, or Both?	<p>Select one of the following from the drop-down menu:</p> <ul style="list-style-type: none"> ◆ 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. <p>You must enter a value for this field before proceeding. All other fields are locked until you respond to <i>Medical, Dental, or Both?</i></p>
Product ID	<p>For products with rules that differ from those entered in row 10, enter the 10-character (e.g., 12345AZ123) HIOS-generated product ID that identifies the product that will be associated with the rules defined in that row.</p> <ul style="list-style-type: none"> ◆ If you enter a product ID, 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 you do not enter a product ID, the rules associated with the HIOS Issuer ID in row 10 will be used.
Plan ID	<p>Enter the 14-character alphanumeric HIOS-generated plan ID (e.g., 12345AZ1234567) that identifies the plan that will be associated with the rules in that row.</p> <ul style="list-style-type: none"> ◆ If you enter a plan ID, 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 you do not enter a plan ID, the rules for the product ID associated with that plan ID will be used. If you also did not enter a product ID rule, the rules associated with the HIOS Issuer ID in row 10 will be used.
Medical or Dental Rule?	<p>Select whether the business rule in the template row applies to medical or dental plans. The drop-down options are:</p> <ul style="list-style-type: none"> ◆ Medical ◆ Dental. <p>The allowed value for this field depends on your response to <i>Medical, Dental, or Both?</i>:</p> <ul style="list-style-type: none"> ◆ If you responded Medical, the issuer-level row (row 10) for <i>Medical or Dental Rule?</i> defaults to Medical. You may only enter Medical for any subsequent rule. ◆ If you responded Dental, the issuer-level row for <i>Medical or Dental Rule?</i> defaults to Dental. You may only enter Dental for any subsequent rule. ◆ If you responded Both, the issuer-level row for <i>Medical or Dental Rule?</i> defaults to Medical. You may enter Medical or Dental for any subsequent rule and must have at least one medical rule and one dental rule within the template.
What is the maximum number of rated underage dependents on this policy?	<p>Select the maximum number of rated underage dependents from the drop-down menu. A rated underage dependent is defined as age 0–20. A QHP cannot rate more than the three oldest covered children when determining the total family premium.¹ This rule does not apply to SADPs, who have the option to enter a value of “Not Applicable.” If you responded Medical for <i>Medical or Dental Rule</i>, the following are allowed:</p> <ul style="list-style-type: none"> ◆ 1 ◆ 2 ◆ 3. <p>If you responded Dental for <i>Medical or Dental Rule</i>, the following are allowed:</p> <ul style="list-style-type: none"> ◆ 1 ◆ 2

¹ 45 Code of Federal Regulations (CFR) 147.102(c)(1).

Business Rules Template	Steps
	<ul style="list-style-type: none"> ◆ 3 ◆ Not Applicable. <p>Note: 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.</p>
Is there a maximum age for a dependent?	<p>Set the maximum age for a dependent for purposes of eligibility at policy issuance or renewal. 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:</p> <ul style="list-style-type: none"> ◆ Yes—if selected, a pop-up will allow you to enter the maximum age for a dependent. If you are a QHP issuer, you must enter a minimum value of 25 for a medical business rule. If you are an SADP issuer, you must enter a minimum value of 18 for a dental business rule. ◆ Note: The age entered is inclusive <u>through</u> that age. For example, if you enter a value of 25, you are offering to provide coverage 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 they attain age 26.² <p>Note: Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 18.</p>
How is age determined for rating and eligibility purposes?	<ul style="list-style-type: none"> ◆ Upon entry of the issuer-level rule and any product or plan-level rule, the template will auto-populate the following value, which defines the method for calculating an enrollee's age for rating and eligibility purposes. ◆ Age on effective date—return the rate based on the consumer's age on the effective date. You must select this option for all Medical and Dental business rules. <ul style="list-style-type: none"> ▪ The template prevents selection of the following discontinued options: Age on January 1 of the effective date year, Age on insurance date (age on birthday nearest the effective date), or Age on January 1 or July 1. <p>Note: Market rules require QHPs to select Age on effective date.³ The Final HHS Notice of Benefit and Payment Parameters for 2024 requires SADPs to select Age on effective date.</p>
How is tobacco status returned for subscribers and dependents?	<p>Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Applicable [x] months—if selected, a pop-up will ask 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.⁴ SADP issuers are not subject to the look-back period. 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, tobacco and non-tobacco rates are not separate. <p>If rates are calculated by adding up individual rates, the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and non-tobacco rates for individuals who qualify for the non-tobacco rate.</p> <p>For states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, tobacco rates are not applicable.</p>

² 45 CFR 147.120.

³ 45 CFR 147.102(a)(I)(iii).

⁴ 45 CFR 147.102(a)(I)(iv).

Business Rules Template	Steps
<p>What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?</p>	<ul style="list-style-type: none"> ◆ Select the relationships that are allowable 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 the primary subscriber or dependent. Choose from the following: <ul style="list-style-type: none"> ▪ Self (selected by default) ▪ 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 you select, indicate Yes or No whether the dependent is required to live in the same household as the primary subscriber: <ul style="list-style-type: none"> ▪ 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 the entry of No for the household residency requirement for child dependents for QHP products and plans that cover child relationships. This rule applies to Child, Foster Child, and Stepson or Stepdaughter relationships. ◆ Select Life Partner to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. 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.

See Figure 2D-1 for a sample completed Business Rules Template.

Figure 2D-1. Sample Business Rules Template

2024 Business Rules Template v13.0		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).						
Finalize		For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.						
		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; Stepson or Stepdaughter, No; Grandson or Granddaughter, No; Brother or Sister, Yes; Life Partner, Yes; Nephew or Niece, Yes	
12345VA001		Dental	Not Applicable	18	Age on effective date	Not Applicable	Self, Yes; Spouse, Yes; Child, Yes; Stepson or Stepdaughter, Yes; Grandson or Granddaughter, Yes; Brother or Sister, Yes; Life Partner, Yes; Nephew or Niece, Yes	

After you enter all data, click **Save** to ensure no data are lost. Once the Business Rules Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Steps Description
Validate Template	Click Validate 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 reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the template to create the .XML file of the template that will need to be uploaded in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend that you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Business Rules section of the QHP Application Instructions.

Section 2E: Essential Community Providers/Network Adequacy

1. Introduction

In the Essential Community Providers (ECP)/Network Adequacy (NA) section of MPMS, QHP issuers must demonstrate that they have a sufficient number and geographic distribution of ECPs and other providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. QHP issuers must submit provider data in each network associated with a QHP (Figure 2E-1).

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

- Medical QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Completed Network ID Template
4. A list of providers in each of the networks. When completing the NA portion of the ECP/NA Template, you may include providers outside the service area, even if they are across state lines in order to satisfy time and distance requirements. If a provider is in-network and enrollees can access that service, include the provider name, National Provider Identifier (NPI), individual provider or facility specialty type, telehealth service availability (only for individual providers), street address of the location providing services, city, state, county, and ZIP Code.
5. When completing the essential community provider portion of the ECP/NA Template, create a list of ECPs in each of the proposed networks by selecting them from the *Select ECPs* tab, including the provider name, NPI, ECP category, street address of the location providing services, city, state, county, ZIP Code, number of contracted full-time-equivalent (FTE) staff or staffed hospital beds at each facility (not to exceed the number reported by the respective provider as displayed on the *Select ECPs* tab), and associated issuer network IDs. You may include only those providers located within the service area and state in which you intend to operate.
6. ECP Write-in Worksheet (as applicable). Issuers applying under the Alternate ECP Standard must submit an ECP Write-in Worksheet. As a reminder, issuers can only qualify to apply under the Alternate ECP Standard if they provide the majority of their covered professional services through providers that the issuer directly employs or through a single contracted medical group, as such providers do not qualify for inclusion on the Final ECP List. Issuers applying under the General ECP Standard have the option of submitting an ECP Write-in Worksheet to reflect contracted providers that have been newly added to the Available List of ECP Write-ins that qualify for inclusion on the subsequent plan year's Final ECP List. Both Alternate and General Standard Issuers will receive credit toward satisfaction of the ECP standard for any providers included on the issuer's submitted and successfully validated ECP Write-in Worksheet.
7. ECP Justification Form (as applicable). Issuers will retrieve a partially populated ECP Justification Form from the PM Community with information regarding their deficient networks. Once issuers have completed their portions of the ECP Justification Form, they will submit the completed form to the PM Community by the required deadline. CMS accepts only official ECP Justification Forms in Excel format and does not accept individually customized supplemental response forms as a substitute for the official form. The ECP Justification Form will be populated from the applicable ECP Tool depending on whether the issuer is a medical QHP or an SADP and whether the issuer is submitting under the General or Alternate ECP Standard.
8. NA Justification Form (as applicable). Issuers will retrieve a partially populated NA Justification Form from the PM Community with information regarding their deficient networks. Once issuers have completed their portions of the NA Justification Form, they will submit the completed form to the PM Community by the required deadline. CMS accepts only the official NA Justification Form in Excel

format and does not accept individually customized supplemental response forms as a substitute for the official form.

3. Quick Reference

Key Changes for PY2024

- ◆ All medical QHPs and SADPs must use a provider network and submit an ECP/NA Template, with the limited exception of SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers as determined by CMS; this exception is not available to medical QHP issuers.
 - Under this limited exception, an area is considered “prohibitively difficult” for the SADP issuer to establish a network of dental providers based on attestations from state departments of insurance with at least 80 percent of their counties classified as counties with extreme access considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Marketplace issuers, or significant geographic limitations impacting consumer access to dental providers.
 - CMS will not be accepting requests for this limited exception directly from SADP issuers. Once an eligible state department of insurance submits to CMS an attestation that they consider the area to be prohibitively difficult to establish a network of dental providers, CMS will review the attestation to determine if an exception will be granted. CMS will notify the SADP issuer directly if they qualify for this limited exception. SADP issuers that qualify for this limited exception will not be required to use a provider network or submit an ECP/NA Template.

Essential Community Providers

- ◆ Issuers will be evaluated against an overall 35 percent ECP provider participation threshold, as in PY2023. New for PY2024, issuers will also be evaluated against a 35 percent threshold for two major ECP categories: Federally Qualified Health Centers (FQHCs) and Family Planning Providers.
- ◆ Two new major ECP categories have been added for PY2024: Substance Use Disorder (SUD) Treatment Centers and Mental Health Facilities. Therefore, there are a total of eight major ECP categories for PY2024. Issuers are required to offer a contract in good faith to at least one ECP in each major ECP category for each county in the service area to participate in the plan’s provider network for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants). The one exception is for the major ECP category of Indian health providers (IHPs), because the third element of the ECP standard requires issuers to offer a contract in good faith to all available IHPs in the issuer’s service area where an IHP is available, as opposed to only one IHP in each county.
- ◆ Rural Emergency Hospitals (REHs) have been added as a provider type under the Other ECP Providers category.

Network Adequacy

- ◆ The *Individual Providers (NA)* and *Facility Providers (NA)* tabs from the ECP/NA Template have been combined into a new tab: *Network Adequacy Provider*.
- ◆ Issuers must report if a provider offers telehealth services within the *Telehealth Services* column of the *Network Adequacy Provider* tab. For this purpose, the term “telehealth” is defined as “professional consultations, office visits, and office psychiatry services through brief communication technology–based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation.”
- ◆ Issuers must enter the provider’s 10-digit NPI in the *NPI* column. CMS no longer accepts dummy entries for the NPI field, as all the provider specialty types and facility provider types for which CMS collects NA data for PY2024 have NPIs. You must obtain the provider’s NPI prior to including the provider on the ECP/NA Template for PY2024. Contact the provider directly for the NPI if you do not know it. An issuer can better gauge its satisfaction of the NA requirements by ensuring that the NPIs that it lists are valid and active in National Plan & Provider Enumeration System (NPPES), as CMS removes invalid or inactive NPIs from an issuer’s ECP/NA Template before conducting time and distance reviews. For NA purposes, submit the provider’s NPI on the *Network Adequacy Providers* tab.
- ◆ For rural counties and CEACs for which issuers report within the issuer’s NA Justification a provider supply shortage of primary care pediatricians, issuers are permitted to enter the family medicine physician provider type to count toward satisfaction of the “Primary Care–Pediatric” specialty type. This is in addition to the family medicine physician provider type currently counting toward issuer satisfaction of the “Primary Care–Adult” specialty type.

Tips for the ECP/NA Section

General

- ◆ Complete the Issuer Information section on the *User Control* tab before creating and entering data into the other tabs.
- ◆ Do not change the file names on ECP/NA files after finalizing the template. This file-naming convention helps CMS identify your ECP/NA Template. If you change the file name, CMS may issue a required correction.
- ◆ Complete the Network ID Template before completing the ECP/NA Template.
- ◆ Issuers must include only providers on the ECP/NA Template that are not at known risk for potential contract termination for the upcoming plan year.
- ◆ HIOS issuers will submit their completed ECP/NA Template via HIOS. SERFF issuers will submit their completed ECP/NA Template via SERFF.
- ◆ ECP Justifications are **only** required when at least one element of the ECP standard is not met. NA Justifications are **only** required when at least one element of the NA standard is not met. Issuers that do not meet all elements of the ECP or NA standards are issued a correction notice.

Essential Community Providers

- ◆ Provide hospital bed-count information as part of the ECP portion of your ECP/NA Template.
- ◆ An issuer will select a “dummy” provider record (ECP reference number ZZ-000001) embedded within the *Select ECPs* tab of your ECP/NA to define a network without providers, rather than manually entering a “dummy” record as instructed in previous years. This “dummy” provider record appears as the last provider within the *Select ECPs* tab of the ECP/NA Template. Only select this “dummy” provider record if you meet one of the following criteria:
 - You operate in a service area in which there are no available ECPs on the Final PY2024 HHS ECP List.
 - You operate an integrated health care delivery system that provides professional health care services exclusively through physicians you employ directly or through a single contracted medical group that does not include any providers on the Final PY2024 HHS ECP List. In this case, you must instead include a list of your providers on the ECP Write-in Worksheet that must be submitted along with the ECP/NA Template.
 - You rely exclusively on the Final PY2024 List of Available ECP Write-ins or have not yet recruited ECPs to participate in your network and are unable to include any providers on the Final PY2024 HHS ECP List.
- ◆ The Available ECP Write-in List for the PY2024 QHP certification process will be made available within the PY2024 ECP Write-in Worksheet.

Network Adequacy

- ◆ Complete the NA sections of the ECP/NA Template, and submit all providers in the network, including ECP providers, in the *Network Adequacy Provider* tab. ECPs must be included even if also submitted in the *Facility ECPs* tab. For the NA portion of the ECP/NA Template, you may include providers in another state that are part of the network if they are within the time and distance allowed for reasonable access. CMS will assess time and distance standards at the county level. Counties will be classified into five county type designations: Large Metro, Metro, Micro, Rural, and CEAC. The latest Medicare Advantage Health Services Delivery (HSD) Reference file¹ contains designations for each county. These parameters are foundationally based on approaches used by the Census Bureau and the Office of Management and Budget. Use this file only to reference the “Provider Time & Distance” tab columns A through E for QHP county type designations. Other information in this HSD Reference file is not applicable to QHP certification.
- ◆ Issuers must not report an individual provider as practicing at more than 10 unique locations on the ECP/NA Template.
- ◆ For issuers with multiple office locations, each with a unique address, issuers should not add a number to the provider’s last name to distinguish each location, for example, Last Name-001.
- ◆ Issuers should reference the *Taxonomy Codes* tab of the ECP/NA Template to learn which provider taxonomy codes can be included in NA data submissions, understand which providers to include in which respective individual provider and facility specialty categories, and know which provider types crosswalk into which respective categories for time and distance standards.

¹ <https://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps>.

Tips for the ECP/NA Section

- ◆ Under the following circumstances, advanced practice registered nurses (APRNs) and physician assistants (PAs) could be included as primary care providers. Under the circumstances below, APRNs who specialize in behavioral health services could be included in the outpatient clinical behavioral health provider category. The purpose of including APRNs and PAs is to inform CMS of the rare instances in which an issuer contracts with non-Medical Doctor (MD)/Doctor of Osteopathy (DO) primary care and behavioral health services providers in underserved counties to serve as the major source of these types of care for enrollees. In these instances, organizations may include submissions under the non-MD/DO primary care and outpatient clinical behavioral health specialty codes if the contracted APRN or PA satisfies the following conditions:
 - (1) Currently licensed in the state;
 - (2) Meets the state's requirements governing the qualifications of that provider type;
 - (3) Fully credentialed by the organization as a provider of primary care or behavioral health services;
 - (4) Functions in accordance with state law as the primary source for the enrollee's primary care or behavioral health services (i.e., not to supplement a physician's care); and
 - (5) Practices in or renders services to enrollees residing in a health professional shortage area (HPSA).
- ◆ NPI Validation Report for NA and network breadth can be retrieved from the PM Community.

Additional Resources

- ◆ There are [supporting documents](#) for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Use the ECP/NA Template to identify each provider and any networks to which the provider belongs. Download the ECP/NA Template and save a copy of the template to your local machine. Ensure macros are enabled before completing the ECP/NA Template. Complete all required fields, which are identified with an asterisk (*).

The following table details the steps for completing the ECP portion of the ECP/NA Template.

Select ECPs Tab	Steps
Filter ECPs	You can filter the columns in the <i>Select ECPs</i> tab to make selecting ECPs easier. For example, you might filter the <i>Site State</i> column to show only ECPs available in your state or filter Column F (ECP Category) to display only dental providers if you are an SADP-only issuer. New for PY2024, the <i>Select ECPs</i> tab also has sorting functionality. Press the “Sort” button to sort by any column on the tab in ascending or descending order.
Add ECPs	<p>Double-click anywhere on the row for the ECPs you want to add to the ECP tabs. Once selected, the row will be highlighted in blue and add will appear in <i>Add ECP?</i> Continue selecting the ECPs until all contracted ECPs from the ECP list are selected.</p> <ul style="list-style-type: none"> ◆ To unselect an ECP, double-click on the selected row a second time. The blue highlighting will be removed, and the ECP will not be added to the ECP tabs unless selected again. ◆ To clear <u>all</u> selected ECPs, click Clear All at the top of the tab. All highlighted ECPs will be deselected and will not be added to the ECP tabs unless selected again. ◆ To show only ECPs that have been selected, click Show Selected ECPs at the top of the tab. To show all ECPs, click Show All ECPs.
Insert ECPs	<ul style="list-style-type: none"> ◆ Click Insert Selected ECPs. The selected ECPs will be inserted into the <i>Facility ECPs</i> tab of the ECP/NA Template. For each record, the following information will be added: row number, NPI, facility name, provider name, ECP category, street address, city, state, ZIP Code, and county. For each record, you must complete any field within the <i>Facility ECPs</i> tab that is not populated from the <i>Select ECPs</i> tab before submitting the template.

See Figure 2E-2 for a sample *Select ECPs* tab.

Figure 2E-2. Sample Select ECPs Tab

Add ECP?	Row Number	Site Name	Organization Name	National Provider Identifier	ECP Category	Hospital Bed Count	Number of Medical FTEs	Number of Dental FTEs
	CO-012439	Valley-Wide Ordway	VALLEY WIDE HEALTH SYSTEMS, IN	1902448186	Federally Qualified Health Centers	0	3	0
	CO-001995	Archuleta Integrated Healthcare	Axis Health System	1417295783	Community Mental Health Centers, Dental Pl	0	1.5	1
	CO-001996	MCPN Pine Tree Health Center	METRO COMMUNITY PROVIDER N	1205098340	Dental Providers, Federally Qualified Health	0	3	1
	CO-001997	Children's Colorado Emergency Car	Children's Hospital Colorado	1144683723	Children's Hospitals (inpatient only)	5	0	0
	CO-001998	Children's Colorado Emergency Car	Children's Hospital Colorado	1750742359	Outpatient Hospital Clinics	0	1.98	0
	CO-001999	Peak Vista Community Health Cent	PEAK VISTA COMMUNITY HEALTH	1619224987	Federally Qualified Health Centers	0	1	0
ADD	CO-002000	GRAND AVENUE HOMELESS CLINIC	PUEBLO COMMUNITY HEALTH CEN	1144589425	Federally Qualified Health Centers	0	1	0
	CO-002001	Pueblo City and County Health Dep	Pueblo City and County Health Dep	1245228022	Family Planning Providers, Sexually Transmit	0	2	0
ADD	CO-002002	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1396098828	Federally Qualified Health Centers	0	1	0
	CO-002003	PARK HILL CLINIC	PUEBLO COMMUNITY HEALTH CEN	1164468336	Federally Qualified Health Centers	0	9	0
ADD	CO-002004	O'ROURKE DENTAL CLINIC	PUEBLO COMMUNITY HEALTH CEN	1245275932	Dental Providers	0	0	7
	CO-002005	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1700139813	Federally Qualified Health Centers	0	1	0
ADD	CO-002006	Centennial HS SBWC	PUEBLO COMMUNITY HEALTH CEN	1720432610	Federally Qualified Health Centers	0	1	0
	CO-002007	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1770529950	Federally Qualified Health Centers	0	26	0
ADD	CO-002008	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1013261023	Federally Qualified Health Centers	0	1	0
	CO-002009	Pueblo Community Health Center	PUEBLO COMMUNITY HEALTH CEN	1649524653	Federally Qualified Health Centers	0	1	0
ADD	CO-002010	Pueblo Community College Health	PUEBLO COMMUNITY HEALTH CEN	1316466816	Federally Qualified Health Centers	0	1	0
	CO-002011	Rangely District Hospital	Rangely Hospital District	1063430346	Inpatient Hospitals (other than children's hos	18	0	0
ADD	CO-002012	Rangely Family Medicine	Rangely District Hospital	1730108747	Dental Providers, Family Planning Providers,	0	4	1

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. You may select multiple network IDs for each ECP, if applicable. If you are an issuer that offers both medical QHPs and SADPs, you must create separate network IDs for your medical and dental plans.
Hospital Bed Count	Enter the number of inpatient hospital beds reported by each provider at each site location, as reflected in Column G (Hospital Bed Count) of the <i>Select ECPs</i> tab.

ECP Write-in Worksheet	Steps
Is this an Alternate ECP Standard Issuer?	Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if you are an Alternate ECP Standard issuer as described in 45 CFR 156.235(b). ◆ No—if you are a General ECP Standard issuer.
Import Network IDs	Click Import Network IDs to import data from the Network ID Template (please refer to 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 PY2024 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 directly by the issuer or practicing in a single contracted medical group), enter “N/A” in this column.
Provider Name	Enter the provider name as it appears on the PY2024 Available ECP Write-in List.
Site Name	Enter the site name as it appears on the PY2024 Available ECP Write-in List.
Organization Name	Enter the organization name as it appears on the PY2024 Available ECP Write-in List.
NPI	Enter the NPI as it appears on the PY2024 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.
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 PY2024 Available ECP Write-in List.
Site Street Address 2	Enter additional street address information as it appears on the PY2024 Available ECP Write-in List, as applicable.
Site City	Enter the city as it appears on the PY2024 Available ECP Write-in List.
Site State	Select the site state from the drop-down list as it appears on the PY2024 Available ECP Write-in List.
Site ZIP Code	Enter the site ZIP Code as it appears on the PY2024 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 PY2024 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 Validate at the top of the worksheet. The worksheet will highlight cells with errors in red. Correct any errors and click Validate again. Repeat until a message appears indicating that no validation errors were found.
Export the Worksheet	Click Export 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.

ECP Write-in Worksheet	Steps
	Submit the .txt file in the Supporting and Justifications Documents section on the ECP/NA tab of the ECP/NA section and label the file “ECP Write-in Worksheet.”

Follow these instructions to complete the NA portion of the ECP/NA Template. For determining appropriate providers to include in the NA portion of your ECP/NA Template, use the following guidelines.

- Include a list of all the providers in each of the proposed networks, even those outside of the immediate geographic area meeting time and distance requirements, as well as ECPs, even when also included in the ECP tabs. Such providers must meet the following requirements:
 - Be appropriately licensed, accredited, or certified to practice in their state, as applicable; and
 - Offer in-person services.
- Include only providers not at known risk for potential contract termination for the upcoming plan year.
- Do not report an individual provider as practicing at more than 10 unique locations.
- For issuers with multiple office locations, each with a unique address, do not add a number to the provider’s last name to distinguish each location, for example, Last Name-001.
- Reference the *Taxonomy Codes* tab of the ECP/NA Template to learn which provider taxonomy codes can be included in NA data submissions, understand which providers to include in which respective individual provider and facility specialty categories, and know which provider types crosswalk into which respective categories for time and distance standards.
- For rural counties and CEACs for which issuers report within the issuer’s NA Justification a provider supply shortage of primary care pediatricians, issuers are permitted to enter the family medicine physician provider type to count toward satisfaction of the “Primary Care–Pediatric” specialty type. This is in addition to the family medicine physician provider type currently counting toward issuer satisfaction of the “Primary Care–Adult” specialty type.
- Under the following circumstances, APRNs and PAs can be included as primary care providers. APRNs who specialize in behavioral health services could be included in the outpatient clinical behavioral health provider category. Including APRNs and PAs informs CMS of the rare instances in which an issuer contracts with non-MD/DO primary care and behavioral health services providers in underserved counties to serve as the major source of these types of care for enrollees. In these instances, organizations can include submissions under the non-MD/DO primary care and outpatient clinical behavioral health specialty codes if the contracted APRN or PA satisfies the following conditions:
 - (1) Licensed in the state
 - (2) Meets the state’s requirements governing the qualifications of that provider type
 - (3) Fully credentialed by the organization as a provider of primary care or behavioral health services
 - (4) Functions in accordance with state law as the primary source for the enrollee’s primary care or behavioral health services (i.e., not to supplement a physician’s care); and
 - (5) Practices in or renders services to enrollees residing in a HPSA.

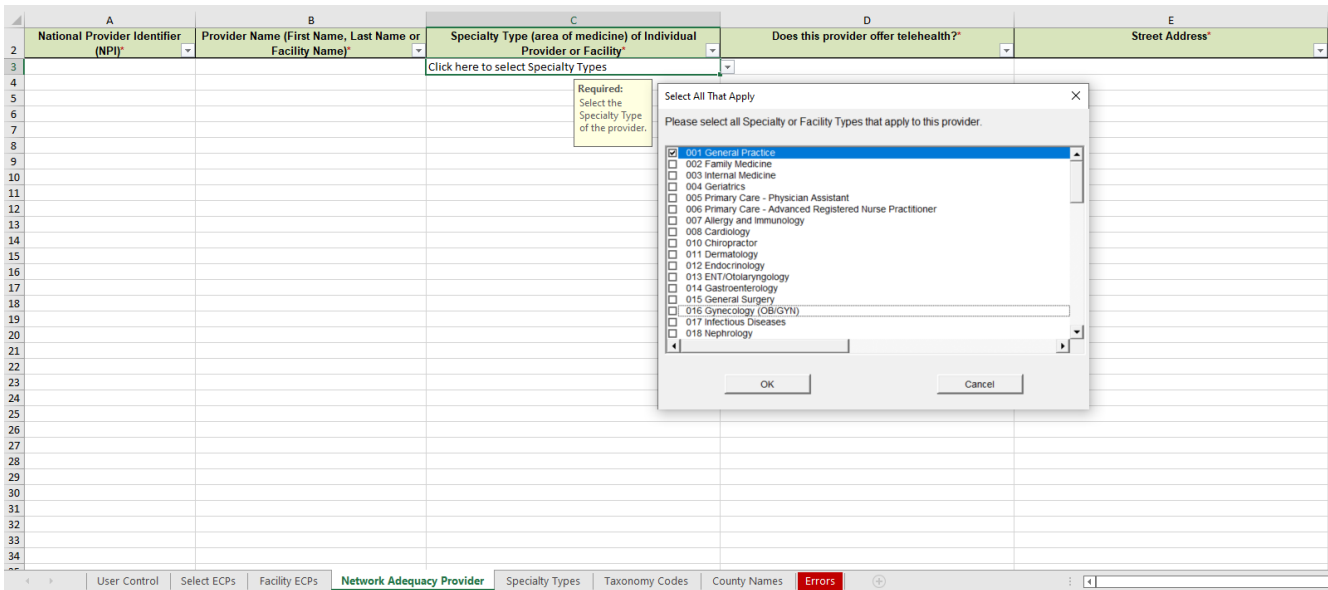
To complete the *Network Adequacy Provider* tab, follow the steps in the tables.

Network Adequacy Provider Tab	Steps
NPI (required)	Enter the provider’s 10-digit NPI. Contact the provider directly to acquire their NPI if you do not know it. For NA purposes, submit the subpart’s NPI. For example, a hospital offers acute care,

Network Adequacy Provider Tab	Steps
	laboratory, and rehabilitation services, and each subpart has its own NPI. ² The parent organization-level NPI should not be reported. You must obtain the provider's NPI before including them on the ECP/NA Template for PY2024. CMS no longer accepts dummy entries for the NPI field. Ensure that the NPI is valid and active in the NPPES database.
Provider Name (First Name, Last Name or Facility Name)	Enter the individual provider's first and last name or the name of the provider facility.
Specialty Type (area of medicine) of Individual Provider or Facility	<p>From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, select all specialties in the same record.</p> <ul style="list-style-type: none"> ◆ The template does not allow direct entry into this field. However, you may copy and paste data into the template if the specialty type names match how they appear in the <i>Specialty Types</i> tab data, such as 001 General Practice. Errors will appear if pasted data do not exactly match the specialty type format used in the <i>Network Adequacy Provider</i> tab. ◆ If you 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 <i>Specialty Types</i> tab, do not list the provider. CMS does not accept specialties that do not fall within our defined Specialty Types lists.
Does this provider offer Telehealth?	<p>For the purpose of this data collection and reporting, the term “telehealth” is defined as “professional consultations, office visits, and office psychiatry services through brief communication technology–based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation.”</p> <p>From the drop-down menu, select Yes or No to indicate whether the provider offers telehealth services. If you have reached out to the provider and are awaiting a response, select Requested information from provider and awaiting their response.</p>
Street Address	Enter the provider's street address. If the provider has multiple locations, enter each street address in a separate row. <u>Do not</u> 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, if 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 <i>County Names</i> tab of the ECP/NA Template. Do not include the Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP Code	Enter the ZIP Code where the provider is located. ZIP Codes must include either five (12345) or nine (12345-6789) digits.
Network ID	When entering network IDs, use the same network IDs as those assigned in the Network ID Template and the Plans & Benefits Template. <u>If you are an issuer that offers both medical QHPs and SADPs, you must create separate network IDs for your medical and dental plans.</u> 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, select all networks in the same record.

² <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/NPI-What-You-Need-To-Know.pdf>.

Figure 2E-5. Sample Network Adequacy Provider Tab



Reference information is provided in the four tabs listed below:

- The *Specialty Types* tab contains the specialty/facility types that can be added into the ECP/NA Template.
- The *Taxonomy Codes* tab contains the taxonomy codes that correspond to provider specialty types listed within the *Specialty Types* tab. You may use the *Taxonomy Codes* tab as a guide for the provider taxonomy types you are required to include in submissions. The *Taxonomy Codes* tab also has columns to show which taxonomy codes crosswalk into each time and distance specialty type.
 - You may not use the National Uniform Claim Committee (NUCC) hospital taxonomy code to report hospitals in submissions due to known data integrity issues. Instead, issuers must report all hospitals as “acute inpatient hospitals,” which are defined as hospitals that provide all-day, year-round emergency services. You must only report contracted facilities that offer specialty codes 041, 042, and 043 in submissions.
- The *County Names* tab contains the county names that are used and accepted in the ECP/NA Template.
- The *Errors* tab displays any validation errors identified when a completed ECP/NA 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 creates 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.

After entering all data, click **Save** to ensure no data are lost. Once you complete the ECP/NA Template, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate on the <i>User Control</i> tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, you will receive the message “No validation errors were identified. Validation is complete.” indicating that you may finalize the template.

Template Validation and Submission Step	Step Description
Errors	Errors will appear on the <i>Errors</i> tab, which shows the data element, cell location, and validation error message for each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Create Documents	Once all validations are complete, click Create Documents on the <i>User Control</i> tab to create a separate .XML file for each tab in the workbook and compress all files into one .ZIP file.
Save Template	Save the .ZIP file and template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .ZIP file for easier reference.
Upload and Link Template	Upload the saved .ZIP file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for additional guidance on how to complete these steps.

After uploading the necessary ECP/NA files and linking them to your application, you may need to upload supporting documentation. You must submit completed ECP and NA Justification Forms via the PM Community. If applicable, the ECP Write-In Worksheet must be submitted through the MPMS by selecting the ECP Write-in Worksheet document type from the drop-down menu. If you do not meet ECP standards because providers are unwilling to contract with you because they are owned by another issuer, attempt to recruit additional providers on the Final ECP List or the ECP Write-in List, and encourage additional providers that may qualify as ECPs to submit an online ECP Petition so that you can enter them on your ECP Write-in Worksheet if they are approved as a qualified ECP Write-in by CMS to count toward your satisfaction of the ECP standard.

Supporting Documents	Steps
ECP Justification Form	<ul style="list-style-type: none"> ◆ If you receive a required correction for not meeting one or more of the following ECP standards, you must complete all required fields in the prepopulated ECP Justification Form generated by CMS, which can be retrieved from the <i>ECP/NA Justifications</i> tab of the PM Community. <ul style="list-style-type: none"> ▪ For issuers applying under the General ECP Standard, the applicant must satisfy the following requirements: <ul style="list-style-type: none"> - Contracted with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network; - Contracted with at least 35 percent of available FQHCs and at least 35 percent of available Family Planning Providers in each plan's service area to participate in the plan's provider network; - Offered a contract in good faith to at least one ECP in each major ECP category for each county in the service area to participate in the plan's provider network for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants); and - Offered a contract in good faith to all available Indian health care providers in the plan's service area to participate in the plan's provider network for the respective QHP certification plan year. ▪ For issuers applying under the Alternate ECP Standard (i.e., issuers eligible to apply under this standard must provide the majority of their plan's covered professional services through physicians employed directly by the issuer or through a single contracted medical group), the applicant must satisfy the following requirements: <ul style="list-style-type: none"> - Contracted with at least 35 percent of available ECPs in each plan's service area to participate in the plan's provider network with providers in HPSAs or ZIP Codes in which 30 percent or more of the population falls below 200 percent of the federal poverty level, including at least 35 percent of available FQHCs and at least 35 percent of family planning providers in the plan's service area; and - 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 to participate in the plan's

Supporting Documents	Steps
	<p>provider network 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 in each ECP category in each county in the plan's service area for the respective QHP certification plan year, where an ECP in that category is available (not applicable to SADP applicants).</p> <ul style="list-style-type: none"> ◆ For guidance on using the PM Community, please reference the user guide and related instructions in the <i>Resources and Training</i> tab on the home page of the PM Community. ◆ The completed ECP Justification Form should be saved in the required macro-enabled Excel format (.xlsm) and submitted via the PM Community by each submission round's required deadline. Do not rename the Justification Form. If you do rename the file, use the following naming convention: (Issuer ID)-ECP-(Plan Type)-(Round Abbreviation). For example, Issuer ID 12345 in the Initial Round that is a Medical QHP would be 12345-ECP-MedQHP-IR, and Issuer ID 12345 in the Initial Round that is an SADP would be 12345-ECP-SADP-IR. Replace IR with SR for the Second Round submission and with FR for the Final Round of submission. ◆ On the <i>ECP Justification & Monitoring</i> tab, you are strongly encouraged to include provider recruitment activities for the network, county, and specialty combinations for which you received a required correction, including any ongoing, concluded, and unsuccessful activities. This additional provider recruitment data will inform next steps that may be required of the you during the Post-certification Compliance Monitoring Program. ◆ All required fields in the ECP Justification Form must be completed before submission. Incomplete justifications will not be accepted. ◆ After submitting your completed ECP Justification Form, CMS will send you additional corrections via the <i>Corrections</i> tab in the PM Community if further corrections are required.
NA Justification Form	<ul style="list-style-type: none"> ◆ If you receive a required correction for not meeting one or more of the NA standards, you must complete all required fields in the prepopulated NA Justification Form generated by CMS, which can be retrieved from the <i>NA Justification</i> tab of the PM Community. For guidance on using the PM Community, please reference the user guide and related instructions in the <i>Resources and Training</i> tab on the home page of the PM Community. ◆ The completed NA Justification Form should be saved in the required macro-enabled Excel format (.xlsm) and submitted via the PM Community by the required deadline for each submission round. Do not rename the Justification Form. If you do rename the file, use the following naming convention: (Issuer ID)-NA-(Round Abbreviation). For example, Issuer ID 12345 in the Initial Round would be 12345-NA-IR. Replace IR with SR for the Second Round submission and with FR for the Final Round of submission. ◆ If CMS learns of local challenges impacting all issuers in a given service area, such as topographical features or insufficient provider supply, which have resulted in assignment of required corrections, CMS will assess any such challenges to verify the extent to which they impede issuers' ability to satisfy the respective NA standard for the purpose of potentially clearing the assigned correction, as CMS deems appropriate. ◆ On the <i>Monitoring & T&D Justification</i> tab of the NA Justification Form you must provide an answer to the four service area monitoring questions at the top of the worksheet for CMS to consider any barriers you report within the "<i>Primary Reasons on Record for Unmet Standard</i>" column. ◆ On the <i>Monitoring & T&D Justification</i> tab of the NA Justification Form, you must provide a Primary Reason(s) for not meeting the standard related to each correction. ◆ On the <i>Additional Activity</i> tab of the NA Justification Form, you are strongly encouraged to include provider recruitment activities for the network, county, and specialty combinations for which you received a required correction, including any ongoing, concluded, and unsuccessful activities. This additional provider recruitment data will inform next steps that may be required of the issuer during the Post-certification Compliance Monitoring Program. ◆ All required fields in the NA Justification Form must be completed before submission. Incomplete justifications will not be accepted.

Supporting Documents	Steps
	<ul style="list-style-type: none">◆ After submitting your completed NA Justification Form, CMS will send you additional corrections via the <i>Corrections</i> tab in the PM Community if further corrections are required.

This concludes the ECP/NA section of the QHP Application Instructions.

Section 2F: Network ID

1. Introduction

In the Network ID template you must assign each of your provider networks—groups of providers providing services in an area—to network IDs. This template is submitted in the ECP/NA section of MPMS.

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

- QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

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

3. Quick Reference

Key Changes for 2024

- ◆ No changes for the 2024 QHP Application.

Tips for the Network ID Section

- ◆ If you are a dual-product issuer, you must create two different network IDs, one each for qualified health plans (QHPs) and stand-alone dental plans (SADPs), regardless of whether the specific network is intended to serve both plan types. If you submit via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF), you must use the same Network Template across all binders or ensure that no network IDs repeat across the binders.
- ◆ If you are a dual-product issuer, you must use the word "dental" in the network area name for your dental network to distinguish the dental network from the medical network.
- ◆ If you offer plans in the Individual and SHOP markets, you must create separate network IDs for each market, regardless of whether the network is intended to serve both markets. If you submit via SERFF, you must use the same Network Template across all binders or ensure that no network IDs repeat across the binders.
- ◆ The Network ID Template syncs to the Plans & Benefits Template. Each plan identified in the Plans & Benefits Template must list the network ID that is associated with it.
- ◆ Although a medical QHP or SADP must always be associated with a single Service Area ID and with a single Network ID, networks and service areas may be used for multiple QHPs or SADPs. You should create one template containing all service areas and identify each service area with a unique Service Area ID. You should also complete the Network ID Template and create a unique Network ID for each network. When you complete the Plans & Benefits Template, it will map each plan to a specific Service Area ID and Network ID as entered in the Service Area and Network ID Templates.
- ◆ Network IDs and Service Area 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 statewide 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).
- ◆ If specific providers are available for some of your products but not others, then establish separate Network IDs to enable mapping the plans to the applicable Network IDs.

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Follow these 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 Create Network IDs . Enter the number of networks when prompted and select OK . This button automatically generates the network IDs based on the number of networks specified. Note: If you submit via SERFF, click Create Network IDs and enter the total number of network IDs you need to ensure that no two templates use the same network ID. For example, if the Individual Market needs three network IDs and the SHOP Market needs two network IDs, enter "5" for the total number of networks.
Network Name	Enter a network name. Dual-product issuers must use the word "dental" in the dental network name to distinguish the dental network from the QHP network.
Network ID	Select a network ID from the drop-down menu. The network IDs consist of the state abbreviation, the letter "N," and a sequenced number (such as MDN001 or MDN002). <u>If you are a dual-product issuer, you must create separate network IDs for your QHP and dental networks.</u>

Repeat these steps for each additional network ID.

See Figure 2F-1 for a sample completed Network ID Template.

Figure 2F-1. Sample Network ID Template

2024 Network Template v13.0	
<i>All fields with an asterisk (*) are required.</i>	
Validate	<i>To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.</i>
Finalize	<i>Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.</i>
<i>Network IDs will populate in the drop-down box in Network ID column.</i>	
<i>Use each Network ID only once.</i>	
HIOS Issuer ID*	12345
Issuer State*	VA
Create Network IDs	
Network Name* Required: Enter the Network Name	Network ID* Required: Select the Network ID
Smith Network	VAN001

After entering all data, click **Save** to ensure no data are lost. Once the Network ID Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate 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 reason for 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 Finalize in the template to create the .XML version of the template you will upload in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application in the ECP/NA section. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Network ID section of the QHP Application Instructions.

Section 2G: Plans & Benefits

1. Introduction

In the Plans & Benefits section of MPMS, you will enter data about your plans, list covered benefits with any quantitative limits or exclusions, and provide cost-sharing values and basic plan variation information for each plan you submit, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. This information is provided via two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet.

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

- QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. Completed Network ID Template
2. Completed Service Area Template
3. Completed Prescription Drug Templates (QHP only)
4. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2024

- ◆ There is new guidance for plan variant marketing names to ensure compliance with requirements at 45 CFR 156.225(c).
- ◆ For SADPs, the template requires a data entry of **Guaranteed Rate** for the field *Guaranteed vs. Estimated Rate*. The template will auto-populate this value, and you will no longer be able to enter the discontinued option of Estimated Rate.
- ◆ There is new guidance relating to non-standardized plan option limits to ensure compliance with requirements at 45 CFR 156.202.

Tips for the Plans & Benefits Section

- ◆ Download the most recent versions of the 2024 Plans & Benefits Template, Plans & Benefits Add-In file, and Actuarial Value Calculator (AVC) from the [QHP certification website](#).
- ◆ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template so the macros will run properly.
- ◆ All data elements that we anticipate 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 in this chapter.
- ◆ 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.
- ◆ Complete and save the Network, Service Area, and Prescription Drug (QHPs only) Templates before filling out the Plans & Benefits Template. The Plans & Benefits Template requires you to assign a network, service area, and formulary ID (QHPs only) to each plan based on the IDs created in these three templates.
- ◆ Complete a separate Benefits Package worksheet for each unique benefits package you wish to offer. To create additional benefits packages, click **Create New Benefits Package** under the Plans & Benefits Add-In. *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, and *Dental Only Plan* will auto-populate.
- ◆ 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 Essential Health Benefit (EHB) percent of total premium calculation should be the multiplicative inverse of the Unified Rate Review Template (URRT) *Benefits in Addition to EHB* field when rounded to the fourth decimal point (e.g., 1 divided by *Benefits in Addition to EHB*).
- ◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See [Appendix A](#) for how these values relate to AV.

Tips for the Plans & Benefits Section

- ◆ Cost sharing and other benefit information included in a plan variant marketing name must accurately reflect plan benefits. For example, a marketing name for a plan variant that requires a \$50 copay for specialist visits should not include the phrase, “free specialist visits.”
- ◆ 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.

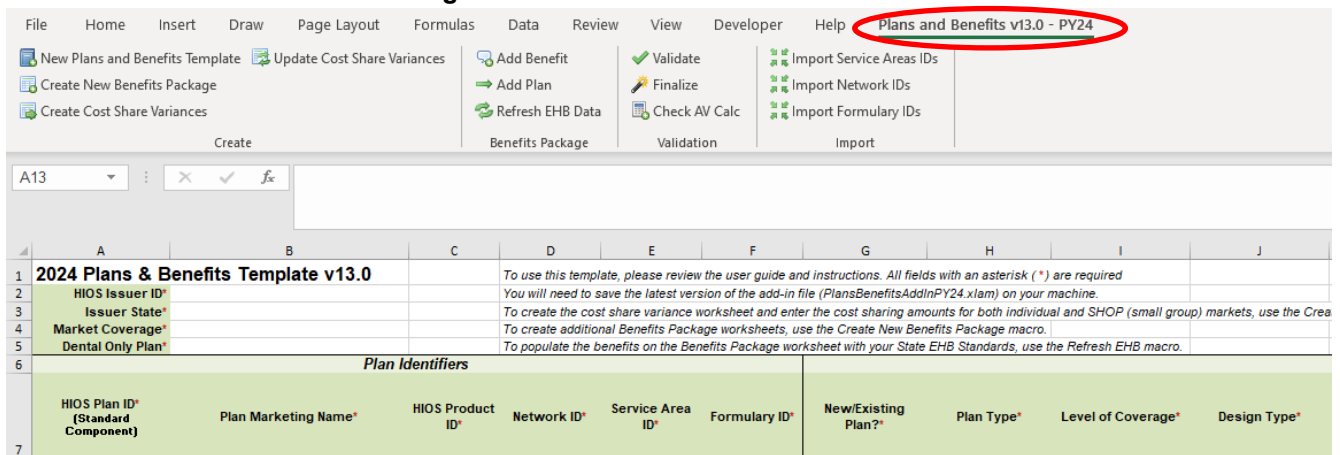
Additional Resources

- ◆ There are [supporting documents](#) for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

If you are asked to enable macros when you open the Plans & Benefits Template, use **Options** on the Security Warning toolbar, and select **Enable this content**. If you enter data before enabling the macros, the template will not recognize those data fields and you will have to reenter them. Once you enable macros, the **Plans and Benefits** ribbon should appear (Figure 2G-1) as a tab on the file's toolbar.

Figure 2G-1. Plans and Benefits Ribbon



Note: Before proceeding, confirm you have downloaded the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the [QHP certification website](#).

4.1 General Information

Enter your basic issuer information in the fields in the upper left portion of the Benefits Package worksheet (Figure 2G-2). After you enter this information in the first Benefits Package worksheet, it will auto-populate in any additional Benefits Package worksheets you generate.

Figure 2G-2. Plans & Benefits Template

2024 Plans & Benefits Template v13.0	
HIOS Issuer ID*	
Issuer State*	
Market Coverage*	
Dental Only Plan*	

General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which you are licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following: <ul style="list-style-type: none"> ◆ Individual—if the plans are offered on the Individual Market. ◆ SHOP (Small Group)—if the plans are offered on the SHOP Market. Note: The Market Coverage for a plan in the <i>Benefits Package</i> tab must match the Market Coverage for that plan stored in HIOS.
Dental-Only Plan*	Indicate whether the plans contained in the template are dental-only plans. Choose from the following: <ul style="list-style-type: none"> ◆ 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 <u>not</u> 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 2G-3). Complete this section for each standard plan you intend 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. After you enter each standard plan in the Benefits Package worksheet, the template will automatically create the necessary plan variations in the Cost Share Variances worksheet.

If you run out of empty rows for new plans, click **Add Plan** on the menu bar under the **Plans and Benefits** ribbon. Each benefits package may include up to 50 plans. Create a second benefits package with an identical structure to accommodate additional plans.

Figure 2G-3. Plan Identifiers Section

2024 Plans & Benefits Template v13.0		
HIOS Issuer ID*		To use this template, please review the user guide and
Issuer State*		You will need to save the latest version of the add-in file
Market Coverage*		To create the cost share variance worksheet and enter
Dental Only Plan*		To create additional Benefits Package worksheets, use
		To populate the benefits on the Benefits Package worksheet
Plan Identifiers		
HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID* Network ID* Service Area ID* Formulary ID*

Plan Identifiers	Steps
HIOS Plan ID (Standard Component)*#	Enter the 14-character, 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. Note: Issuers that want to add cost sharing and other benefit information to a plan marketing name can do so at the plan variant marketing name level. Any cost sharing or other benefit information in a plan variant marketing name must accurately reflect that plan variant’s benefit information. (See Section 4.10 Plan Cost-Sharing Attributes for additional guidance.)
HIOS Product ID*	Enter the 10-character, HIOS-generated product ID number.

Plan Identifiers	Steps
Network ID*	Click Import Network IDs on the menu bar under the Plans and Benefits ribbon and select the Network ID Template Excel file you completed previously to import its network ID values, then select the appropriate network ID from the drop-down menu.
Service Area ID*	Click Import Service Area IDs on the menu bar under the Plans and Benefits ribbon and select the Service Area Template Excel file you completed previously to import its service area ID values, then select the appropriate service area ID from the drop-down menu.
Formulary ID	Click Import Formulary IDs on the menu bar under the Plans and Benefits ribbon and select the Prescription Drug Template Excel file you completed previously to import its values, then select the appropriate formulary ID from the drop-down menu. Note: Standardized Plan Options (SPOs) of different metal levels must have distinct formulary IDs selected to ensure the appropriate cost sharing is assigned for that plans level of coverage.

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 2G-4).

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

Plan Attributes						
Unique Plan Design?*	QHP/Non-QHP*	Notice Required for Pregnancy*	Plan Level Exclusions	Limited Cost Sharing Plan Variation - Est Advanced Payment	Does this plan offer Composite Rating?*	Child-Only Offering*

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following: <ul style="list-style-type: none"> ◆ New—if this is a new plan that was not offered last year. This includes any plan offered last year but not considered to be the “same plan” as described in 45 CFR 144.103. New plans should use a new plan ID that was <u>not</u> used for the 2023 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. Existing plans should use <u>the same</u> plan ID that was used for the 2023 plan year.
Plan Type**	Select the plan type that best corresponds to plan definitions provided in state law or regulations in your state. Plan type selections must be consistent with your state form-filing submissions. Choose from the following: <p>Indemnity</p> <ul style="list-style-type: none"> ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point of service) ◆ EPO (exclusive provider organization). <p>Note: The plan type for a plan in the <i>Benefits Package</i> tab must match the plan type for the product in HIOS.</p>
Level of Coverage [^] **	Select the metal level of the plan based on its AV. A de minimis variation of -2/+2 percentage points is allowed for standard metal-level plans. 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 on the Exchange, as described in Section 1302(d)(1) of the Patient Protection and Affordable Care Act (PPACA). Choose from the following: <ul style="list-style-type: none"> ◆ Bronze—AV of 60 percent

Plan Attributes	Steps
	<ul style="list-style-type: none"> ◆ Expanded Bronze—AV of 58–65 percent. A plan may use this option if it either covers and pays for at least one major non-preventive service 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 ◆ 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. SADPs must complete the <i>Level of Coverage</i> field. Selecting High or Low will allow the template to validate for PY2024. The selection will not display to issuers in Plan Preview or to consumers in Plan Compare, as described in 45 CFR 156.140: <ul style="list-style-type: none"> ◆ Low—AV of 70 percent ◆ High—AV of 85 percent.
Design Type*	<p>If the plan is not following a standardized plan option, select “Not Applicable” for this particular plan. SADPs and SHOP plans also should select “Not Applicable” for this field. If the plan is following a standardized plan option, and if this plan is being offered through an FFE or SBE-FP excluding the FFEs of Delaware or Louisiana, select “Design Type 1” for this particular plan. If the plan design is following a standardized plan option, and if the plan is being offered through the FFEs in Delaware or Louisiana, select “Design Type 2” for this particular plan. If this plan is following a standardized plan option, and if the plan is being offered through the SBE-FP in Oregon, select “Design Type 3” for this particular plan. This designation is selected at the plan level but must be applied to all associated plan variations. For example, if the issuer selects “Design Type 1” for a silver plan, all of the corresponding silver plan variations must follow the cost-sharing structure for their respective CSR standardized plan plan designs. For more information on the standardized plan plan design and populating plans’ cost sharing using the SPOs Add-In, see Section 5.12.</p>
Unique Plan Design	<p>Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available by HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix A. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if unique plan design features cause the AVC to yield an AV result that materially differs from that of other approved methods described in 45 CFR 156.135(b). This indicates the plan is not compatible with the AVC. If you select Yes for this reason, upload the Unique Plan Design Supporting Documentation and Justification Form. 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 <u>not</u> unique.
QHP/Non-QHP*	<p>Indicate whether the plan will be offered only on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following:</p> <ul style="list-style-type: none"> ◆ On the Exchange—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. If you offer a plan on the Exchange, select Both unless an exception to guaranteed availability applies. ◆ Off the Exchange—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange as part of the risk corridor program (see 45 CFR 153.500 for more details). ◆ Both—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.

Plan Attributes	Steps
Notice Required for Pregnancy	<p>Indicate whether consumers or providers must notify you of a pregnancy before pregnancy benefits are covered. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if a notice is required before pregnancy benefits are covered. ◆ No—if a notice is <u>not</u> required before pregnancy benefits are covered.
Plan Level Exclusions*	Enter any plan-level exclusions.
Limited Cost-Sharing Plan Variation—Est. Advance Payment	Leave this field blank. This data element is not required for PY2024. As specified in the <i>2015 HHS Notice of Benefit and Payment Parameters</i> , beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost-sharing plan variations.
Does this plan offer Composite Rating?	Select No for this field. This field is not applicable for PY2024.
Child-Only Offering*	<p>Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (a plan for individuals who have not attained the age of 21 for QHPs and 19 for SADPs at the beginning of the plan year); 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.</p> <p>Choose from the following:</p> <ul style="list-style-type: none"> ◆ Allows Adult and Child-Only—if the plan allows adult- and child-only enrollment and is offered at a child-only rate. ◆ Allows Adult-Only—if the plan does <u>not</u> allow child-only enrollment. Children may enroll for this plan, but an adult must be 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, which must be available to child-only subscribers. ◆ Allows Child-Only—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 in <i>Child-Only Offering</i> . Enter the 14-character plan ID for the corresponding child-only plan if this plan does <u>not</u> 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 and must have the same selection for <i>Level of Coverage</i> as the allows adult-only plan for which you are entering data.
Tobacco Wellness Program Offered	<p>Indicate whether 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, as required to rate for tobacco use in the Small Group Market. (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:</p> <ul style="list-style-type: none"> ◆ 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 <u>not</u> 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: <ul style="list-style-type: none"> ▪ The plan is offered in the Individual Market. ▪ The plan is offered in the SHOP Market and does not rate for tobacco use.
Disease Management Programs Offered#	<p>Indicate whether the plan offers disease management programs. Choose one or more of the following:</p> <ul style="list-style-type: none"> ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure and High Cholesterol ◆ Low Back Pain

Plan Attributes	Steps
	<ul style="list-style-type: none"> ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs.
EHB Percent of Total Premium	<p>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). Note: This field is not applicable for SHOP Market plans or catastrophic plans. The <i>EHB Percent of Total Premium</i> field should be the multiplicative inverse of the Unified Rate Review Template (URRT) <i>Benefits in Addition to EHB</i> field when rounded to the fourth decimal point (e.g., 1 divided by <i>Benefits in Addition to EHB</i>). As part of data integrity review, CMS will identify any mismatch between EHB percent of total premium and the multiplicative inverse of <i>Benefits in Addition to EHB</i> for a non-catastrophic Individual Market QHP, and prompt you to confirm that the submitted values for <i>EHB Percent of Total Premium</i> from the Plans & Benefits Template and <i>Benefits in Addition to EHB</i> from the URRT are correct.</p> <p>Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia should not be considered EHB, even if the State EHB Benchmark plan covers such benefits.¹</p> <p>A state may require a QHP to offer benefits in addition to the EHB, but the state is required to defray the cost of such state-required benefits to the enrollee or to the QHP issuer on behalf of the enrollee.² How an Individual Market QHP issuer should handle the portion of premium related to these services depends on whether the state makes these defrayal payments to the enrollee or to the issuer:</p> <p>In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer:</p> <ul style="list-style-type: none"> ◆ You <u>should not</u> factor the cost of the state-required benefit the state is defraying into the calculation for the <i>EHB Percent of Total Premium</i> field on the Plans & Benefits Template and <u>should not</u> factor the cost of the state-required benefit into the total premium from which the EHB percent of premium is calculated. <ul style="list-style-type: none"> ▪ Indicate in the <i>Benefits Information</i> field on the Plans & Benefits Template that the QHP covers the state-required benefit in question as a non-EHB. To add a benefit not already listed on the Plans & Benefits Template, click the Add Benefit button on the menu bar under the Plans and Benefits ribbon. Select Not EHB as the <i>EHB Variance Reason</i>. ▪ You will not experience a warning error or any problems that would prevent validation of the Plans & Benefits Template if you exclude coverage of the state-required benefit when calculating the EHB Percent of Total Premium, even though the QHP issuer should indicate that the state-required benefit is covered as a non-EHB under the Benefits Information. <p>In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee:</p> <ul style="list-style-type: none"> ◆ You <u>should not</u> include the cost of the state-required benefit the state is defraying in the <i>EHB Percent of Total Premium</i> field on the Plans & Benefits Template. However, you should include the cost of the state-required benefit in the total premium from which the EHB Percent of Total Premium is calculated (therefore treating it as non-EHB for purposes of the total premium). <ul style="list-style-type: none"> ▪ The QHP issuer should also indicate in the <i>Benefits Information</i> field on the Plans & Benefits Template that the QHP covers the state-required benefit in question as a non-EHB. ▪ To add a benefit not already listed on the Plans & Benefits Template, QHP issuers can click the Add Benefit button on the menu bar under the Plans and Benefits ribbon. QHP issuers should mark the benefit as Not EHB as the <i>EHB Variance Reason</i>.

¹ 45 CFR 156.115(d).

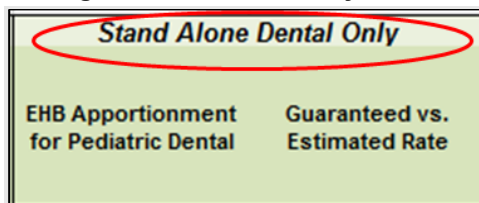
² 45 CFR 155.170.

Plan Attributes	Steps
	<p>For plans that include coverage of abortion services for which public funding is prohibited (also known as non-Hyde abortion services)³ offered in states where the benefits package of the EHB benchmark plan includes such abortion services, you must handle the portion of the premium related to these services using one of the two methods described below:</p> <ul style="list-style-type: none"> ◆ If the plan is a QHP offered on the FFE or a State-based Exchange (SBE), do not include the percentage of the premium associated with such abortion services in the EHB percentage (even if these services are in the EHB benchmark package). The EHB percentage is used to calculate subsidy amounts and subsidy payments may not be provided for costs associated with such abortion services. Therefore, costs associated with such abortion services must be excluded from the EHB proportion, and reflected accordingly in the adjustment for benefits in addition to EHB. ◆ If the plan is a QHP that is only offered off the Exchange (<u>not</u> offered in the FFE or in an SBE), the percentage of the premium associated with abortion services for which public funding is prohibited may be included in the EHB percentage. <p>For plans that include coverage of abortion services for which public funding is permitted and that is offered in states where the benefits package of the EHB benchmark plan includes such abortion services, the plan should include the percentage of premium associated with these services in the EHB percentage.</p> <p>For plans that include coverage of abortion services for which public funding is prohibited and that the plan is covering outside of the scope of the state's EHB benchmark package, reflect any such covered abortion services as benefits in addition to EHB.</p>

4.4 Stand-Alone Dental Only

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

Figure 2G-5. SADP-Only Fields



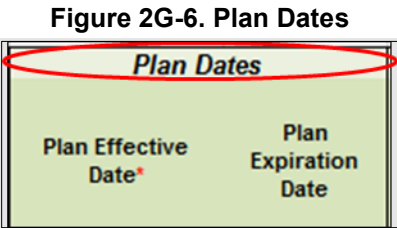
Stand-Alone Dental Only	Steps
EHB Apportionment for Pediatric Dental*	<p>Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies only to pediatric rates. If the rates are family-tiered, use the EHB percent 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). All SADP issuers must attest to the Stand-Alone Dental Plans Attestation. HIOS issuers will complete the attestation in MPMS and issuers in states that perform plan management functions will complete the attestation in the State Partnership Exchange Issuer Program Attestation Response Form.</p> <p>Note: This field is no longer applicable for SHOP Market plans.</p>

³ 45 CFR 156.280(d).

Stand-Alone Dental Only	Steps
Guaranteed vs. Estimated Rate*	<p>This indicates whether the rate for this SADP is a guaranteed rate. By selecting Guaranteed Rate, you commit to charging only the premium shown to the consumer on HealthCare.gov, which is calculated by taking into account the consumer’s geographic location, age, and other permissible rating factors within the Rates Table Template and Business Rules Template. Beginning PY2024, CMS no longer allows SADP issuers to submit estimated rates.⁴ If entering a value of “Yes” for the “Dental Only Plan” field, the “Guaranteed Rate” option will be automatically populated for the “Guaranteed vs. Estimated Rate” column on each <i>Benefits Package</i> tab of the Plans & Benefits Template.</p> <p>Select that this plan offers guaranteed rates. Choose the following:</p> <ul style="list-style-type: none"> ◆ Guaranteed Rate—if the plan offers a guaranteed rate. SADP issuers must submit guaranteed rates. <p>The template prevents selection of the discontinued option of Estimated Rate.</p>

4.5 Plan Dates

The fields in this section are for each plan’s plan effective date and plan expiration (Figure 2G-6). The FFE rating engine uses the rate effective dates in the Rates Table Template, not the Plans & Benefits Template.



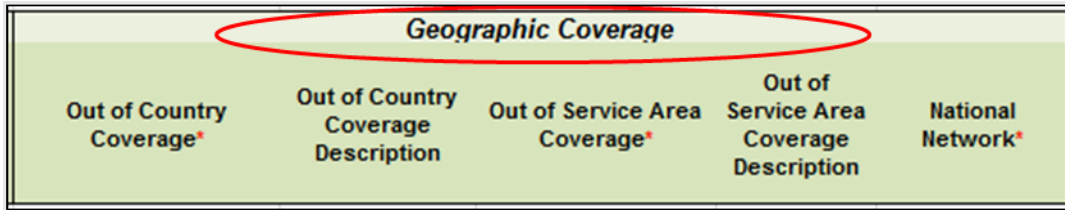
Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2024 plan year—even for existing plans offered on Exchange in 2023. Enter the effective date of the plan using the mm/dd/yyyy format. This must be 01/01/2024 for all plans that will be offered on the FFE and the Federally-facilitated Small Business Health Options 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 12/31/2024 for the Individual Market). FF-SHOP plans are effective for a 12-month plan year, so the plan expiration date is 12 months after the plan effective date.

4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Only select **Yes** for these data elements if your plan offers the entire benefit package for the geographic unit. Select **No** if the plan covers only emergency services for the geographic unit (Figure 2G-7).

⁴ Final HHS Notice of Benefit and Payment Parameters for 2024.

Figure 2G-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: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained out of the country. ◆ No—if the plan does <u>not</u> cover care obtained out of the country.
Out of Country Coverage Description*	If you select Yes for the <i>Out of Country Coverage</i> field, you must 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: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained outside the plan service area. ◆ No—if the plan does <u>not</u> cover care obtained outside the plan service area.
Out of Service Area Coverage Description*	If you select Yes for the <i>Out of Service Area Coverage</i> field, you must enter a short description of the care obtained outside the service area that the plan covers.
National Network**	Indicate whether a national network is available. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if a national network is available. ◆ No—if a national network is <u>not</u> available.

4.7 Benefit Information

The Benefit Information section of the template indicates the scope of benefits your plan covers (Figure 2G-8).

Figure 2G-8. Benefit Information Section

<i>Benefit Information</i>				
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
Primary Care Visit to Treat an Injury or Illness				
Specialist Visit				
Other Practitioner Office Visit (Nurse, Physician Assistant)				
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)				
Outpatient Surgery Physician/Surgical Services				
Hospice Services				
Routine Dental Services (Adult)				
Infertility Treatment				
Long-Term/Custodial Nursing Home Care				
Private-Duty Nursing				

Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. If this benefits package has multi-state plans (MSPs) using an alternate benchmark, click **Yes** in the pop-up. If it does not, 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 that is not listed on the template, click **Add Benefit** on the menu bar under the **Plans and Benefits** ribbon.

- Determine whether the benefit is listed in the drop-down menu; if it is, select it. If the benefit is not listed in the drop-down menu, click **Custom** and type in the new benefit name. New benefit names must be different from existing benefit names.
- A row for this benefit will appear below the last row in the Benefit Information section.
- If you add a benefit by mistake, you may do one of the following:
 - Select **Not Covered** under *Is this Benefit Covered?* (see 4.9 Out of Pocket Exceptions).
 - Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, and Out of Pocket Exceptions sections, including the benefit added by mistake.
- If you are adding a benefit that is not found in the state’s benchmark and are not substituting it for an EHB found in the state’s benchmark, select **Not EHB** as the EHB variance reason.
- If you are adding a benefit that is not found in the state’s benchmark and are substituting it for an EHB found in the state’s benchmark, select **Additional EHB Benefit** as the EHB variance reason.
- If you are adding 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.
- Do not add multiple benefits with the same name to a benefits package. If you offer 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

Use this section to provide information on each benefit in the benefits package, such as benefit coverage, benefit limits, applicable exclusions, and benefit explanations (Figure 2G-9).

Figure 2G-9. General Information Fields

Benefit Information		General Information						
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Exclusions	Benefit Explanation	EHB Variance Reason
Primary Care Visit to Treat an Injury or Illness								
Specialist Visit								
Other Practitioner Office Visit (Nurse, Physician Assistant)								
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)								
Outpatient Surgery Physician/Surgical Services								

General Information	Steps
EHB*	<p>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. You cannot edit this field.</p> <p>Note: Carefully review the benefits covered by your applicable EHB benchmark plan as identified on our Information on Essential Health Benefits (EHB) Benchmark Plans website. After reviewing the applicable EHB benchmark plan documents, you may need to update the Benefits Package worksheet to accurately reflect your coverage of EHB benchmark benefits. See the instructions for the <i>EHB Variance Reason</i> field for more information on updating the Benefits Package worksheet.</p>
Is this Benefit Covered?*	<p>This field is auto-populated with Covered for benefits identified in the template as EHBs. If you change this field to Not Covered, you must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification Form to support the actuarial equivalence of the substitution (see the <i>EHB Variance Reason</i> field). 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:</p> <ul style="list-style-type: none"> ◆ Covered—if this benefit is covered by the plan. A benefit is considered covered if you cover the cost of the benefit via first-dollar coverage or in combination with a cost-sharing mechanism (e.g., copays, coinsurance, or deductibles). ◆ Not Covered—if this benefit is <u>not</u> covered by the plan. A benefit is considered not covered if the consumer is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service?*	<p>If you selected Covered in the <i>Is this Benefit Covered?</i> field, complete this field. This field is auto-populated for EHBs. If you change this field for an EHB, you must provide an EHB variance reason and supporting documents. For benefits that are not EHBs, choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if this benefit has quantitative limits. ◆ No—if this benefit does <u>not</u> have quantitative limits. <p>Note: Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, you 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, you must provide a separate limit for those benefits.</p>
Limit Quantity*#	<p>If you selected Yes for <i>Quantitative Limit on Service?</i>, complete this field. This field is auto-populated for EHBs. If you change this data element, you must provide an EHB variance reason. For benefits that are not 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).</p>
Limit Unit*#	<p>If you selected Yes for <i>Quantitative Limit on Service?</i>, complete this field. This field is auto-populated for EHBs. If you change this data element, select the Substantially Equal EHB variance reason. Enter the unit used to restrict this benefit (e.g., to set a limit of two specialist visits per year, enter Visits per year here). Choose from the following:</p> <ul style="list-style-type: none"> ◆ 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

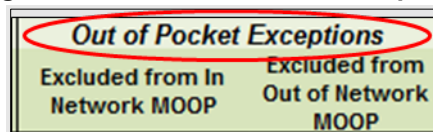
General Information	Steps
	<ul style="list-style-type: none"> ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. <p>Limit units that do not align with the list above (such as a limit of one hearing aid per ear every 48 months for subscribers up to age 18) will not auto-populate in the <i>Limit Unit</i> field, but will auto-populate in the <i>Benefit Explanation</i> field.</p> <p>Quantitative limits that span several types of services will not auto-populate. For instance, the benefit “Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services” will only appear in the <i>Benefit Explanation</i> field.</p> <p>Multiple limit units will not auto-populate. To implement multiple limits, complete the <i>Limit Quantity</i> and <i>Limit Unit</i> fields with the information that should be displayed on the Plan Compare function of the FFE website, then put all other quantitative limits in the <i>Benefit Explanation</i> field. For example, to enter the benefit “Outpatient Rehabilitative Services—90 days per year; two treatments per year,” you should enter 90 in the Limit Quantity field, Days per year in the <i>Limit Unit</i> field, and Two treatments per year in the <i>Benefit Explanation</i> field.</p> <p>The message “Quantitative limit units apply, see EHB benchmark” may appear in the <i>Benefit Explanation</i> field for benefits that do not have quantitative limits in the Benefits and Limits section of the Information on EHB Benchmark Plans page on the Center for Consumer Information and Insurance Oversight (CCIIO) website. This message appears when benefits identified in the Other Benefits section of the EHB Benchmark Benefit Template have quantitative limits that do not apply to all services in the higher-level benefit category.</p>
Exclusions**	<p>Enter any benefit-level exclusions.</p> <ul style="list-style-type: none"> ◆ If you cover particular services or diagnoses only under some circumstances, list the specific exclusions. ◆ If you do <u>not</u> exclude services or diagnoses, leave this field blank.
Benefit Explanation**	<p>Enter any benefit explanations.</p> <p>You might explain 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.</p>
EHB Variance Reason*	<p>If you have changed the <i>Is this Benefit Covered?</i>, <i>Limit Units</i>, or <i>Limit Quantity</i> fields, or if your state’s benchmark has an unallowable limit or exclusion under the PPACA, complete this field. Select from the following EHB variance reasons if this benefit differs from the state’s benchmark:</p> <ul style="list-style-type: none"> ◆ Not EHB—if this benefit is <u>not</u> an EHB. <ul style="list-style-type: none"> ▪ If you have added a new benefit not found in the state’s benchmark, the <i>EHB</i> field will be blank and you should set the EHB variance reason to Not EHB. This benefit is <u>not</u> considered an EHB. ▪ If a benefit auto-populated as Yes in the <i>EHB</i> column, but we or your state have directed you that the benefit should not be considered an EHB, set the EHB variance reason to Not EHB. This benefit is <u>not</u> considered an EHB. ◆ Substituted—if a benefit is included in your state’s EHB benchmark, the <i>EHB</i> field auto-populates as Yes. If you substitute a different benefit for an EHB, set the <i>EHB Variance Reason</i> to Substituted and <i>Is this Benefit Covered?</i> to Not Covered. The benefit you substitute must be designated as an Additional EHB Benefit.

General Information	Steps
	<ul style="list-style-type: none"> ◆ Substantially Equal—if the limit quantity or limit unit for a benefit differs from the limit quantity or limit unit in the EHB benchmark but is substantially equal to the EHB benchmark, select Substantially Equal as the variance reason. For example, a benchmark limit of 40 hours per month is substantially equal to a plan limit of 5 days per month where a day is defined as 8 hours. ◆ Using Alternate Benchmark—select this EHB variance reason for any benefit that has auto-populated Yes in the <i>EHB</i> column, 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 is not represented in the state’s EHB benchmark plan, set <i>Is this Benefit Covered?</i> to Covered and set the variance reason to Other Law/Regulation. (State-required benefits that were enacted after December 31, 2011, are <u>not</u> EHBs. Use Not EHB as the variance reason for such benefits.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan and the state requires coverage only in the Individual Market. ◆ Additional EHB Benefit—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list, change the benefit to Covered, and choose Additional EHB Benefit as the EHB variance reason. For example, covered non-preferred brand drug benefits may not appear to be covered in the auto-populated table. 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 you are only covering the dental EHB using a separate dental-only plan, set the EHB variance reason to Dental Only Plan Available. For example, if you offer SADPs to cover pediatric dental benefits, you do not need to cover pediatric dental in QHPs. Select Not Covered and 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.) <p>Note: EHB benchmark plan benefits are based on plans that were sold previously and may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, you may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Carefully review the information available on the Information on EHB Benchmark Plans page on the CCIIO website.</p> <p>If more than one EHB variance reason applies, select the variance reason related to EHB designation instead of the one related to limits because the EHB variance reason affects non-discrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to CSR plan variations. For example, if an issuer adds a new benefit that is an EHB and changes its limits, select Additional EHB Benefit variance reason instead of Substantially Equal.</p>

4.9 Out of Pocket Exceptions

This section allows you 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, you must create a new benefits package and complete a new Cost Share Variances worksheet (Figure 2G-10).

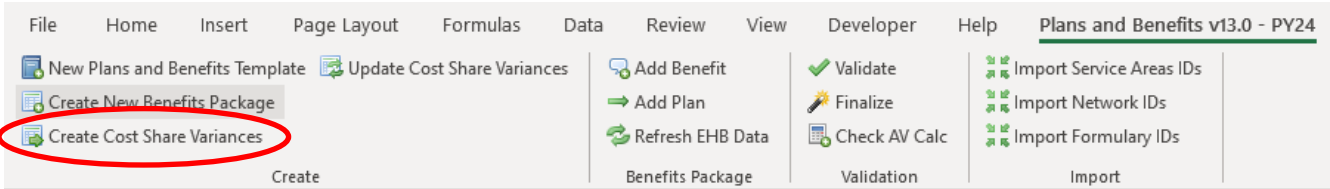
Figure 2G-10. Out of Pocket Exceptions



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: <ul style="list-style-type: none"> ◆ Yes—if this benefit is excluded from the in-network MOOP. ◆ No—if this benefit is <u>not</u> 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: <ul style="list-style-type: none"> ◆ Yes—if this benefit is excluded from the out-of-network MOOP. ◆ No—if this benefit is <u>not</u> excluded from the out-of-network MOOP.
<ul style="list-style-type: none"> ◆ If the plans only have a combined (no separate, in-network) MOOP, set <i>Excluded from In Network MOOP</i> equal to <i>Excluded from Out of Network MOOP</i>. ◆ If <i>Is this Benefit Covered?</i> is Not Covered or blank, leave the <i>Excluded from In Network MOOP</i> and <i>Excluded from Out of Network MOOP</i> fields blank. ◆ If the plans do not have an out-of-network MOOP, select Yes for <i>Excluded from Out of Network MOOP</i>. 	

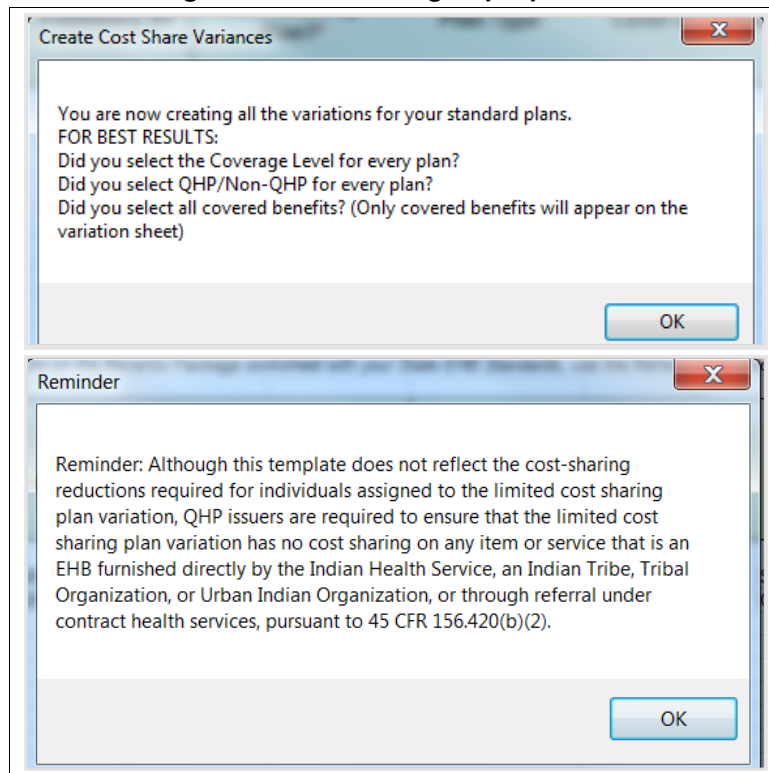
After the above benefit-related information is entered in the Benefits Package worksheet, click **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon (Figure 2G-11). The Cost Share Variances worksheet collects detailed cost-sharing benefit design information for all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

Figure 2G-11. Create Cost Share Variances Button



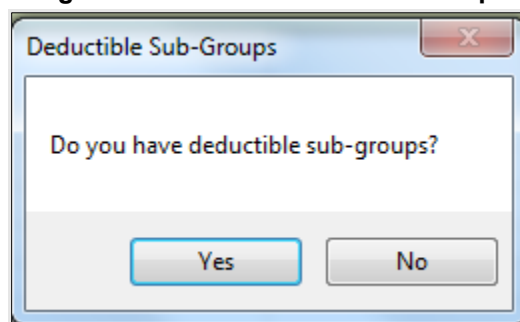
Click **OK** after reading the warnings (Figure 2G-12) and make any necessary changes.

Figure 2G-12. Warning Pop-Up Boxes



After you address the warnings, the following series of questions regarding deductible sub-groups appears (Figure 2G-13). Use deductible sub-groups to identify benefits or groupings of benefits that have separate deductibles. Deductible sub-groups are not separate from the maximums allowed, and they still contribute to the overall MOOP and deductible limits. You are not required to use deductible sub-groups.

Figure 2G-13. Deductible Sub-Groups

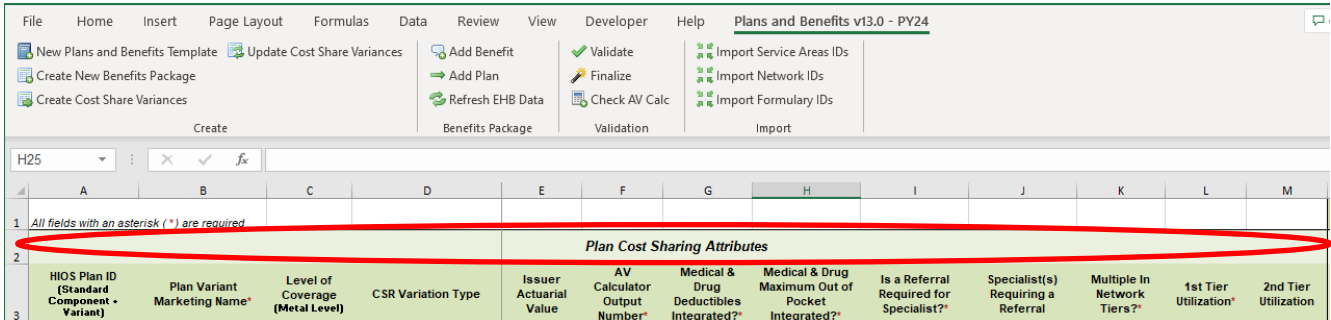


1. Do you have any deductible sub-groups?
 - a. **Yes**—if the plan contains deductible sub-groups.
 - b. **No**—if the plan does not contain deductible sub-groups.
2. If you select **Yes** for the previous question, the following questions will appear:
 - a. How many deductible sub-groups do you have?
 - i. Enter the correct number and click **OK**.

- b. What is the name of this deductible sub-group?
 - i. Enter a sub-group name and click **OK**. Repeat for each of your deductible sub-groups. You must use a different name for each sub-group.

A new Cost Share Variances worksheet is created for each Benefits Package worksheet (Figure 2G-14). Verify that any auto-populated information is accurate, then enter information for each benefits package in the corresponding Cost Share Variance worksheet, which will be labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2.

Figure 2G-14. Cost Share Variances Worksheet



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

4.10 Plan Cost-Sharing Attributes

This section collects 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 you submit, but CSRs do not apply to SADPs.

Plan Cost-Sharing Attributes	Steps
HIOS Plan ID*	<p>The HIOS-generated number auto-populates for each cost-sharing plan variation.</p> <ul style="list-style-type: none"> ◆ Standard plans to be offered on the Exchange have a plan ID variant suffix of “-01,” and standard plans to be offered off 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 (plan ID variant suffix “-02”) and one with limited cost sharing (plan ID variant suffix “-03”). <ul style="list-style-type: none"> ▪ In the zero cost-sharing plan variation, consumers do not 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 another provider with a referral from an Indian health care provider. ◆ In the Individual Market, each silver plan has three additional CSR plan variations: a 73 percent AV plan (plan ID variant suffix “-04”), an 87 percent AV plan (plan ID variant suffix “-05”), and a 94 percent AV plan (plan ID variant suffix “-06”). <ul style="list-style-type: none"> ▪ These silver plan variations lower the MOOP and the amounts consumers pay out of pocket for deductibles, coinsurance, and copayments. Consumers qualify for these plans if their income is below a certain level.

Plan Cost-Sharing Attributes	Steps
Plan Variant Marketing Name*#	The name of the plan auto-populates the standard plan's marketing name for all standard plans and plan variations. You must adjust any references to cost sharing or other benefit information so that the information is accurate for the applicable plan variation name. The name entered in this field will display to consumers, so enter the name for each of your plan variations in this field. The field has a limit of 255 characters, but the marketing name must not exceed 150 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, as a standard off-Exchange plan, or as one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	<p>If you entered Yes for <i>Unique Plan Design</i> in the Benefits Package worksheet, enter the AV. This applies to health plans that indicate they are a unique plan for AV purposes.</p> <p>Note: SADP issuers are not required to enter a value for this field for the template to validate. Instead, attest to the Stand-Alone Dental Plan Attestation. HIOS issuers will complete the attestation in MPMS and issuers in states that perform plan management functions will complete the attestation in the State Partnership Exchange Issuer Program Attestation Response Form, available on the QHP Certification website.</p>
AVC Output Number	After completing the cost-sharing information and benefits package information, click Check AV Calc on the Plans and Benefits ribbon and select the correct file to populate this field with the AV for all plans on this worksheet using non-unique plan designs. For more information, see Appendix A. This field is required for QHPs but optional for SADPs.
Medical & Drug Deductibles Integrated?^	<p>Indicate whether your 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:</p> <ul style="list-style-type: none"> ◆ Yes—if the medical and drug deductibles are integrated. If you enter Yes, do not enter information in the Medical Deductible section (4.16) or the Drug Benefits Deductible section (4.17). ◆ No—if the medical and drug deductibles are <u>not</u> integrated. If you enter No, do not enter information in the Combined Medical & Drug Deductible section (4.18).
Medical & Drug Maximum Out of Pocket Integrated?^	<p>Indicate whether the medical and drug MOOPs are integrated. An integrated MOOP allows 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:</p> <ul style="list-style-type: none"> ◆ Yes—if the medical and drug MOOPs are integrated. If you enter Yes, do not enter information in the Maximum Out of Pocket for EHB Benefits section (4.13) or the Maximum Out of Pocket for Drug Benefits section (4.14). ◆ No—if the medical and drug MOOPs are <u>not</u> integrated. If No is entered, issuers should not enter information in the Maximum Out of Pocket for EHB and Drug Benefits (Total) section (4.15).
Is a Referral Required for a Specialist?	<p>Indicate whether consumers must be referred to see a specialist. Choose from the following:</p> <ul style="list-style-type: none"> ◆ 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#	Enter the types of specialists that require a referral if Yes is entered for <i>Is a Referral Required for a Specialist?</i>

Plan Cost-Sharing Attributes	Steps
Multiple In Network Tiers?^*	<p>Indicate whether multiple in-network provider tiers allow the plan to apply different levels of in-network cost sharing depending on the provider or facility tier. The value must be the same for all variations of a plan. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—for multiple in-network provider tiers. Enter Tier 1 information in the <i>In Network</i> and <i>In Network (Tier 1)</i> sections and Tier 2 information in the <i>In Network (Tier 2)</i> sections. ◆ No—if there are <u>not</u> multiple in-network provider tiers. If you select this response, you cannot enter information in the <i>In Network (Tier 2)</i> sections, which will be grayed out and locked.
1st Tier Utilization^*	<p>If you respond Yes to <i>Multiple In Network Tiers?</i>, enter the 1st Tier Utilization as a percentage. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. The field auto-populates to 100% if you respond No to <i>Multiple In Network Tiers?</i> (All plan variations must match the standard plan 1st Tier Utilization.)</p>
2nd Tier Utilization^*	<p>If you respond Yes to <i>Multiple In Network Tiers?</i>, enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked if you respond No to <i>Multiple In Network Tiers?</i> (All plan variations must match the standard plan 2nd Tier Utilization.)</p>

4.10.1 Plan Variant Marketing Name

45 CFR 156.225, as finalized in the HHS Notice of Benefit and Payment Parameters for 2024, requires that QHP plan and plan variation marketing names include correct information, without omission of material fact, and do not include content that is misleading. Issuers may, but are not required to, add cost sharing and/or other benefit information to a plan marketing name here. This information must:

- Accurately reflect the plan variant’s benefits, including any quantitative limits (see Section 4.8) and limitations or cost variations based on tiering, benefit category, or service type. For example:
 - Plan Variant Marketing Names that list a non-integrated deductible or MOOP must specify if the deductible refers to “Medical” or “Drug,” remove references to a deductible or MOOP, or list the combined deductible or MOOP amount. If including a number without a modifier that refers to a deductible or MOOP, we encourage issuers to include the full amount for which an enrollee may be responsible.
 - Cost-sharing information must include any applicable limitations to a certain prescription drug category, specific providers, or to a certain number of visits.
- Correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and/or in other materials submitted as part of the QHP certification process such as the Summary of Benefits and Coverage (SBC).
- Be consistent with and clearly resemble the plan or plan variant name in other plan documents, such as the SBC, even if it is not identical.
- Not include references to benefits that the PPACA requires all QHPs to cover as though they were unique to that plan, such as “free preventive care” or “no exclusions for pre-existing conditions.”
- Not indicate health savings account (HSA) eligibility if the plan is not a High Deductible Health Plan (HDHP).
- Not exceed 150 characters.

Consumers applying for coverage should be able to understand references to benefit information in plan marketing names, and they should be able to confirm any information from a plan marketing name in the plan’s publicly available benefit descriptions.

4.11 Summary of Benefits and Coverage

4.11.1 Summary of Benefits and Coverage Scenario

You will complete three SBC scenarios in this section. Additional information on SBC scenarios and further resources for completing the scenarios can be found on the [Summary of Benefits and Coverage and Uniform Glossary page](#) of the CCIO website. Direct any concerns or requests for technical assistance 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). This section is not applicable to SADPs.

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.

4.11.2 Summary of Benefits and Coverage Mapping

The SBC URL review compares the SBC URL's in- and out-of-network cost-sharing data to the cost-sharing data in an issuer's Plans & Benefits Template to ensure data consistency. The following table shows the benefits in the Plans & Benefits Template that map to the benefits on the SBC Template. This review enables CMS to uncover inaccuracies in an issuer's SBC Form as well as unintentional data errors in an issuer's Plans & Benefits Template.

CMS no longer accepts any cross mappings for maternity-related services. The "If you are pregnant – Office visits" benefit from the SBC Template must correlate to the "Prenatal and Postnatal Care" benefit in the Plans & Benefits Template. The "Childbirth/delivery professional services" benefit cost sharing from the SBC Template must be entered into the Benefits Explanation section for the "Delivery and All Inpatient Services for Maternity Care" benefit in the Plans & Benefits Template. The "Childbirth/delivery facility services" benefit cost sharing from the SBC Template must correlate to the "Delivery and All Inpatient Services for Maternity Care" benefit in the Plans & Benefits Template.

Common Medical Event	SBC Form Benefit Name	Plans & Benefits Template Benefit Name
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visit to Treat an Injury or Illness
	Specialist visit	Specialist Visit
	Preventive care/screening/immunization	Preventive Care/Screening/Immunization
If you have a test	Diagnostic test (x-ray, blood work)	X-rays and Diagnostic Imaging
	Imaging (CT/PET scans, MRIs)	Imaging (CT/PET Scans, MRIs)
If you need drugs to treat your illness or condition	Generic drugs	Generic Drugs
	Preferred brand drugs	Preferred Brand Drugs
	Non-preferred brand drugs	Non-Preferred Brand Drugs
	Specialty drugs	Specialty Drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
	Physician/surgeon fees	Outpatient Surgery Physician/Surgical Services
If you need immediate medical attention	Emergency room care	Emergency Room Services
	Emergency medical transportation	Emergency Transportation/Ambulance
	Urgent care	Urgent Care Centers or Facilities

Common Medical Event	SBC Form Benefit Name	Plans & Benefits Template Benefit Name
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient Hospital Services (e.g., Hospital Stay)
	Physician/surgeon fees	Inpatient Physician and Surgical Services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral Health Outpatient Services
	Inpatient services	Mental/Behavioral Health Inpatient Services
If you are pregnant	Office visits	Prenatal and Postnatal Care
	Childbirth/delivery professional services	Delivery and All Inpatient Services for Maternity Care (Place the cost-sharing value in the Benefits Explanation field for this benefit.)
	Childbirth/delivery facility services	Delivery and All Inpatient Services for Maternity Care
If you need help recovering or have other special health needs	Home health care	Home Health Care Services
	Rehabilitation services	Outpatient Rehabilitation Services
	Habilitation services	Habilitation Services
	Skilled nursing care	Skilled Nursing Facility
	Durable medical equipment	Durable Medical Equipment
	Hospice services	Hospice Services
If your child needs dental or eye care	Children's eye exam	Routine Eye Exam for Children
	Children's glasses	Eye Glasses for Children
	Children's dental check-up	Dental Check-Up for Children

4.12 Maximum Out of Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Complete sections 4.13 and 4.14 only if you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; complete section 4.15 only if you responded **Yes**. Complete sections 4.16 and 4.17 only if you responded **No** to *Medical & Drug Deductibles Integrated?*; complete section 4.18 only if you responded **Yes**. If you only issue SADPs, skip to sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (5.1 MOOP and Deductible Guidance provides direction on completing and meeting all requirements in the MOOP and deductible sections of the template.)

The *Family* fields for the *In Network*, *In Network (Tier 2)*, and *Out of Network* MOOP and deductible values 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 field:

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan and for the specific CSR plan variations.⁵ See 5.5 Requirements for CSR Plan Variations for details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.

⁵ The final values are subject to change upon finalization of policies in *Premium Adjustment Percentage*, *Maximum Annual Limitation on Cost Sharing*, *Reduced Maximum Annual Limitation on Cost Sharing*, and *Required Contribution Percentage for the 2024 Benefit Year*. Issuers must comply with policies that are incorporated into this guidance.

- You must enter a per-person amount and per-group amount for MOOP and deductible; you may not enter **Not Applicable** for all these cells in all *Family* fields unless a 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 2G-15.

Figure 2G-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

Use this section to input MOOP values for medical EHBs only if your medical and drug MOOPs are not integrated (i.e., you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **Yes**, this section will be grayed out and locked). 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .
In Network—Family ^{^#}	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .
In Network (Tier 2)—Individual [^]	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Maximum Out of Pocket for Medical EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Maximum Out of Pocket for Medical EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the MOOPs are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .
Out of Network—Family	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for <i>Out of Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are <u>not</u> integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .
Combined In/Out Network—Family [#]	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .

4.14 Maximum Out of Pocket for Drug EHB Benefits

Use this section to input MOOP values for drug EHBs only if your medical and drug MOOPs are not integrated (i.e., you responded **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Maximum Out of Pocket for Drug EHB Benefits</i> .

MOOP Drug EHB Benefits	Steps
In Network—Family [#]	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Maximum Out of Pocket for Drug EHB Benefits</i> .
In Network (Tier 2)—Individual [^]	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the <i>In Network—Individual</i> field.)
In Network (Tier 2)—Family	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Maximum Out of Pocket for Drug EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the <i>In Network—Family</i> field.)
Out of Network—Individual	If the MOOPs are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits</i> .
Out of Network—Family	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Maximum Out of Pocket for Drug EHB Benefits</i> .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are <u>not</u> integrated, enter the <i>Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits</i> .
Combined In/Out Network—Family [#]	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits</i> .

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

Use this section to input MOOP values for medical and drug EHBs only if your medical and drug MOOPs are integrated (i.e., you responded **Yes** to *Medical & Drug Maximum Out of Pocket Integrated?*; if you responded **No**, this section will be grayed out and locked). Using the drop-down 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 <i>Total In Network Individual Maximum Out of Pocket</i> .
In Network—Family [#]	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total In Network Family Maximum Out of Pocket</i> .
In Network (Tier 2)—Individual [^]	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the dollar amount for the <i>Total In Network (Tier 2) Individual Maximum Out of Pocket</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
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 amounts for the <i>Total In Network (Tier 2) Family Maximum Out of Pocket</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the MOOPs are integrated, enter the dollar amount for the <i>Total Out of Network Individual Maximum Out of Pocket</i> .
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total Out of Network Family Maximum Out of Pocket</i> .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are integrated, enter the dollar amount for the <i>Total Combined In/Out of Network Individual Maximum Out of Pocket</i> .
Combined In/Out Network—Family [#]	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total Combined In/Out of Network Family Maximum Out of Pocket</i> .

4.16 Medical EHB Deductible

Use this section to input deductible values for medical EHBs only if your medical and drug deductibles are not integrated (i.e., you responded **No** to *Medical & Drug Deductibles Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Medical EHB Deductible</i> .
In Network—Family [#]	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Medical EHB Deductible</i> .
In Network—Default Coinsurance [^]	If the deductibles are <u>not</u> integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are <u>not</u> integrated, you must complete this field for the AV calculation if your plan uses the AVC.
In Network (Tier 2)—Individual [^]	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Medical EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Medical EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Default Coinsurance [^]	If the deductibles are <u>not</u> 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.
Out of Network—Individual	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Medical Deductible</i> .
Out of Network—Family	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Medical EHB Deductible</i> .
Combined In/Out Network—Individual ^{^#}	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Medical EHB Deductible</i> .
Combined In/Out Network—Family [#]	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Medical EHB Deductible</i> .

4.17 Drug EHB Deductible

Use this section to input deductible values for drug EHBs only if the medical and drug deductibles are not integrated (i.e., you responded **No** to *Medical & Drug Deductibles Integrated?*; if you responded **Yes**, this section will be grayed out and locked). Using the drop-down 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Drug EHB Deductible</i> .
In Network—Family [#]	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Drug EHB Deductible</i> .
In Network—Default Coinsurance [^]	If the deductibles are <u>not</u> integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual [^]	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked. (If you have multiple tiers

Drug EHB Deductible	Steps
	for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the <i>In Network—Individual</i> field.)
In Network (Tier 2)—Family	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for <i>In Network (Tier 2) Family Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the <i>In Network—Family</i> field.)
In Network (Tier 2)—Default Coinsurance [^]	If the deductibles are <u>not</u> 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. (If you have multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the <i>In Network—Default Coinsurance</i> field.)
Out of Network—Individual	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Drug EHB Deductible</i> .
Out of Network—Family	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Drug EHB Deductible</i> .
Combined In/Out Network—Individual ^{^#}	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Drug EHB Deductible</i> .
Combined In/Out Network—Family [#]	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Drug EHB Deductible</i> .

4.18 Combined Medical and Drug EHB Deductible

Use this section to input deductible values for medical and drug EHBs only if the medical and drug deductibles are integrated (i.e., you responded **Yes** to *Medical & Drug Deductibles Integrated?*; if you responded **No**, this section will be grayed out and locked). Using the drop-down 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 <i>In Network Individual Combined Medical and Drug EHB Deductible</i> .
In Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Combined Medical and Drug EHB Deductible</i> .
In Network—Default Coinsurance [^]	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are integrated, you must complete this field for the AV calculation if your plan uses 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 <i>In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
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 amounts for <i>In Network (Tier 2) Family Combined Medical and Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
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.
Out of Network—Individual	If the deductibles are integrated, enter the dollar amount for <i>Out of Network Individual Combined Medical and Drug EHB Deductible</i> .
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Combined Medical and Drug EHB Deductible</i> .
Combined In/Out Network—Individual ^{^#}	If the deductibles are integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible</i> .

Medical and Drug EHB Deductible	Steps
Combined In/Out Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Combined Medical and Drug EHB Deductible</i> .

4.19 Maximum Out of Pocket for Dental EHB Benefits

Use this section to input SADP MOOP values for dental EHBs. When entering the SADP MOOP values, ensure that the values are equal to or below the required limits for one covered child and two or more covered children as specified in [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year](#). 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 drop-down menus, enter the appropriate values for the individual and family SADP MOOPs for dental EHBs in the following areas of the template.

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

4.20 Dental EHB Deductible

Use this section to input deductible values for dental EHBs. The deductible value may not be higher than the MOOP value. Using the drop-down 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 <i>In Network Individual Dental Deductible</i> .
In Network—Family ^{**}	Enter the per-person and per-group dollar amounts for <i>In Network Family Dental Deductible</i> .
In Network—Default Coinsurance ^{*^}	Enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual ^{*^}	Enter the dollar amount for <i>In Network (Tier 2) Individual Dental Deductible</i> .
In Network (Tier 2)—Family [*]	Enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Dental Deductible</i> .

Dental EHB Deductible	Steps
Out of Network—Individual*	Enter the dollar amount for <i>Out of Network Individual Dental Deductible</i> .
Out of Network—Family*	Enter the per-person and per-group dollar amounts for <i>Out of Network Family Dental Deductible</i> .
Combined In/Out Network—Individual*^#	Enter the dollar amount for <i>Combined In/Out of Network Individual Dental Deductible</i> .
Combined In/Out Network—Family**	Enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Dental Deductible</i> .

4.21 Other Deductible

Complete this section if you have deductible sub-groups; you 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. Any value entered under Other Deductible contributes to the MOOP and deductible limits.)

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

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

HSA/HRA Detail	Steps
HSA-Eligible^#	<p>Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if the plan meets all HSA requirements. ◆ No—if the plan does <u>not</u> meet all HSA requirements. <p>Note that you should select No for zero cost-sharing plan variations and limited cost-sharing plan variations because they do not meet the requirements to be HSA-eligible. Entering an incorrect response will result in a Data Integrity review error.</p>
HSA/HRA Employer Contribution^	<p>If you are offering a small group plan, indicate whether the employer contributes to an HSA/HRA. Leave this field blank for the Individual Market. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if the plan has an HSA/HRA employer contribution. ◆ No—if the plan does <u>not</u> have an HSA/HRA employer contribution.

HSA/HRA Detail	Steps
HSA/HRA Employer Contribution Amount^	If you responded Yes to <i>HSA/HRA Employer Contribution</i> , enter a numerical value representing the employer contribution amount to the HSA/HRA. Leave this field blank for Individual Market plans; the template does not permit an Individual Market plan to enter an HSA/HRA contribution amount. As discussed at 78 <i>Federal Register</i> 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 AVC Additional Benefit Design

This section contains optional fields, which you may fill out to use as inputs in the AVC.

AVC Additional Benefit Design	Steps
Maximum Coinsurance for Specialty Drugs^	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?^	Enter the maximum number of days a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost Sharing After a Set Number of Visits?^	Enter the maximum number of fully covered visits before primary care cost sharing begins (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?^	Enter the maximum number of copay primary care visits that can occur before visits become subject to the deductible and/or coinsurance (1–10). If this option does not apply, leave the field blank.

4.24 Covered Benefits

Use this section to enter copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

- If the cost sharing of a benefit varies based on the **benefit setting** or the type of provider and the benefit does not specifically imply the place of service or type of provider (i.e. “Laboratory Services”), fill out the copay and coinsurance **for the most common setting for provision of that benefit**. **Briefly detail the cost sharing for any less common settings** in the *Benefit Explanation* field. Clearly communicate any cost-sharing information that varies based on the location of service or type of provider in the plan brochure.
 - For example, a Specialist Visit could take place in an office setting or a hospital and the copay or coinsurance could differ depending on the location. If the benefit does not specifically apply to either location, input the cost sharing for the location in which you expect the enrollee to most commonly redeem the benefit.
- If you offer plans that do not cover a given benefit out of network at 100 percent charge to the consumer, enter **Not Applicable** for the out-of-network copay fields and **100%** for the out-of-network coinsurance fields.
- If you charge only a copay or a coinsurance for a benefit, enter **Not Applicable** for the one you do not charge. For example, if you charge a \$20 copay for a benefit, enter **\$20** for the copay and **Not Applicable** for the coinsurance. Note: **No Charge** was used for this scenario in past years, but **Not Applicable** is the correct option in the 2024 template.
- Set the “Multiple In Network Tiers?” drop-down menu option to **“Yes”** if you have multiple in-network tiers, and evaluate whether the following scenarios apply:

- a. If you have multiple in-network tiers, enter the cost sharing for Tier 1 In-Network and the cost sharing for In Network Tier 2 by benefit. For those benefits without in-network tiering, enter **Not Applicable** for the In Network (Tier 2) cost sharing. For example, if you have multiple in-network tiers only for your inpatient hospital covered benefits, you should enter the cost sharing for both tiers for inpatient hospital covered benefits, and **Not Applicable** for the In Network (Tier 2) copay and coinsurance for other covered benefits.
 - b. If cost sharing does not vary by network and changes after a set number of visits for the specified benefit, input the highest-charged cost sharing into In Network (Tier 1) and set In Network (Tier 2) copay and coinsurance for that benefit to **Not Applicable**. Briefly detail any exceptions to the highest-charged cost sharing in the *Benefit Explanation* field.
5. For further instructions on coordinating 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.
 6. For further instructions on filling out the copayment and coinsurance fields corresponding to the AVC, please see [Appendix A](#).
 7. See 5.5 Requirements for CSR Plan Variations for cost-sharing requirements for the CSR silver plan variations and the zero and limited cost-sharing plan variations.

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

Figure 2G-16. Benefit Information Fields

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

Covered Benefits	Steps
Copay—In Network (Tier 1)*A#	<p>If you charge an in-network copayment, enter the dollar amount in this field. If no copayment is charged, enter Not Applicable. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if a coinsurance is charged. ◆ No Charge after deductible—after the consumer first meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, 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 <u>not</u> 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)*A#	<p>If a plan has multiple in-network tiers and you charge an in-network copayment, enter the dollar amount in this field. If you do not charge a copayment, enter Not Applicable. For any benefit category that does not have tiers, enter Not Applicable for this field and</p>

Covered Benefits	Steps
	<p><i>Coinsurance—In Network (Tier 2)</i>. This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copay if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, 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, <u>or</u> this benefit does not have multiple tiers. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
<p>Copay—Out of Network*#</p>	<p>If you charge an out-of-network copayment, enter the amount in this field. If you do not charge a copayment, enter Not Applicable. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, 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 <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
<p>Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network</p>	<p>The following are only available for Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility benefits. 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.</p> <p>The benefits Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services include these options as well as those described in <i>Copay—In Network (Tier 1)</i> above. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, 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 <u>not</u> subject to the deductible).

Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ \$X Copay per Stay—the consumer pays a copayment per stay (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay per Day after deductible—after the consumer meets the deductible, 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—after the consumer meets the deductible, 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—after the consumer pays the copay per day, 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—after the consumer pays the copay per stay, 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 <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit. <p>For Inpatient Hospital Services and Skilled Nursing Facility covered benefits, <u>do not</u> copy and paste cost-sharing values entered for other benefits (e.g., \$25 copay). Instead, enter values with the “per day” or “per stay” qualifiers. Copying and pasting any other cost-sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.</p>
Coinsurance—In Network (Tier 1) ^{*^#}	<p>If you charge an in-network coinsurance, enter the percentage the consumer will pay in this field. If you do not charge a coinsurance, 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:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> 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 <u>not</u> 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) ^{*^#}	<p>If a plan has multiple in-network tiers and you charge an in-network coinsurance, enter the percentage the consumer will pay in this field. If you do not charge a coinsurance, 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 in this field and in the <i>Copay—In Network (Tier 2)</i> field. This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible).

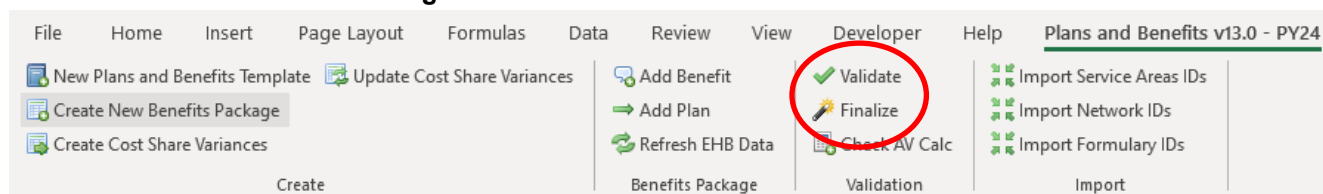
Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> 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 <u>not</u> 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 ^{*#}	<p>If you charge an out-of-network coinsurance, enter the percentage the consumer pays here. If you do not charge a coinsurance, 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 you do not cover this benefit out of network, enter 100%. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> 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 <u>not</u> 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

After entering all data, including all Benefits Package and Cost Share Variances worksheets, click **Save** to ensure no data are lost. Once the Plans & Benefits Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate on the menu bar under the Plans and Benefits ribbon. 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 reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize on the menu bar under the Plans and Benefits ribbon to create the .XML version of the template you will upload in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

Figure 2G-17. Validate and Finalize Buttons



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. Read this section to ensure your plans comply with all requirements.

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. See [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year](#) for more details on the annual limitation on cost-sharing values. Ensure that the following limits are met for the in-network EHB MOOP:
 - a. If a plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.
 - b. For standard and AV silver plan variations, the plan's in-network EHB MOOP values must be less than or equal to the MOOP for an individual (self-only) or the MOOP for a family (other than self-only) as set forth in the guidance described above.
 - c. For the zero cost-sharing plan variations, the in- and out-of-network MOOP and deductible values for EHBs must be \$0. These fields will auto-populate and should not be changed for EHBs.
 - d. 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 will auto-populate with the values entered for a standard plan and should not be changed.
2. Family MOOP Requirements.⁶ Ensure that the following limits are taken into consideration:
 - 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 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 and for the specific CSR plan variations as detailed in Annual Limitation on Cost Sharing 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 Section 2D: Business Rules for more details on offering self-only coverage and eligible dependent relationships.)

⁶ See the guidance titled *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year*.

3. Family Deductible Requirements.⁷ Ensure that the following limits are taken into consideration:
 - 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 deductible for both per group and per person.
 - b. For plans that allow only self-only coverage (individual plans), all family deductible 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 Section 2D: Business Rules for more details on offering self-only coverage and eligible dependent relationships.)
4. Definition of **Not Applicable** and **\$0** for deductibles and MOOPs.
 - a. Enter **\$0 not Not Applicable** if there is a zero-dollar deductible or MOOP. For example, if a plan has separate medical and drug deductibles, but there is no drug deductible, you must enter **\$0**.
 - b. Enter **Not Applicable** in the *In Network* MOOP or deductible fields only to imply that in-network service costs accumulate toward the *Combined In/Out of Network* MOOP or deductible.
 - c. If you enter **Not Applicable** in *Individual In Network* and *Individual Combined In/Out of Network*, the template will return an error when calculating the plan's AV using the AVC.
5. Use the *Family* MOOP and deductible fields to include multiple children in child-only plans.
6. The following explains how the values for various MOOP and deductible fields are related:
 - a. Plans may have a combined deductible and combined MOOP, separate deductibles and separate MOOPs, or both (deductibles combined, MOOPs separate OR deductibles separate and MOOPs combined) for both in-network and out-of-network charges. When defining deductibles and MOOPs, ensure your plan adheres to the guidelines.
 - b. If the plan does not have multiple in-network tiers, the following apply:
 - i. If *In Network* is equal to a dollar value (\$X), *Combined In/Out of Network* can be either a dollar value or **Not Applicable**.
 - ii. If *In Network* is **Not Applicable**, *Combined In/Out of Network* must contain a dollar value.
 - iii. *Out of Network* 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 *In Network* and *In Network (Tier 2)* are equal to dollar values, *Combined In/Out of Network* can be either a dollar value or **Not Applicable**.
 - ii. If *In Network* is **Not Applicable**, *In Network (Tier 2)* must be **Not Applicable** and *Combined In/Out of Network* must contain a dollar value.
 - iii. If *In Network (Tier 2)* is **Not Applicable**, *In Network* must be **Not Applicable** and *Combined In/Out of Network* must contain a dollar value.
 - iv. *Out of Network* 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.

⁷ See the guidance titled *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year*.

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 [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year](#).
7. They have an out-of-network deductible and an out-of-network MOOP greater than or equal to the annual limitation on cost sharing or that are identified as **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP and a combined in- and 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 identified as **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 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 for how cost-sharing information is displayed to the consumer on Plan Compare.)
11. All benefits except primary care visits and coverage of preventive health services are subject to the in-network deductible and you must provide benefits for at least three primary care visits and cover preventive health services before the customer reaches the deductible, in accordance with Section 2713 of the PHS Act.
12. Coverage of preventive health services is not subject to the in-network deductible and does not impose any other cost-sharing requirement, in accordance with Section 2713 of the PHS Act.

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 -2/+2 percentage points is used for standard plans.
 - a. The AV for a bronze plan must be between 58 percent and 62 percent.
 - b. The AV for an expanded bronze plan must be between 58 percent and 65 percent.
 - c. The AV for a silver plan (small group) must be between 68 percent and 72 percent.
 - d. The AV for a silver plan (individual, on-exchange) must be between 70 percent and 72 percent.
 - e. The AV for a silver plan (individual, off-exchange) must be between 68 percent and 72 percent.
 - f. The AV for a gold plan must be between 78 percent and 82 percent.
 - g. The AV for a platinum plan must be between 88 percent and 92 percent.
2. A de minimis variation of -0/+1 percentage point is used for silver plan variations.
 - a. The AV for the 73 percent AV silver plan variation must be between 73 percent and 74 percent.
 - b. The AV for the 87 percent AV silver plan variation must be between 87 percent and 88 percent.
 - c. The AV for the 94 percent AV silver plan variation must be between 94 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 changing the template:

1. If you add a benefit as an additional benefit by mistake, you may do one of the following to remove it:
 - a. Select **Not Covered** under *Is this Benefit Covered?* When the Cost Share Variances worksheet is generated, this benefit will not appear on that worksheet.
 - b. Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, Deductible, and Out of Pocket Exceptions sections, including the benefit added by mistake.
2. If you wish to remove an additional benefit or change whether it is **Covered** on the Benefits Package worksheet after you create the Cost Share Variances worksheet, you must delete the entire Cost Share Variances worksheet and generate a new one by clicking **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon.
3. To add or remove plans after creating the Cost Share Variances worksheet, do the following:
 - a. Add the new plan to the Benefits Package worksheet, then click **Update Cost Share Variances** on the menu bar under the **Plans and 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, then cut and paste the data for any plans beneath that row up to fill the empty row (as shown in Figure 2G-18) and click **Update Cost Share Variances**. For example, to delete Plan 2, you would delete all data from row 10, cut and paste Plan 3 into row 10 and Plan 4 into row 11, then click **Update Cost Share Variances** to remove Plan 2 from the Cost Share Variances worksheet, but leave Plan 3 and Plan 4. Any plans below an empty row and their corresponding data will be deleted from the Cost Share Variances worksheet if you click **Update Cost Share Variances** when there is an empty row between plans.

Figure 2G-18. Deleting a Plan

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI11111111	Plan 1
10	12345MI22222222	Plan 2
11	12345MI33333333	Plan 3
12	12345MI44444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI11111111	Plan 1
10		
11	12345MI33333333	Plan 3
12	12345MI44444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI11111111	Plan 1
10	12345MI33333333	Plan 3
11	12345MI44444444	Plan 4
12		

- c. If you change any benefits package data for an existing plan, only the following changes will be reflected on the Cost Share Variances worksheet when you click **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. To update the information for an existing plan, do the following:
 - i. Delete that plan on the Benefits Package worksheet, as explained above, and then click **Update Cost Share Variances** to delete it from the Cost Share Variances worksheet.
 - ii. Reenter the plan and associated data on the Benefits Package worksheet, and click **Update Cost Share Variances** to add the plan back to the Cost Share Variances worksheet.

5.5 Requirements for CSR 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 with a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the MOOP and 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.⁸ 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.

⁸ 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.

- 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.
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 73 percent and 74 percent, and must 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 87 percent and 88 percent.
 - d. The AV for the 94 percent AV silver plan variation must be between 94 percent and 95 percent.
 - e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the PPACA and in the [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year](#) for an individual (self-only) and 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 the annual limitation on cost sharing as described in Section 1302(c)(1) of the PPACA and in the [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year](#) for an individual (self-only) and 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 CSR 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 responses in *EHB* and *EHB Variance Reason* on the Benefits Package worksheet as outlined in 4.9 Out of Pocket Exceptions. Table 2G-1 explains when a benefit is considered an EHB based on different inputs.

Table 2G-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

EHB Field Value	EHB Variance Reason Field Value	Evaluated as an EHB?
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 CSR Plan Variations, successive cost sharing is required to offer multiple plan variations and data fields. Successive cost sharing ensures that parts of a given plan variation always offer equal or more generous cost-sharing value for the consumer than 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. 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. 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. 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.

MOOP, deductible, copay, and coinsurance may be used for successive cost sharing. Because successive cost sharing requires that the plan always be equal or preferable to the consumer, you may not change the cost-sharing structures such that the consumer in the higher AV plan variation may pay increased cost sharing in any circumstance. The following 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 cost of the service determines which is the better value.
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 if the deductible has not been reached.

Tables 2G-2 through 2G-8 show compliant and noncompliant data entry options for cost-sharing fields, as well as numerous examples.

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

Plan	Coinsurance	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	0%	

Plan	Coinsurance	Compliance
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%	
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 2G-6. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Options 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	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Copay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ 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	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay ◆ \$0 Copay After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (when greater than 0) ◆ \$Y Copay With Deductible (all values)
\$X Copay	<ul style="list-style-type: none"> ◆ No Charge ◆ \$Y Copay (when $Y \leq X$) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (when $Y > X$) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$Y Copay (when $\\$Y \leq \\X) ◆ \$Y Copay After Deductible (when $\\$Y \leq \\X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (when $\\$Y > \\X) ◆ \$Y Copay With Deductible (all values)
\$X Copay With Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ \$Y Copay (when $\\$Y < \\X) ◆ \$Y Copay With Deductible (when $\\$Y \leq \\X) ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (when $\\$Y > \\X)
Not Applicable	<ul style="list-style-type: none"> ◆ Not Applicable ◆ No Charge 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

Table 2G-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	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day (when $\\$Y \leq \\X) ◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$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	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ \$0 Copay Per Day ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$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)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay Per Day With Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when \$Y < \$X) ◆ \$Y Copay Per Stay With Deductible (when \$Y < \$X) ◆ No Charge ◆ No Charge After Deductible ◆ \$Y Copay per Day (when \$Y < \$X) ◆ \$Y Copay per Stay (when \$Y < \$X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when \$Y > \$X) ◆ \$Y Copay Per Day (when \$Y > \$X) ◆ \$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 \$Y > \$X) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay With Deductible	<ul style="list-style-type: none"> ◆ \$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 	<ul style="list-style-type: none"> ◆ \$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	<ul style="list-style-type: none"> ◆ \$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 ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$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) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay After Deductible	<ul style="list-style-type: none"> ◆ \$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 	<ul style="list-style-type: none"> ◆ \$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)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
No Charge After Deductible	<ul style="list-style-type: none"> ◆ 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 	<ul style="list-style-type: none"> ◆ \$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	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Per Day ◆ \$0 Per Stay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$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 2G-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

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

Example	Copay	Compliance
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: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. We understand that plans may have drug benefits that do not fit neatly into

the Plans & Benefits Template. You may translate your cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template using any of the following:

1. Enter the cost-sharing data for the tier in the Prescription Drug Template that has the highest generic drug utilization in 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 that have 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 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 that has 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 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. Although tiers are 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 would 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 non-preferred pharmacy cost sharing under the Tier 2 fields in 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 to **Not Applicable**.

Maximum Coinsurance for Specialty Drugs is defined only once in the Plans & Benefits Template for each plan; it cannot change among plan variations and 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, you are not required to submit a separate formulary in the Prescription Drug Template for plan variations.

Regardless of how you 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

Table 2G-9 and Table 2G-10 list the Plans & Benefits Template data elements that we anticipate displaying on Plan Compare. This list is not final and may change after these instructions are published, but you should use it as a reference as you prepare your QHP Application.

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

Plan Compare Label Name	Template Value	Data Source
Deductibles and Maximum Out of Pocket Rules	<ul style="list-style-type: none"> ◆ If medical and drug amounts are integrated, the combined amount will display. ◆ If medical and drug amounts are not integrated, the medical and drug amount will display on the Plan Summary page (the drug amount will also display in the Prescription Drug Details section). Medical and prescription drug deductibles will also display in the Details Section. ◆ For non-integrated deductibles, the total deductible (Medical + Rx) will display in the Plan Summary/Plan Results page. ◆ 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 the text “Per Group.” 	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in 4.16–18)	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 4.16–18)	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	URL Template
Insurance Company + Plan Marketing Name + Plan Type (Issuer Legal Name as recorded in HIOS will display if the Issuer Exchange Marketing Name is null)	Issuer Exchange Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
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

Plan Compare Label Name	Template Value	Data Source
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 <i>Level of Coverage</i>	Plans & Benefits Template
Reduced Costs	Indicates whether the plan is a CSR variant	Based on Consumer Eligibility information

Table 2G-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 <i>This Benefit Covered?</i> 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
Health 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	URL 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 <i>Medical & Drug Deductibles Integrated?</i> value is Yes , the text “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 <i>Medical & Drug MOOP Integrated?</i> value is Yes , the text “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

Plan Compare Label Name	Template Value	Template Source
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
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

This section lists the anticipated display logic for the deductible, MOOP, copay, and coinsurance cost sharing on Plan Compare for Individual Market coverage that is effective starting January 1, 2024. It covers most situations but is not exhaustive. This list is not final and may change after these instructions are published, but you should use it as a reference as you prepare your QHP Application.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug MOOP and deductible amounts are integrated, the combined total for the medical and drug data element will display on the Plan Summary page. The text “Included in Plan Deductible/ Included in Plan’s Out-of-Pocket Maximum” will display on the Plan Details page under the drug amounts.

- If medical and drug MOOP and deductible amounts are not integrated, the medical and drug amount will display on the Plan Summary page. The medical amount will display in the Costs for Medical Care section on the Plan Details page and 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.
- If more than one person is in the enrollment group, the Family Per Group MOOP amount will display on the Plan Summary page. The dollar amount will display followed by the text “Per Group.”
- If there is more than one person in the enrollment group and if you entered **\$0** or a positive dollar amount for *Family Per Group*, the Family Per Group deductible amount will display on the Plan Summary page. The dollar amount will display followed by the text “Per Group.”
- On the Plan Details page, the Family Per Group and 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

If you open the Plans & Benefits Add-In file before the Plans & Benefits Template, Excel sometimes loads an older version of the Add-In file that is not compatible with the template, which can cause run-time errors when you are entering data in the template or clicking buttons on the **Plans and Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for the best results.
2. Never rename the Add-In file.
3. Delete all extra copies of the Add-In file on the computer. When you download a new copy or version of the Add-In file, always choose the option to replace the old version.

If you still experience 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 new blank sheet in Excel. Excel should not load the **Plans and Benefits** ribbon.
 - a. If the **Plans and Benefits** ribbon appears, go to File > Options > Add-Ins (Figure 2G-19) > Manage: Excel Add-Ins > Go (Figure 2G-20) > uncheck Plansbenefitsaddin > OK (Figure 2G-21).
2. Verify that the **Plans and Benefits** ribbon is gone. Ensure you have only the correct version of the Add-In file on your computer.
3. Open the Plans & Benefits Template.
4. If the template opens the Add-In automatically after you click **Enable Macros**, the template has successfully loaded the Add-In.

Figure 2G-19. Excel Options Window

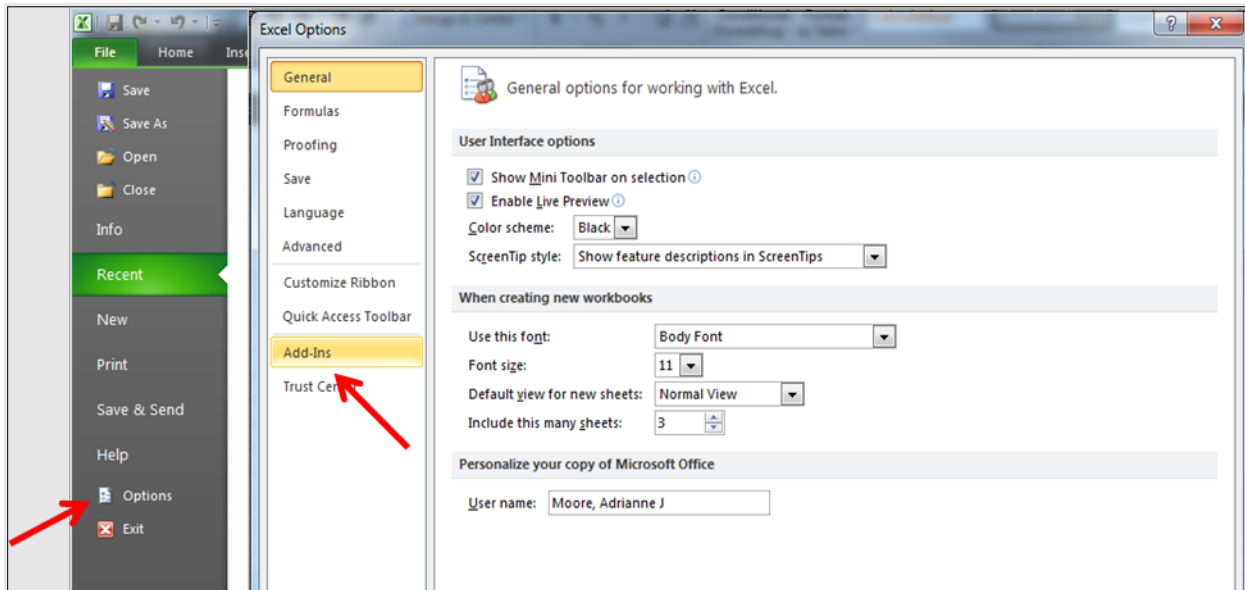


Figure 2G-20. Add-Ins Tab in Excel Options Window

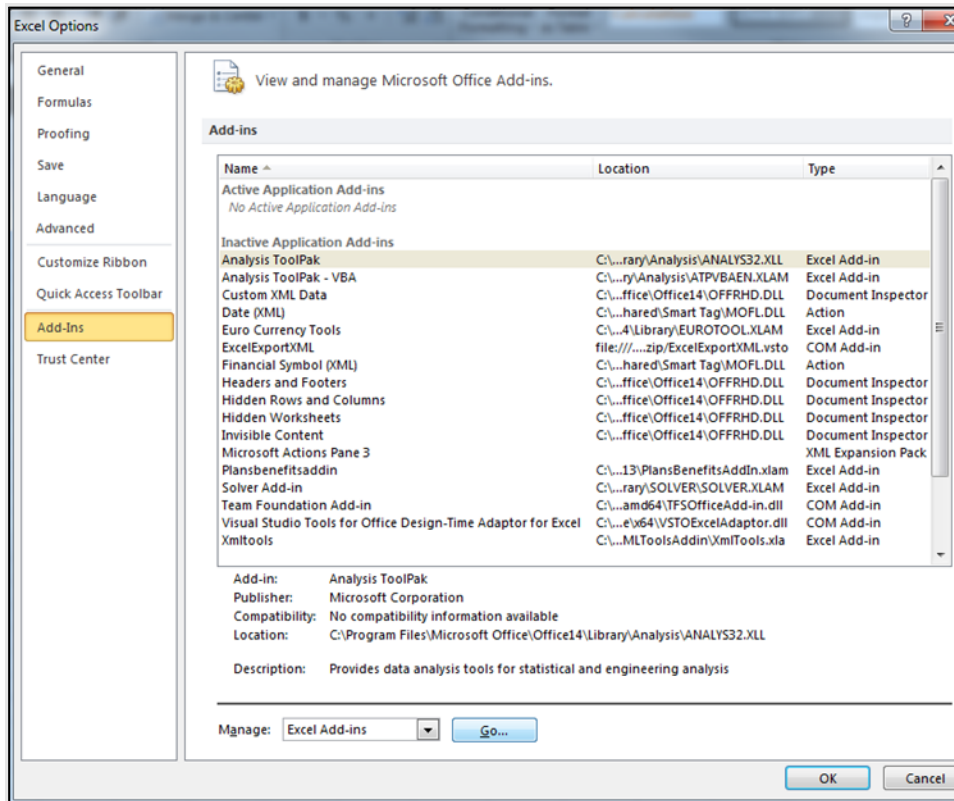
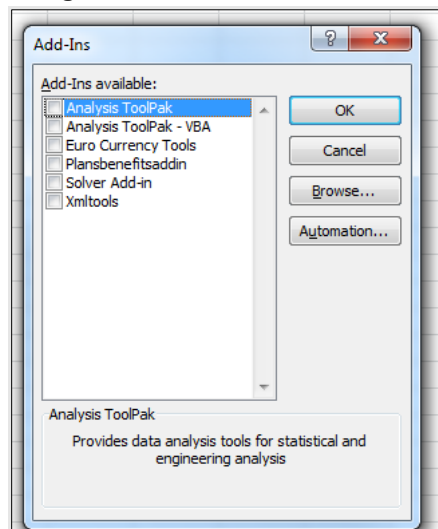


Figure 2G-21. Add-Ins Window



5.12 Standardized Plan Options and Corresponding Add-In File

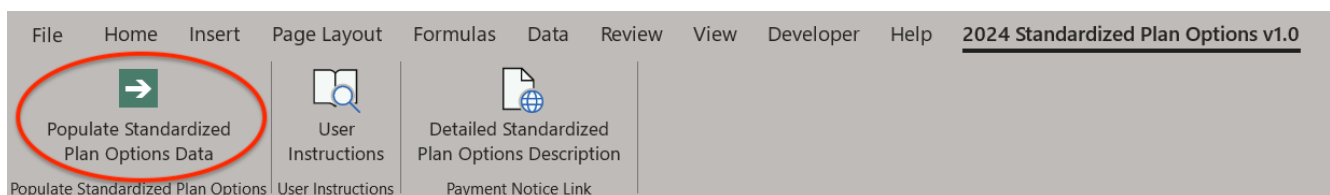
1. The SPOs Add-In file is provided to help users populate the cost-sharing information for plans that are using standardized plan options. Details regarding the purpose and parameters of the standardized plan options are specified in 45 CFR 156.201 of the preamble to the Final HHS Notice of Benefit and Payment Parameters.
2. Standardized plan options simplify the consumer shopping experience by offering plans that are easier for consumers to more meaningfully compare across issuers in the individual market. Standardized plan options have fixed MOOP values, fixed deductibles, and fixed copayment amounts or coinsurance rates

for a key set of EHBs. These benefits correspond to the EHB categories in the AVC, with the addition of the urgent care benefit category. Altogether, these benefit categories are responsible for a large percentage of the total allowable costs for an average enrollee. With the MOOPs, deductibles, and cost-sharing parameters for EHB standardized, consumers can take other important plan attributes into consideration during the plan selection process, such as plans' provider networks, formularies, quality ratings, and premiums.

Each state has one set of standardized plan option with a specified MOOP, deductible, and cost-sharing structure at each of the expanded bronze, silver, silver CSRs (73% AV, 87% AV, and 94% AV plan variations), gold, and platinum metal levels. HHS did not create standardized plan options for catastrophic plans. Issuers of QHPs are required to offer standardized plan options in accordance with 45 CFR 156.201 to offer QHPs through the Exchanges. The standardized plan options requirements at 45 CFR 156.201 are not applicable to SADPs or SHOP plans.

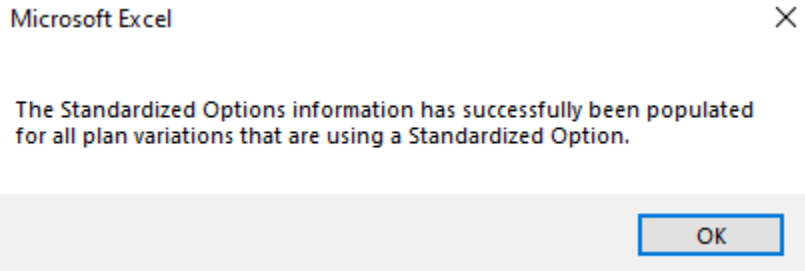
3. SPOs show the covered benefits and cost sharing amounts for each of the standardized plan options.
4. Populate the rest of the Benefits Package worksheet following the instructions detailed in Section 4 of these Plans & Benefits instructions. For details about the benefits and cost sharing expectations for each standardized plan design, including specific drug benefit cost sharing requirements, refer to the tables describing standardized plan designs in the Final HHS Notice of Benefit and Payment Parameters for 2024 (also found in Appendix G). The first set of standardized plan options applies to all FFE and SBE-FP issuers excluding those in Delaware, Louisiana, and Oregon. The second set of standardized plan options applies to issuers in Delaware and Louisiana. The third set of standardized plan options (which HHS did not design and are not included in the Final HHS Notice of Benefit and Payment Parameters for 2024) are those that have been designed by Oregon and, thus, apply to issuers in Oregon.
 - a. On each Benefits Package worksheet that has one or more plans using a standardized plan option, set every benefit listed in the applicable standardized plan option table as **Covered** under the *Is this Benefit Covered?* field; otherwise, the Add-In will not run.
5. Create the corresponding Cost Share Variances worksheet using the Plans & Benefits Add-In file. For further instructions on how to create a Cost Share Variances worksheet, please refer to Section 4.
6. To load the Standardized Plan Add-In, open the file. Unlike the Plans & Benefits Template Add-In, you must open the Standardized Plan Add-In or it will not load into the Plans & Benefits Template.
7. Press the **Populate Standardized Plan Options Data** button under the Standardized Plan Options Add-In ribbon (Figure 2G-22).

Figure 2G-22. Populate Standardized Plan Data Button



8. If everything runs correctly, the issuer will see the message below appear (Figure 2G-23); otherwise an error message will appear and indicate what needs to be corrected to proceed. After everything has been corrected, press the **Populate Standardized Plan Options Data** button again.
 - a. The **Populate Standardized Plan Options Data** button will populate all applicable fields on the Cost Share Variances worksheet. The populated values depend on the metal level of the standardized plan option and correspond to the values listed in the standardized plan options set forth in the Final HHS Notice of Benefit and Payment Parameters for 2024.

Figure 2G-23. Successful Population of Standardized Plan Data



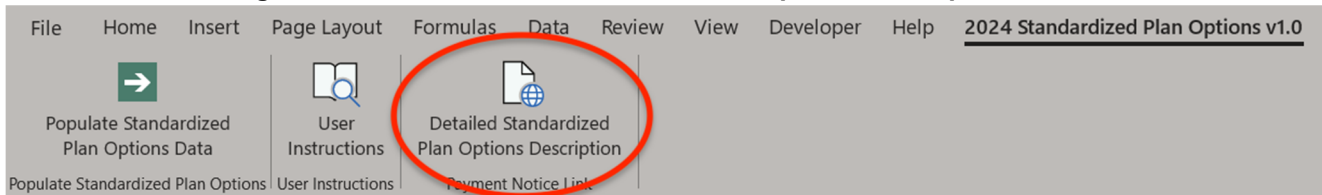
9. The SPOs Add-In file contains two buttons in addition to the main **Populate Standardized Plan Options Data** button.
 - a. The **User Instructions** button (Figure 2G-24) contains convenient abbreviated instructions similar to the instructions detailed here for reference while working in the Plans & Benefits Template.
 - b. The **Detailed Standardized Plan Options Description** (Figure 2G-25) button hyperlinks to the Final HHS Notice of Benefit and Payment Parameters for 2024 for a detailed description of the standardized plan options purpose and parameters.

Figure 2G-24. User Instructions Button

User Instructions

Standardized Options Add-in User Instructions	
1)	Populate all information on the Benefits Package tab before running the Standardized Options Add-in.
2)	Please ensure that every plan which is a standardized option is indicated as so in the "Design Type" column. To indicate that a plan is a standardized option, all FFE, SPE, SBE-FP States excluding Delaware, Louisiana, and Oregon, select "Design 1" from the drop down menu. To indicate that a plan is a standardized option in the States of Delaware and Louisiana, select "Design 2" from the drop down menu. To indicate that a is a standardized option in the State of Oregon, select "Design 3" from the drop down menu. Plans with a value of "Design 4", "Design 5", or "Not Applicable" in the "Design Type" column will not be treated as using a standardized option.
3)	The following benefits must be covered by any plan that is using a standardized option. Please ensure that all of these benefits are listed as "Covered" in the "Is this Benefit Covered?" field on all Benefits Packages that contain one or more plans using a standardized option. <ol style="list-style-type: none"> 1) Primary Care Visit to Treat an Injury or Illness 2) Specialist Visit 3) Outpatient Facility Fee (e.g., Ambulatory Surgery Center) 4) Outpatient Surgery Physician/Surgical Services 5) Urgent Care Centers or Facilities 6) Emergency Room Services 7) Inpatient Hospital Services (e.g., Hospital Stay) 8) Skilled Nursing Facility 9) Mental/Behavioral Health Outpatient Services 10) Mental/Behavioral Health Inpatient Services 11) Substance Abuse Disorder Outpatient Services 12) Substance Abuse Disorder Inpatient Services 13) Generic Drugs 14) Preferred Brand Drugs 15) Non-Preferred Brand Drugs 16) Specialty Drugs 17) Imaging (CT/PET Scans, MRIs) 18) Preventive Care/Screening/Immunization 19) Rehabilitative Speech Therapy 20) Rehabilitative Occupational and Rehabilitative Physical Therapy 21) Laboratory Outpatient and Professional Services 22) X-rays and Diagnostic Imaging
4)	Create corresponding Cost Share Variances tab(s) for all Benefits Package tab(s) in the Plans and Benefits Template.
5)	Everything is now ready for the Standardized Options Add-in. Press the "Populate Standardized Options Data" button. The macro will let you know whether any data errors were identified. If no data errors were identified, the macro will let you know that all Standardized Options data was populated.

Figure 2G-25. Detailed Standardized Plan Options Description Button



After you have entered all data, click **Save** to ensure no data are lost.

5.13 Non-Standardized Plan Option Limits

1. Non-standardized plan option limits are intended to improve the consumer shopping experience by reducing the risk of plan choice overload and suboptimal plan selection, allowing consumers to more easily and more meaningfully compare available plan options. Details regarding limits on non-standardized plan options are specified in 45 CFR 156.202 of the preamble to the Final HHS Notice of Benefit and Payment Parameters for 2024. Under the requirements at 45 CFR 156.202, issuers are limited to offering four non-standardized plan options through Exchanges on the Federal platform (including SBE-FPs) per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area, for PY2024, as a condition of QHP certification. The non-standardized plan option limit requirements at 45 CFR 156.202 are not applicable to SADPs or SHOP plans.
2. This limit will be further reduced to two non-standardized plan options per product network type, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage, in any service area, for PY2025 and subsequent plan years.
3. For PY2024, you may offer up to four non-standardized plan options per the following combination:
 - a. Product network type, as described in the definition of “product” at 45 CFR 144.103
 - b. Metal level (excluding catastrophic plans)
 - c. Service area (defined by county)
 - d. Dental and/or vision benefit coverage (Figure 2G-26)
4. Differing dental and/or vision benefit coverage is indicated by plans offering a different combination of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage.
 - a. Adult dental benefit coverage is defined as covering any combination of the following in the “Benefits” column within the Plans & Benefits Template:
 - i. Routine Dental Services (Adult)
 - ii. Basic Dental Care—Adult
 - iii. Major Dental Care—Adult.
 - b. Pediatric dental benefit coverage is defined as covering any combination of the following in the “Benefits” column within the Plans & Benefits Template:
 - i. Dental Check-Up for Children
 - ii. Basic Dental Care—Child
 - iii. Major Dental Care—Child.
 - c. Adult vision benefit coverage is defined as covering the following in the “Benefits” column within the Plans & Benefits Template:
 - i. Routine Eye Exam (Adult).

Figure 2G-26. Non-Standardized Plan Option Limits—Applicable Benefits for the Inclusion of Dental and/or Vision Benefits within the Plans & Benefits Template

Weight Loss Programs			Benefit Information		
	Yes	Covered	Benefits	EHB	Is this Benefit Covered?
Routine Eye Exam for Children	Yes	Covered	Primary Care Visit to Treat an Injury or Illness	Yes	Covered
Eye Glasses for Children	Yes	Covered	Specialist Visit	Yes	Covered
Dental Check-Up for Children	Yes	Covered	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered
Rehabilitative Speech Therapy	Yes	Covered	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered	Outpatient Surgery Physician/Surgical Services	Yes	Covered
Well Baby Visits and Care	Yes	Covered	Hospice Services	Yes	Covered
Laboratory Outpatient and Professional Services	Yes	Covered	Routine Dental Services (Adult)		
X-rays and Diagnostic Imaging	Yes	Covered	Infertility Treatment		
Basic Dental Care – Child	Yes	Covered	Long-Term/Custodial Nursing Home Care		
Orthodontia – Child	Yes	Covered	Private-Duty Nursing		
Major Dental Care – Child	Yes	Covered	Routine Eye Exam (Adult)		
Basic Dental Care – Adult					
Orthodontia – Adult					
Major Dental Care – Adult					

5. More than four plans may be offered in each product type, metal level, and service area combination due to differing dental and/or vision benefit coverage, as described above. However, non-standardized plan options are only permitted to have up to four distinct sets of cost-sharing data for plans sharing the same product type, metal level, and service area. This includes the following fields within the Plans & Benefits Template:
 - a. Maximum Out of Pocket (Figure 2G-27)
 - i. *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 1 or Tier 2)—Individual or Family*
 - b. EHB Deductible (Figure 2G-28)
 - i. *Medical EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*
 - ii. *Drug EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*
 - iii. *Combined Medical & Drug EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*
 - c. In Network (Tier 1) and In Network (Tier 2) Copay and Coinsurance for all benefits except the following dental and vision benefits:
 - i. Routine Dental Services (Adult)
 - ii. Basic Dental Care—Adult
 - iii. Major Dental Care—Adult
 - iv. Routine Eye Exam (Adult)
 - v. Dental Check-up for Children
 - vi. Basic Dental Care—Child
 - vii. Major Dental Care—Child
 - viii. Routine Eye Exam for Children
 - ix. Orthodontia—Child
 - x. Orthodontia—Adult
 - xi. Eyeglasses for Children.

Figure 2G-27. Non-Standardized Plan Option Limits—Applicable MOOP/Deductible Sections within the Plans & Benefits Template

All fields with an asterisk (*) are required

Plan Cost Sharing Attributes												
HIOS Plan ID (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage (Metal Level)	CSR Variation Type	Service Type	AV Calculation Output Number*	Medical & Drug Deductibles Integrated?*	Medical & Drug Maximum Out of Pocket Integrated?*	Is a Referral Required for Specialist?*	Specialist(s) Requiring a Referral	Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
10333TX0050020-00	PB Med Indl 1	Bronze	Standard	Off Excl	60.00%	Yes	Yes	No		No	100%	
10333TX0050020-01	PB Med Indl 1	Bronze	Standard	On Excl	60.00%	Yes	Yes	Yes	Podiatrist	No	100%	
10333TX0050020-02	PB Med Indl 1	Bronze	Zero Cost	Plan V	100.00%	Yes	Yes	No		No	100%	

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
\$2,403	\$7,000 per person \$13,000 per group			\$2,403	\$7,000 per person \$13,000 per group
\$9,100	\$9,100 per person \$18,200 per group			\$2,403	\$7,000 per person \$13,000 per group
\$0	\$0 per person \$0 per group			\$0	\$0 per person \$0 per group
\$9,100	\$9,100 per person \$18,200 per group			\$2,403	\$7,000 per person \$13,000 per group
\$9,400	\$9,400 per person \$18,800 per group			\$9,000	\$9,000 per person \$18,000 per group
\$9,400	\$9,400 per person \$18,800 per group			\$9,000	\$9,000 per person \$18,000 per group

Figure 2G-28. Non-Standardized Plan Option Limits—Applicable Cost-Sharing Sections within the Plans & Benefits Template

Primary Care Visit to Treat an Injury or Illness				
Copay		Out of Network	Coinsurance	
In Network (Tier 1)	In Network (Tier 2)		In Network (Tier 1)	In Network (Tier 2)
\$50.00		\$50.00	75.00%	
No Charge after deductible		\$50.00	Not Applicable	
\$0.00		\$0.00	0.00%	
No Charge after deductible		\$50.00	Not Applicable	
\$50.00		\$0.00	Not Applicable	

6. There may be no more than four variations of each non-standardized plan option per issuer, product network type, metal level, and service area combination for each plan structure with unique cost-sharing data. However, in addition to offering up to four non-standardized plan options (each with a distinct set of cost-sharing data), you may offer each one of those plans in four variations based on the inclusion of dental and vision benefit coverage:
 - a. No dental benefit coverage and no vision benefit coverage
 - b. Dental benefit coverage (adult, pediatric, or both) but no vision benefit coverage
 - c. Vision benefit coverage but no dental benefit coverage (neither adult nor pediatric)
 - d. Dental benefit coverage (adult, pediatric, or both) and vision benefit coverage.

This concludes the Plans & Benefits section of the QHP Application Instructions.

Section 2H: Prescription Drug

1. Introduction

In the Prescription Drug section of MPMS, you will create cost-sharing values for each tier of drug benefits and select the drugs that will be offered at each tier level. These instructions do not apply to SADP-only issuers.

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

- QHP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. A drug list with RxNorm Concept Unique Identifiers (RXCUIs) and formulary tier numbers. You may offer drugs that do not have associated RXCUIs, but may not include such drugs on the Prescription Drug Template.¹

3. Quick Reference

Key Changes for 2024

- ◆ For Standardized Plan Options (SPOs), issuers should have four tiers of prescription drug cost sharing. The cost sharing should conform with the following benefits specified in the Final HHS Notice of Benefit and Payment Parameters for 2024: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. If you include the Zero Cost Share Preventive Drugs tier type, that tier type must be entered as Tier 1 for the associated formulary ID within the Prescription Drug Template. If you include the Medical Service Drugs tier type, that tier type must be entered as the highest tier for the associated formulary ID within the Prescription Drug Template. Finally, if you include both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types in their standardized plan options, you should enter Zero Cost Preventive Drugs for Tier 1, Generic Drugs for Tier 2, Preferred Brand Drugs for Tier 3, Non-preferred Drugs for Tier 4, Specialty Drugs for Tier 5, and Medical Services Drugs for Tier 6.
- ◆ The template will now allow you to enter a duplicate instance of an RXCUI on the *Drug Lists* tab. Each RXCUI you choose to duplicate may only be duplicated once in the template. If you offer one drug list, the one instance of the duplicate RXCUI must be assigned to a tier that corresponds to the Zero Cost Share Preventive Drugs tier type on the *Formulary Tiers* tab. If you offer more than one drug list, you may enter values of “NA” for both instances of the RXCUI, denoting the RXCUI is not covered on that drug list, or you may enter the value of “NA” for one instance of the duplicate RXCUI and may assign the second instance of the duplicate RXCUI to any other tier.
- ◆ SPOs of different metal levels must have distinct formulary IDs selected to ensure the appropriate cost sharing is assigned for that plan’s level of coverage.

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.
- ◆ Each drug list may have only one tier structure, as indicated by number of tiers and drug tier types, and all formularies associated with each drug list must be identical. The .XML file generated from the template and submitted to MPMS includes only the Number of Tiers and Drug Tier Type fields for the first formulary associated with each drug list.
- ◆ If you offer plans in the Individual and SHOP Markets, you must create separate formulary IDs for each market, regardless of whether the formulary is intended to serve both markets. If you submit via the National Association of Insurance Commissioners’ (NAIC’s) System for Electronic Rates & Forms Filing (SERFF) you must use the same Prescription Drug Template across all binders or ensure that no formulary IDs repeat across the binders.

¹ 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.

Additional Resources

- ◆ There are [supporting documents](#) for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Complete the Drug Lists worksheet before you fill out the Formulary Tiers worksheet in the template. See Figure 2H-1 for a sample completed Drug Lists worksheet.

Figure 2H-1. Drug Lists Worksheet

Drug Lists							
All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.							
Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.							
After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.							
Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.							
Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).							
Drug List ID 1				Drug List ID 2			
RXCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required	
Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
405550	3 No	No	No	3 No	No	No	
405551	2 No	No	Yes	NA			
405552	1 No	No	No	1 No	No	No	
405553	1 No	No	No	1 No	No	No	
405554	2 No	No	No	2 No	No	No	
405555	3 No	No	No	3 No	No	No	
405556	3 No	No	No	3 No	No	No	
405557	2 No	No	No	NA			
405558	1 No	No	No	NA			
405559	1 No	No	No	1 No	No	No	
405560	2 No	No	No	2 No	No	No	
405561	3 No	No	No	3 No	No	No	
405562	3 No	No	No	3 No	No	No	
405563	2 No	No	No	2 No	No	No	
405564	1 No	No	No	1 No	No	No	
405565	1 No	No	No	NA			
405566	2 No	No	No	2 No	No	No	
405567	3 No	No	No	3 No	No	No	
405568	3 No	No	No	3 No	No	No	

Before entering details for each drug list, enter all RXCUIs included in any of the drug lists into Column A, beginning in Row 9. After entering all of the unique RXCUIs, enter the drug list-specific information in each row.

Drug List	Steps
RXCUI	<p>When selecting RXCUIs to include, use the December 5, 2022, full monthly release of RxNorm data to find a list of valid RXCUIs. To download the file, you will need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account. You can obtain a license and account at no charge by following the instructions at the National Library of Medicine.</p> <p>Application resources including the EHB RX Crosswalk, a reformatted RxNorm database, and state review tools can be found on the Review Tools page of the qualified health plan (QHP) certification website.</p> <p>RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK.</p> <p>The drug list should include all drugs on your formulary, even those that are not in a category or class identified in the summary of EHB benchmark information. This includes all drugs you list as “medical service drugs.”</p>
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	<p>Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if prior authorization is required. ◆ No—if prior authorization is <u>not</u> required.

Drug List	Steps
	If Tier Level is “NA,” leave this column blank.
Step Therapy Required	<p>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:</p> <ul style="list-style-type: none"> ◆ Yes—if step therapy is required. ◆ No—if step therapy is <u>not</u> required. <p>If Tier Level is “NA,” leave this column blank.</p>

To add another drug list, click **Add Drug List** (Figure 2H-2). You must complete the Tier Level, Prior Authorization Required, and Step Therapy Required columns as described above to complete the new drug list.

Figure 2H-2. Add Drug List Button

Drug List	Steps
	If Tier Level is “NA,” leave this column blank.
Step Therapy Required	<p>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:</p> <ul style="list-style-type: none"> ◆ Yes—if step therapy is required. ◆ No—if step therapy is <u>not</u> required. <p>If Tier Level is “NA,” leave this column blank.</p>

To remove a drug list, click **Remove Drug List** (Figure 2H-3). Drug lists are removed in reverse order, meaning the last drug list created is removed first. To remove a drug list other than the last drug list created, copy the data from the last created drug list and paste it into the drug list you wish to delete to overwrite the data you wish to remove, then click **Remove Drug List** to remove the final drug list you have just duplicated.

Delete any unused drug lists that link to formulary IDs that are not linked to a standard component ID in the Plans & Benefits Template. Before deleting a drug list, make sure all remaining formulary IDs link to the correct drug lists.

Figure 2H-3. Remove Drug List Button

Drug List	Steps
	If Tier Level is “NA,” leave this column blank.
Step Therapy Required	<p>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:</p> <ul style="list-style-type: none"> ◆ Yes—if step therapy is required. ◆ No—if step therapy is <u>not</u> required. <p>If Tier Level is “NA,” leave this column blank.</p>

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 in which the template will apply from the drop-down menu.
Generate Formulary IDs	<p>Click Create Formulary IDs to create the formulary IDs.</p> <ul style="list-style-type: none"> ◆ A pop-up dialog box will appear and prompts you to enter the number of formularies.

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ 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 <i>Formulary ID</i> column.
Formulary ID	<p>Select the formulary ID from the drop-down menu.</p> <ul style="list-style-type: none"> ◆ 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	<p>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, you must complete it before you can proceed.</p>
Number of Tiers	<p>Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a given formulary must correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created within a tier. All drugs within each tier should have the same cost-sharing structure.</p>
Drug Tier ID	<p>Do not edit the <i>Drug Tier ID</i> column; it is controlled by the template. The template populates this column based on the selection in Number of Tiers and grays out cells that do not apply.</p>
Drug Tier Type	<p>Click the drop-down menu, and select Click here to select to open a dialog box. Choose 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.</p> <ul style="list-style-type: none"> ◆ 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, choose the preferred generic tier type. The same applies for a tier with preferred and non-preferred brand drugs. ◆ Multiple tiers may have the same drug tier types, but each tier should have unique 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. <p>Zero Cost Share Preventive Drugs:</p> <ul style="list-style-type: none"> ◆ When Zero Cost Share Preventive Drugs is selected for a tier, it is the only tier type that can be selected. Classify 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 be set to \$0 and 0 percent, respectively, when you choose this tier type. The remaining pharmacy benefit types can still be edited. If remaining pharmacy benefits are offered, enter the subsequent cost-sharing values as \$0 and 0 percent. ◆ If you offer 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 <i>Explanation</i> field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page. <p>Medical Service Drugs:</p> <ul style="list-style-type: none"> ◆ Use this tier type to indicate that a formulary contains medical service drugs. We recognize that some state benchmarks contain medical service drugs in various categories and classes; a Medical Service Drugs tier can help identify these drugs in the formulary.

Formulary Tiers	Steps
	<ul style="list-style-type: none"> ◆ 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	<p>This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i>. You must indicate whether each tier 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:</p> <ul style="list-style-type: none"> ◆ 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 Order² 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	<p>Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use Not Applicable, <u>not</u> No Charge, for copayment if a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, 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. You may only select Not Applicable for coinsurance and copay if the drug tier type is Medical Service Drugs.
Coinsurance	<p>Enter the coinsurance amount for the given pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use Not Applicable, <u>not</u> No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, 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. You may only select Not Applicable for copay and coinsurance if the drug tier type is Medical Service Drugs.

² 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).

Complete cost-sharing fields in the Prescription Drug Template 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 *Benefit Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page.

We will review tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing your formulary tier structure, use standard industry practices. Tier 1 should be considered the lowest cost-sharing tier available, which means a Zero Cost Share Preventive Drugs tier should be listed first. Subsequent tiers in the formulary structure should be higher cost-sharing tiers listed in ascending order. Place the Medical Service Drugs tier as the last tier for all formulary designs.

Under the Patient Protection and Affordable Care Act (PPACA), preventive services must be covered without requiring the consumer to pay a copayment or coinsurance or meet a deductible. For more information on covering preventive services, see the [preventive health services web page](#) on [HealthCare.gov](#).

We recommend you place preventive drugs in a separate Zero Cost Share Preventive Drugs tier in the Prescription Drug Template. If you have 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 *Benefit Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page.

If you have used all seven available tiers, include the 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 one of the seven tiers is a Medical Service Drugs tier, remove the Medical Service Drugs tier and add a Zero Cost Preventive Drugs tier as the first tier.

If you offer a tier with cost sharing of zero that is not a preventive tier, you 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. **Not Applicable** may only be used for copayment and coinsurance in a Medical Service Drugs tier.

The Prescription Drug Template does not capture minimum or maximum copay or coinsurance. 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 the plan brochure, and on the formulary web page.

You are now required to have four drug tiers for all SPOs. Enter the cost-sharing for generic drugs for Tier 1, the cost-sharing for preferred brand drugs for Tier 2, the cost-sharing for non-preferred brand drugs for Tier 3, and the cost-sharing for specialty drugs for Tier 4. You may add the Zero Cost Share Preventive Drugs tier and the Medical Service Drugs tier in addition to the four tiers specified in this plan design, if so desired. If you choose to include the Zero Cost Share Preventive Drugs tier type, that tier type must be entered as Tier 1 for the associated formulary ID and if you include the Medical Service Drugs tier type that tier type must be entered as the highest tier for the associated formulary ID. Finally, if you choose to include both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types, then you should enter Zero Cost Preventive Drugs for Tier 1, Generic Drugs for Tier 2, Preferred Brand Drugs for Tier 3, Non-preferred Drugs for Tier 4, Specialty Drugs for Tier 5, and Medical Services Drugs for Tier 6.

After entering all data, click **Save** to ensure no data are lost. Once the Prescription Drug Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate 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.

Template Validation and Submission Step	Step Description
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the template to create the .XML file of the template you will upload in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

Section 2I: Service Area

1. Introduction

In the Service Area section of MPMS, you identify the service areas associated with your QHPs, SADPs, or both, by state and county. You must submit the Service Area Template as part of your QHP Application.

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

The U.S. Department of Health and Human Services (HHS) prefers only service areas covering full counties. If you propose a service area covering a partial county, you must provide a partial county supplemental response.

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

1. A template for identifying your proposed service area and the included counties and ZIP Codes, if you do not intend to cover the entire state.¹
2. A detailed [Partial County Supplemental Response Form](#), if you are proposing a plan covering a partial county.
3. Written evidence from the appropriate Federally-facilitated Exchange (FFE) state regulator indicating that the state has approved your proposed plan to cover a partial county.

2. Data Requirements

To complete the template for this section, you will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Names and IDs for proposed service areas to be associated with your QHPs or SADPs
4. Names of counties that you are applying to cover if you do not include an entire state in a service area
5. ZIP Codes in any county that you are applying to cover if you do not include an entire county in a service area.

3. Quick Reference

Key Changes for 2024

- ◆ No changes for the 2024 QHP Application.

Tips for the Service Area Section

- ◆ If you are a dual-product issuer, you must create two different service area IDs, one each for QHPs and SADPs, regardless of whether the service area is intended to serve both plan types.
- ◆ If you are a dual-product issuer, you must use the word “dental” in the service area name for your dental service area to distinguish the dental service area from the QHP service area.
- ◆ If you offer plans in the Individual and SHOP Markets, you must create separate service area IDs for each market, regardless of whether the service area is intended to serve both markets.

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

- QHP
- SADP

See Appendix E for additional information.

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

Tips for the Service Area Section

- ◆ You can make changes to your plan’s service area after the initial submission deadline without first submitting a data change request (DCR) for Centers for Medicare & Medicaid Services (CMS) authorization. After the final submission deadline in the PY2024 QHP Data Submission and Certification Timeline bulletin, a DCR is required for any change to QHP data, including service area.

Additional Resources

- ◆ There are [supporting documents](#) for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Follow these steps 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 you intend to offer coverage using the drop-down menu.
Service Area ID	<p>Click Create Service Area IDs at the top of the Service Area Template and enter the total number of desired service areas for the identified state. The template will generate and add the requested number of service area IDs to the <i>Service Area ID</i> drop-down menu. For example, if you enter “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, request one service area. The service area ID consists of the state abbreviation plus an “S” and then a sequenced number (for example, AZS001 or AZS002).</p> <p>Note: If you submit via SERFF, click Create Service Area IDs and enter the number of service area IDs you need to ensure that no two templates use the same service area ID. For example, if the Individual Market needs three service area IDs and the SHOP Market needs two service area IDs, enter “5” for the total number of service areas.</p> <p>Each plan can only be associated with one service area ID, but a service area ID can be associated with multiple plans. In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.</p>
Service Area Name	<p>Enter a name for the service area selected.</p> <p>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 plan name.</p> <p>If you are a dual-product issuer, you must use the word “dental” in the name for your dental service area to distinguish the dental service area from the QHP service area.</p> <p>The service area name will not display to the public on HealthCare.gov.</p>
State	<p>Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—if the service area includes the entire state. No additional information is required for the identified service area. Add 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. Add service areas and counties as appropriate until all service areas have been identified. <p>Note: The same service area ID <u>cannot</u> be used for both a service area that covers the entire state <u>and</u> a service area that covers only certain counties in the state.</p>
County Name	<p>Use the drop-down menu to select the name of each county included in the identified service area if you indicated that the identified service area does not cover the entire state.</p> <p>If a service area includes multiple counties, you must add a new row for each new county using the same service area ID and service area name.</p>

Service Area Template	Steps
	If your service area counties are not in the drop-down menu, contact the Marketplace Service Desk by phone at 855-267-1515 or by email at CMS_FEPS@cms.hhs.gov .
Partial County	Choose from the following: <ul style="list-style-type: none"> ◆ 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 Codes column and a Partial County Justification Filename column will appear on the template.
Service Area ZIP Code	Enter the five-digit ZIP Code (e.g., 12345) you propose to cover in the partial county. If you are entering more than one ZIP Code, separate each ZIP Code with a comma.
Partial County Justification Filename	Save the Partial County Justification Form using the naming convention in Table C-1. For example, "12345_AZ_service_area_partial_county."

See **Figure 2I-1** for a sample completed Service Area Template.

Figure 2I-1. Sample Service Area Template

A	B	C	D	E	F	G
2024 Service Area v13.0						
<i>All fields with an asterisk (*) are required</i>						
Validate	To validate, press the Validate button or Ctrl + Shift + I. To finalize, press the Finalize button or Ctrl + Shift + F					
Finalize	Click Create Service Area IDs button (or Ctrl + Shift + R) to Create Service Area IDs based on your state					
Service Area IDs will populate in the drop-down box in Service Area ID column						
For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)						
HIOS Issuer ID: 12345						
Issuer State: AZ						
Create Service Area IDs						
Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code(s)	Partial County Justification Filename
Required: Enter the Service Area ID	Required: Enter the Service Area Name	Required: Does this Service Area cover the entire state?	Required if State is "No": Select the County - FIPS this Service Area covers	Required if State is "No": Does this Service Area include a partial county?	Required if Partial County is "Yes": Enter the zip codes in this county that are covered by this Service Area	Required if Partial County is "Yes": Enter the filename of the partial county justification file you are uploading to SERFF or HIOS
AZS001 Service Area One		Yes		No		
AZS002 Service Area Two		No	Mohave - 04015	No		
AZS003 Service Area Three		No	La Paz - 04012	Yes	85325, 85328	12345_AZ_service_area_partial_county
AZS004 Service Area Four		No	Yuma - 04027	No		
AZS005 Service Area Five		No	Maricopa - 04013	No		
AZS006 Service Area Six		No	Apache - 04001	Yes	85920, 85924, 85925	12345_AZ_service_area_partial_county

If you request to serve a partial county (i.e., if you select **Yes** in Column E of the Service Area Template), you must complete the following steps.

Partial County Justification Supplemental Response

HHS allows issuers to cover partial county service areas only in extraordinary circumstances. You must submit a detailed supplemental response substantiating why you will not serve the entire county for each exception you request. You must justify how the partial county service area is necessary, non-discriminatory, and in the best interests of consumers and the Exchange program, consistent with 45 CFR 155.1055.

Answer the questions on the [Partial County Supplemental Response Form](#). If you do not respond to each of these questions, your partial county request will be denied.

You may request partial county service areas only if you have received state authorization. If you request a partial county service area in an FFE state and submit the QHP Application via HIOS, provide written evidence that the appropriate state regulator has authorized your partial county service area, such as email correspondence with the state that lists the specific ZIP Codes in the partial county requested.

If your state performs plan management functions, you must submit a partial county supplemental response but are not required to submit evidence of state approval. If the state transmits the request, that will serve as state approval.

After completing the supplemental response, 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 naming convention in Table C-1. For example, "12345_AZ_service_area_partial_county." Enter this file name in Column G, *Partial County Justification Filename*, of the Service Area Template.

Partial County Justification Supplemental Response

Upload the completed Partial County Supplemental Response Form and evidence of state approval into the Service Area section of MPMS.

After entering all data, click **Save** to ensure no data are lost. Once the Service Area Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate 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 reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the template to create the .XML version of the template you will upload in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

When establishing service areas, consider existing health care delivery markets in the states in which you are applying to offer plans. If the distance people in a rural county travel to see a provider is consistent with state-permitted practices, it may not be necessary to have a contracted provider in all parts of a rural county. In such cases, you might consider establishing a service area for the entire state to enable members in rural parts of the county to see providers in other ZIP Codes. Alternatively, you might exclude an entire county from a service area if no providers are available in the excluded ZIP Codes.

A service area can be associated with multiple plans. For example, you might have five plans and four service areas as follows: 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. Create one template for all service areas and identify each service area with a unique service area ID. Complete the Network ID Template and create a unique network ID for each network. The Plans & Benefits Template 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, you may have a single state-wide network that is identified with a network ID and assigned to all of your plans, but have two service area IDs that are each made up of half the state and each assigned to a different plan.

The Exchange does not require your service area to cover a complete rating area, but you are bound by state service area requirements. Carefully review state guidance on this topic to ensure your 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.

If your state performs plan management functions and you file via SERFF, we strongly encourage you to submit a Microsoft Excel (.XLSM) version of your Service Area Template.

This concludes the Service Area section of the QHP Application Instructions.

Section 2J: Accreditation

1. Introduction

In the Accreditation section of MPMS, you enter information to satisfy the accreditation QHP certification requirement (Figure 2J-1). You can provide information for an accredited product in the Commercial, Medicaid, or Exchange markets. These instructions apply only if you are filing via HIOS to issue a QHP on the FFE.

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

- QHP
- See Appendix E for additional information.

If your state performs plan management functions or has a State-based Exchange on the Federal Platform (SBE-FP), comply with the requirements for accreditation data collection specified by your state.

2. Data Requirements

To complete this section, you will need the following:

1. Information about which accrediting entity you are accredited by—the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAHC).
2. The Quality Improvement Strategy (QIS). Information about submission criteria and supporting documentation can be found in Appendix C.

Figure 2J-1. Accreditation Application Section

Accreditation

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333TX-2024-01	2024	10333 - TX - TEST 14.0	QHPs Only	Individual Only

[Return to Application Overview](#)

Question 1

Authorization

1. Does the applicant currently have any commercial, Medicaid, or Exchange health plans in this state, TX, accredited by an HHS recognized accrediting entity?

Yes

No

Supporting and Justifications Documents

[Add document](#)

[Save](#) [Save and Next](#)

3. Quick Reference

Key Changes for 2024

Issuers must submit their Plan ID Crosswalk template in the PM Community at the same time they submit the Issuer Accreditation grouping in MPMS to ensure all related information is available for review.

Tips for the Accreditation Section

- ◆ Only provide information on accredited products in the same state and for the same legal entity that submits the QHP Application.
- ◆ Provide accrediting entities with your legal issuer name and the HIOS Issuer ID used in your QHP Application to ensure the HIOS Issuer ID is included in the data file the accrediting entity provides to us.

Additional Resources

- ◆ There are [optional supporting documents](#) for this section.
- ◆ There are no instructional videos for this section.
- ◆ There are no templates for this section.

4. Detailed Section Instructions

If the answer to the accreditation question (Question 1 in MPMS) is **Yes**, an additional section will appear for you to select an accrediting entity from the list.

Accreditation Question	Steps
Does the applicant currently have any Commercial, Medicaid, or Exchange health plans in this state, [state of issuer identified], accredited by an HHS-recognized accrediting entity?	Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if you have existing health plan accreditations on any products in the Exchange, Commercial, or Medicaid market from NCQA, URAC, or AAAHC. If you are a dual-product issuer with an accredited medical plan, you should also select Yes. Proceed to the next step. ◆ No—if you are not currently accredited by NCQA, URAC, or AAAHC.

Accreditation Responses	Steps
If you respond Yes to the accreditation question, you must select the accrediting entity.	Choose from the following. If you are accredited by multiple entities, select all that apply: <ul style="list-style-type: none"> ◆ NCQA—if you are accredited by NCQA. ◆ URAC—if you are accredited by URAC. ◆ AAAHC—if you are accredited by AAAHC.
Irrespective of whether you respond Yes or No to the accreditation question, proceed to the Authorization.	All issuers must respond to the Terms and Conditions attestation regardless of whether they are accredited. Note: Issuers who are not accredited are strongly encouraged to schedule a review of their QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). Issuers do not need to be accredited in their initial year of QHP certification, but must be accredited 90 days before the first day of Open Enrollment when entering any subsequent year of QHP certification.

After responding to the above question, complete the Terms and Conditions attestation (Figure 2J-2), regardless of your response.

Figure 2J-2. Authorization for All Issuers

Accreditation

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333TX-2024-01	2024	10333 - TX - TEST 14.0	QHPs Only	Individual Only

[← Return to Application Overview](#)

- ✔ Question 1
- **Authorization**

The QHP Issuer authorizes the release of its accreditation data from its accrediting entity to the Federally Facilitated Exchange (FFE) (if applicable).

I agree to the terms and conditions.

[Back](#)

Save

Save and Complete

You may upload copies of your accreditation certificates into MPMS along with your answer(s) to Question 1.

Accreditation Certificate	Steps
Scan Certificate	Scan each accreditation certificate (one per accredited market type). If you are accredited by NCQA and do not have a copy of your accreditation certificate, use the NCQA Interactive Survey System (ISS) to get a copy of the survey results. Log into ISS, click on the <i>Results</i> tab, view the survey results, and print the results screen.
Name File	Save the accreditation certificate using the naming convention in Table C-1. For example: "12345_NCQA.pdf."
Upload Certificate	Upload the saved files in the Accreditation section of MPMS. Refer to the MPMS User Guide for further instruction.

Issuers in their initial year of QHP certification must schedule (or plan to schedule) a review of their QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). Issuers do not need to be accredited in their initial year of QHP certification, but **must** be accredited 90 days before the first day of Open Enrollment when entering any subsequent year of QHP certification.

Issuers entering their second year (or later) of QHP certification must be accredited by a recognized accrediting entity 90 days prior to Open Enrollment on the policies and procedures that are applicable to its Exchange products, or receive commercial or Medicaid health plan accreditation granted by one of the recognized accrediting entities.

Second-year issuers that immediately pursued Exchange certification after their initial year of certification and have an accreditation status of "scheduled" or "in process" are asked to upload documentation from their accrediting entity indicating that they have completed the policies and procedures review and are scheduled for or are in the process of completing additional review.

Issuers entering their fourth year (or later) of QHP participation must have Exchange health plan accreditation 90 days prior to Open Enrollment with one of the following statuses:

1. AAAHC—Accredited
2. NCQA—Accredited or Provisional
3. URAC—Full or Conditional.

Note: If you were previously QHP certified, but did not pursue certification in the preceding year and are pursuing certification in the current year, you will be held to the second-year accreditation standard, i.e., you must be accredited 90 days prior to Open Enrollment. If you go on to pursue certification the following year, you will be considered a third-year issuer, and so forth.

Note: CMS reviews issuers that crosswalk enrollees to a new HIOS Issuer ID for accreditation based on their cumulative years of certification. Therefore, you must ensure that the receiving HIOS Issuer ID issuer is appropriately accredited. For example, if Issuer A participated for 3 consecutive years and is crosswalking all of their plans to Issuer B who has only participated for 1 year, Issuer B would now be considered a fourth-year issuer and must meet the requirements for issuers in their fourth year (or later) of participation.

This concludes the Accreditation section of the QHP Application Instructions.

Section 2K: Transparency in Coverage

1. Introduction

This document provides instructions for QHP issuers submitting Transparency in Coverage data for PY2024.¹

If you are submitting a QHP Application for PY2024, you must make accurate and timely disclosures of transparency reporting² 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 PY2024, including issuers in FFEs where states perform plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs). This includes:

- On-Exchange Medical QHPs
- On-Exchange SADPs
- Off-Exchange-only SADPs seeking QHP certification
- 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.

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

- QHP
- SADP

See Appendix E for additional information.

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 2022
- HIOS Issuer IDs and all PY2024 plan IDs
- Number of PY2022 claims and denials
- Number of PY2022 appeals
- Claims Payment Policy and Other Information URL (“Transparency in Coverage URL”).

To apply for PY2024 QHP certification, except in an SBE state not on the federal platform, you must submit a Transparency in Coverage Template that includes all on-Exchange PY2024 plan IDs. You cannot submit your QHP Application without this template. However, only certain on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2022, through December 31, 2022. Off-Exchange SADP issuers and on-Exchange issuers not on the Exchange in PY2022

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 Public Health Service (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.

should complete the template indicating reporting requirements are not applicable. See Table 2K-1 for more information.

- The Transparency in Coverage Template must include all on-Exchange PY2024 plan IDs. If you have more than one HIOS Issuer ID in a state, you must submit a separate Transparency in Coverage Template for each unique HIOS Issuer ID. Only report claims data for plan IDs that were offered on the Exchange in PY2022 and will be offered on Exchange again in PY2024. If a PY2024 plan ID was not offered on the Exchange in PY2022, but will be offered on the Exchange in PY2024, include it in the plan level tab of the template but indicate that PY2022 claims data is not applicable for that plan ID by entering “N/A” in the relevant fields. See Table 2K-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 2K-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 PY2022	Yes	Yes. Do not include or count claims data for off-Exchange QHP enrollment.	Yes
On-Exchange SADP that was offered in PY2022	Yes	Yes. Do not include claims data for off-Exchange SADP enrollment.	Yes
Off-Exchange SADP that was offered in PY2022	Yes	No. Do not include claims data associated with any off-Exchange plans or plan IDs.	No
On-Exchange QHP that was <u>not</u> offered in PY2022	Yes	No. Note as N/A in the template.	Yes
On-Exchange SADP that was <u>not</u> offered in PY2022	Yes	No. Note as N/A in the template.	Yes

3. Quick Reference

Key Changes for 2024

- ◆ The deadline for submitting Transparency in Coverage data and the Claims Payment Policies and Other Information URL is now aligned with QHP certification; both will be due on June 14, 2023. The Issuer Level and Plan Level data tabs now require that in- and out-of-network claims receipt and denial data are reported separately.
- ◆ There are two new Issuer Level data fields for resubmitted in- and out-of-network claims.
- ◆ There are two new Plan Level data fields for resubmitted in- and out-of-network claims.
- ◆ There are four new Plan Level data fields for claim denial reasons:
 - Number of Plan Level Claims with Date of Service (DOS) in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022
 - Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022
 - Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2022
 - Number of Plan Level Claims with DOS in 2022 That Were Also Denied for Administrative Reasons in Calendar Year 2022.
- ◆ 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 on-Exchange plans for PY2024 but did not offer on-Exchange plans in PY2022, 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.
- ◆ 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.
- ◆ 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 Market 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. Note that this is different from the process used for other templates submitted as part of the QHP application and certification process, wherein each binder should include a unique template.

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

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

Note if you are submitting via SERFF: Issuers should complete only one Transparency in Coverage Template containing necessary information and submit that template in all SERFF binders. CMS will only process the most recent Transparency in Coverage Template transferred by the state, and all other Transparency in Coverage Template data or versions will be overwritten. Include the same Transparency in Coverage Template across all SERFF binders. For example, if you have an Individual Market SERFF binder with 3 on-Exchange plan IDs and a SHOP Market SERFF binder with 7 on-Exchange plan IDs, you should submit an identical Transparency in Coverage Template that contains all 10 on-Exchange plan IDs in both SERFF binders.

Figure 2K-1. Transparency in Coverage Template

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 2024 v4.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2022?*	
SADP Only?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2022 That Were Also Received in Calendar Year	
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2022*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2022 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2022*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2022 Appeals*	
Notes:	
Please enter any comments/notes here.	

Note: If you were not on the Exchange in 2022 or will offer only off-Exchange SADPs for 2024, 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 2022?*	Enter Yes or No to indicate whether or not this issuer was on the Exchange in 2022. <ul style="list-style-type: none"> ◆ 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
<p>Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*</p>	<p>Enter the number of <u>issuer level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of your network (such as a health maintenance organization [HMO] or preferred provider organization [PPO]). Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value.</p> <ul style="list-style-type: none"> ◆ 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. ◆ <u>Claims that were pending 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:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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. <p><u>Do not include out-of-network claims. The value you submit in this field must include in-network received claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of in-network plan level received claims reported elsewhere in the template may be less than the in-network issuer level received claims reported here.</p>
<p>Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*</p>	<ul style="list-style-type: none"> ◆ Enter the number of <u>issuer level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> 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. 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. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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 <u>all</u> denials in the total number of claims denied in calendar year 2022, including: <ul style="list-style-type: none"> ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims.

Issuer Level Data	Steps
	<p><u>Do not include out-of-network claims. The value you submit in this field must include in-network denied claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of in-network plan level denied claims reported elsewhere in the template may be less than the in-network issuer level denied claims reported here.</p>
<p>Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*</p>	<p>Enter the number of <u>issuer level</u> claims resubmissions received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (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.</p> <ul style="list-style-type: none"> ◆ 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). ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all of the following should count as one resubmission: <ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Note: <u>Regardless of who initiates the resubmission</u>—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. <p><u>Do not include out-of-network claims. The value you submit in this field must include in-network resubmitted claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of in-network plan level resubmitted claims reported elsewhere in the template may be less than the in-network issuer level resubmitted claims reported here.</p>
<p>Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*</p>	<p>Enter the number of <u>issuer level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital, physician, or pharmacy) that is not 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.</p> <ul style="list-style-type: none"> ◆ 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. ◆ <u>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:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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. <p><u>Do not include in-network claims. The value you submit in this field must include out-of-network received claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of out-of-network plan level received claims</p>

Issuer Level Data	Steps
<p>Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*</p>	<p>reported elsewhere in the template may be less than the out-of-network issuer level received claims reported here.</p> <p>Enter the number of <u>issuer level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital, physician, or pharmacy) that is not contracted to be part of your network (such as an HMO or PPO) that you subsequently denied. Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value.</p> <ul style="list-style-type: none"> ◆ 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. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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 <u>all</u> denials in the total number of claims denied in calendar year 2022, including: <ul style="list-style-type: none"> ▪ 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 in-network claims. <p><u>Do not include in-network claims. The value you submit in this field must include out-of-network denied claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of out-of-network plan level denied claims reported elsewhere in the template may be less than the out-of-network issuer level denied claims reported here.</p>
<p>Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*</p>	<p>Enter the number of <u>issuer level</u> claims resubmissions received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital or doctor) that is not contracted to be part of the network for an issuer (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.</p> <ul style="list-style-type: none"> ◆ 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). ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all of the following should count as one resubmission: <ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved)

Issuer Level Data	Steps
	<ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Note: Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. <p><u>Do not include in-network claims. The value you submit in this field must include in-network resubmitted claims for all QHPs in 2022, including QHPs not returning to the Exchange in 2024.</u> Therefore, the sum of out-of-network plan level resubmitted claims reported elsewhere in the template may be less than the out-of-network issuer level resubmitted claims reported here.</p>
Number of Issuer Level Internal Appeals Filed in Calendar Year 2022*	Enter the number of requests for internal appeals involving adverse determinations you received from or on behalf of consumers pursuant to 45 <i>Code of Federal Regulations</i> (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 2022 that you received, fully adjudicated, and completed in 2022. 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 2022 That Were Also Denied in Calendar Year 2022.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2022 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for internal review, <u>in whole or in part</u> , 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.
Number of Issuer Level External Appeals Filed in Calendar Year 2022*	Enter the number of requests for external appeals of final adverse determinations sent by or on behalf of consumers 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 2022 that you received, fully adjudicated, and completed in 2022. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2022 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for external review, <u>in whole or in part</u> , 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 2K-2. Transparency in Coverage 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 Level Data															
Plan ID*	Number of Plan Level In-Network Claims with Dates of Service (DOS) in 2022 That Were Also Received in Calendar Year 2022*	Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-Of-Network Provider in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, <u>excluding</u> Behavioral Health <u>only</u> , in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity (Behavioral Health <u>only</u>) in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Reasons in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Administrative Reasons in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied for "Other" Reasons in Calendar Year 2022*

You must include all on-Exchange plan IDs that are present in your PY2024 QHP Application in the Transparency in Coverage Template. If you were not on the Exchange in 2022, 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 2022 That Were Also Denied in Calendar Year 2022*.



4.2 Plan Level Data Tab

PY2024 Plan Data	Steps
2024 On-Exchange Plan ID*	<p>Enter the 14-character PY2024 on-Exchange plan ID on the <i>Plan Level Data</i> 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 PY2024 plan ID to report for a single HIOS Issuer ID, add each plan line-by-line in the <i>Plan Level Data</i> tab.</p> <p><u>All plan variants should be rolled up to one plan ID or line in the template.</u> For example:</p> <ul style="list-style-type: none"> ◆ Reported claims for 12345AZ1234567 would include claims that fall under this plan ID from members on all associated plan variants: <ul style="list-style-type: none"> ▪ 12345AZ1234567-01: 100 claims ▪ 12345AZ1234567-02: 500 claim ▪ 12345AZ1234567-03: 200 claims ▪ 12345AZ1234567-04: 50 claims. <p>Reporting for plan ID 12345AZ1234567 should be entered as <u>one</u> plan ID in <u>one</u> row of the template with a total of 850 claims (100 + 500 + 200 + 50) for the applicable data field.</p>
Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	<p>Enter the number of <u>plan level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> 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. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A.</u> All other on-Exchange plans (including SADPs) must enter a value in this field; <u>0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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: <ul style="list-style-type: none"> ▪ 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 because it lacks 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. <p>The total issuer level claims received data may include plans not offered in 2024. Therefore, the plan level claims total may not total the issuer level claims.</p>

PY2024 Plan Data	Steps
<p>Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022⁴ (Plan Level Claims Denied)*</p>	<p>Enter the number of <u>plan level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> 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. Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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 <u>all</u> denials in the total number of claims denied in calendar year 2022, including: <ul style="list-style-type: none"> ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. <p>The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. <u>Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the Number of Plan Level Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022 because individual claims may be denied for more than one reason.</u></p>

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 10 denial categories:

1. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022
2. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2022
3. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022
4. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2022
5. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2022
6. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022
7. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022
8. Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2022
9. Number of Plan Level Claims with DOS in 2022 That Were Also Denied for Administrative Reasons in Calendar Year 2022
10. Number of Plan Level Claims with DOS in 2022 That Were Also Denied for "Other" Reasons in Calendar Year 2022.

In this example, you would only report that 3,000 plan-level claims were denied, but could report more than 3,000 denial reasons in the 10 reporting categories if any claims were denied for more than one reason.

PY2024 Plan Data	Steps
<p>Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*</p>	<p>Enter the number of <u>plan level</u> claim resubmissions you received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (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. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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). ◆ Any claim that is resubmitted one or more times after the initial submission should be <u>counted as one resubmitted claim, regardless of the outcome of the claim</u>. This means that all of the following should count as one resubmission: <ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Note: <u>Regardless of who initiates the resubmission</u>—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. <p>Include claims for all QHPs that fall under the reporting plan ID. The total issuer level claims received data may include plans not offered in 2024. Therefore, the plan level claims total may not total the issuer level claims.</p>
<p>Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*</p>	<p>Enter the number of <u>plan level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital, physician, or pharmacy) that is not 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. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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: <ul style="list-style-type: none"> ▪ 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 because it lacks 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. <p>The total issuer level claims received data may include plans not offered in 2024. Therefore, the plan level claims total may not total the issuer level claims. <u>Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal</u></p>

PY2024 Plan Data	Steps
<p>Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p><u>to the Number of Plan Level Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022 because individual claims may be denied for more than one reason.</u></p> <p>Enter the number of <u>plan level</u> claims you received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital, physician, or pharmacy) that is not contracted to be part of the network for an issuer (such as an HMO or PPO) that you subsequently denied. Include pediatric dental and vision claims. Count claims by DOS and report claims data with a single numerical value. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> <ul style="list-style-type: none"> ▪ 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 because it lacks 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 <u>all</u> denials in the total number of claims denied in calendar year 2022, including: <ul style="list-style-type: none"> ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. <p>The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. <u>Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the Number of Plan Level Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022 because individual claims may be denied for more than one reason.</u></p>
<p>Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*</p>	<p>Enter the number of <u>plan level</u> claim resubmissions you received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider (such as a hospital or doctor) that is not contracted to be part of the network for an issuer (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. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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). ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all of the following should count as one resubmission: <ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved)

PY2024 Plan Data	Steps
	<ul style="list-style-type: none"> ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). <p>◆ Note: Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim.</p> <p>Include claims for all QHPs that fall under the reporting plan ID.</p> <p>The total issuer level claims resubmitted data may include plans not offered in 2024. Therefore, the plan level claims resubmitted total may not match the issuer level claims resubmitted total.</p>
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>Note: The following claim denial reporting instructions for columns H, I, J, K, L, M, N, O, P, & Q of the <i>Plan Level</i> tab are different than the instructions for claim denial reporting on the <i>Issuer Level</i> tab and columns C & F of the <i>Plan Level</i> 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:</p> <ul style="list-style-type: none"> ◆ For the <i>Issuer Level</i> tab and columns C & F of the <i>Plan Level</i> tab: <ul style="list-style-type: none"> ▪ 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 H, I, J, K, L, M, N, O, P, & Q: <ul style="list-style-type: none"> ▪ 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 H (Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022) and twice in column J (Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022). <p>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, from when a claim was first received to its final adjudication. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ 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. <p>Include claims for all QHPs that fall under the reporting plan ID. Do not include out-of-network claims.</p>

PY2024 Plan Data	Steps
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>plan level</u> denials you issued for claims for service from outside the plan's network of health care providers if the plan has a closed network, from when a claim was first received to its final adjudication. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ 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. ◆ <u>Do not include in-network claims.</u>
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims for excluded or non-covered services. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ 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 because a drug is not 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ 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.
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health, in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 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. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Include the following denials for lack of medical necessity (individual claim line of service item):</p> <ul style="list-style-type: none"> ◆ Payment for services related to medical surgical diagnosis, including medical and pharmacy point of sales. ◆ Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: <ul style="list-style-type: none"> ▪ Analgesics

PY2024 Plan Data	Steps
	<ul style="list-style-type: none"> ▪ 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. <p>Do not include the following claims:</p> <ul style="list-style-type: none"> ◆ Behavioral or mental health claims or payment for services. <ul style="list-style-type: none"> ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders.

PY2024 Plan Data	Steps
	<ul style="list-style-type: none"> ▪ 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 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. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ If a claim is denied because it lacks medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because it lacks medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category.
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 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, from when a claim was first received to its final adjudication. <u>If a plan is off-Exchange, an SADP offered by an issuer offering only SADPs, and/or a plan that did not exist in PY2022, enter N/A. All other on-Exchange plans, including SADPs offered by an issuer offering both SADPs and QHPs, must enter a numerical value in this field; 0 is acceptable.</u></p> <ul style="list-style-type: none"> ◆ 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. <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> ▪ Anti-addiction/substance abuse treatment agents ▪ Antidepressants ▪ Antipsychotics ▪ Anxiolytics ▪ Bipolar agents. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ If a claim is denied because it lacks medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because it lacks medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category. <p>Do not include payment for services related to medical surgical diagnosis, including medical and pharmacy point of sales.</p>

PY2024 Plan Data	Steps
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims denied due to the beneficiary reaching their benefit limit. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ Total number of claims denied because a beneficiary has reached or exceeded the benefit limit for their plan. ◆ 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ If a claim is denied because the beneficiary reached their benefit limit, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because the beneficiary reached their benefit limit, resubmitted with updated documentation, and paid, it will count as one denial in this category.
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims denied due to beneficiary enrollment status. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ Total number of claims denied because of the beneficiary's enrollment status. ◆ 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ If a claim is denied because of beneficiary enrollment status, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because of beneficiary enrollment status, resubmitted with updated documentation, and paid, it will count as one denial in this category.
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims denied because the procedure was investigational, cosmetic, or experimental. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ◆ Total number of claims denied because the procedure for which the claim is submitted is considered investigational, cosmetic, or experimental. ◆ 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). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: <ul style="list-style-type: none"> ▪ If a claim is denied because the relevant procedure was investigational, experimental, or cosmetic, resubmitted, and denied again for the same reason, it will count as two denials in this category.

PY2024 Plan Data	Steps
	<p>If a claim is denied because the relevant procedure was investigational, experimental, or cosmetic, resubmitted with updated documentation, and paid, it will count as one denial in this category.</p>
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied for Administrative Reasons in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims denied for administrative reasons. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>Issuers should include the following claims (individual claim line of service items):</p> <ul style="list-style-type: none"> ▪ Duplicate Claim ▪ Missing/Insufficient Information ▪ Untimely Claim Filing ▪ Billing Provider Not Approved ▪ Coordination of Benefit ▪ Inconsistent Procedure Code/Diagnosis ▪ Workers Comp/Liability Issue ▪ Paid by Auto or Other Insurance ▪ Unable to identify patient. <p>◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example:</p> <ul style="list-style-type: none"> ▪ If a claim is denied for administrative reasons, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for administrative reasons, resubmitted with updated documentation, and paid, it will count as one denial in this category.
<p>Number of Plan Level Claims with DOS in 2022 That Were Also Denied for “Other” Reasons in Calendar Year 2022 (Plan Level Claims Denied)*</p>	<p>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 claims rejected for reasons other than those specified in the above categories, from when a claim was first received to its final adjudication. <u>If a plan is off-Exchange or did not exist in PY2022, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable.</u></p> <p>◆ <u>Include all instances of <i>this type of</i> denial throughout the life of a claim in the total reported for this column.</u></p> <p>Do not include out-of-network claims.</p>

Verify the following before submitting the PY2024 Transparency in Coverage Template:

- The number of issuer level In-Network Claims Received reported on the Issuer Level tab is greater than or equal to the sum of in-network claims received across all plan IDs on the Plan Level tab.
- The number of issuer level In-Network Claims Denied reported on the Issuer Level tab is greater than or equal to the sum of in-network claims denied reported across all plan IDs on the Plan Level tab.
- The number of issuer level In-Network Claims Resubmitted reported on the Issuer Level tab is greater than or equal to the sum of in-network claims resubmitted across all plan IDs on the Plan Level tab.
- The number of issuer level Out-of-Network Claims Received reported on the Issuer Level tab is greater than or equal to the sum of out-of-network claims received across all plan IDs on the Plan Level tab.
- The number of issuer level Out-of-Network Claims Denied reported on the Issuer Level tab is greater than or equal to the sum of out-of-network claims denied reported across all plan IDs on the Plan Level tab.
- The number of issuer level Out-of-Network Claims Resubmitted reported on the Issuer Level tab is greater than or equal to the sum of out-of-network claims resubmitted across all plan IDs on the Plan Level tab.

- The sum of issuer level In-Network and Out-of-Network 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 2022.
- The sum of plan level reasons for denied claims (columns H, I, J, K, L, M, N, O, P, & Q) is greater than or equal to the sum of reported in-network and out-of-network claims denied (columns C & F) for each plan ID.

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

To apply for PY2024 QHP certification, you must submit a Transparency in Coverage Template that includes all your on-Exchange PY2024 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 with no PY2022 on-Exchange plan
- 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 2K-3) and all PY2024 plan IDs in the *Plan Level Data* tab (Figure 2K-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 2022?*	No
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID.

Issuer Level Data	Expected Value
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	N/A
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	N/A
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2022*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2022 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2022*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2022 Appeals*	N/A

Figure 2K-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 2024 v4.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2022?*	No
SADP Only?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2022 That Were Also Received in Calendar Year	N/A
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	N/A
Number of Issuer Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2022*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2022 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2022*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2022 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
2024 On-Exchange Plan ID*	Enter the 14-character PY2024 plan ID on the <i>Plan Level Data</i> 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 <i>Plan Level Data</i> tab.
Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	N/A
Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022* (Plan Level Claims Denied)	N/A
Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2022 (Plan Level Claims Denied)*	N/A

Plan Level Data	Expected Value
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health in Calendar Year 2022</u> (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health only, in Calendar Year 2022</u> (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied for Administrative Reasons in Calendar Year 2022 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2022 That Were Also Denied for "Other" Reasons in Calendar Year 2022 (Plan Level Claims Denied)*	N/A

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

All fields with an asterisk () are required. To validate the template, press Validate button or Ctrl + Shift + V. To finalize the template, press Finalize button or Ctrl + Shift + F.*
All plan IDs submitted via Plans & Benefits Templates(s) must be included in this template.

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2024
Plan Level Data

Plan ID*	Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	Number of Plan Level In-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Received in Calendar Year 2022*	Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Denied in Calendar Year 2022*	Number of Plan Level Out-of-Network Claims with DOS in 2022 That Were Also Resubmitted in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to an Out-of-Network Provider in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, <u>excluding Behavioral Health</u> , in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health</u> , in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied Due To Investigational, Experimental, or Cosmetic	Number of Plan Level Claims with DOS in 2022 That Were Denied Due to Administrative Reasons in Calendar Year 2022*	Number of Plan Level Claims with DOS in 2022 That Were Also Denied for "Other" Reasons in Calendar Year 2022*	Notes: (Please enter any comments/notes here.)
TTTTTTTTT	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

After you have entered all data, click **Save** to ensure no data are lost. Once the Transparency in Coverage Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the <i>Issuer Level Data</i> tab 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 reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.



Template Validation and Submission Step	Step Description
Finalize Template	Click Finalize in the top left of the <i>Issuer Level Data</i> tab of the template to create the .XML file of the template that will need to be uploaded in the Plan Validation Workspace in MPMS. If you are submitting via SERFF, your Transparency in Coverage Template will be uploaded in your SERFF binders.
Save Template	Save the .XML template. We recommend that you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS, link the validated template to your application and complete submission of your Transparency in Coverage URL. If you are submitting via SERFF, submit your Transparency in Coverage Template in your SERFF binders and your Transparency in Coverage URL in MPMS. Refer to the MPMS User Guide for details on how to complete these steps.

5. Claims Payment Policy and Other Information URL

Issuers applying for PY2024 QHP certification, including issuers offering off-Exchange SADPs, must submit a Transparency in Coverage URL in the MPMS (Figure 2K-5). Although SERFF issuers will submit their Transparency in Coverage Template in SERFF, the Transparency in Coverage URL must be submitted in MPMS.

Figure 2K-5. MPMS Submission Screen for Transparency in Coverage URL

Transparency in Coverage

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333TX-2024-01	2024	10333 - TX - TEST 14.0	QHPs Only	Individual Only

[← Return to Application Overview](#)

✔ [Transparency in Coverage](#)

Please upload your completed Transparency in Coverage document.

URL must include http:// or https:// at the beginning.
URL must not include the following invalid characters: < > , - ' and spaces.

Transparency in Coverage URL:

Documents Attached

For any template type documents, navigate to the Workspace to upload and resolve errors.

Document Type	File Name	Validation Status	Uploaded By	Action
Transparency in Coverage	TX10333 PY23 Transparency in Coverage_no_error_found_xlsm	No Errors Found	Jane Issuer 11/14/2022 12:54PM	Open Workspace

[Back](#)

[Save](#)

[Save and Complete](#)

Although a URL submission is required to apply for PY2024 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.

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 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.

PY2024 URL Contents	Minimum Requirements
Claims Payment Policies & Other Information URL	<p>Enter the active and easily accessible URL. Ensure it meets the following requirements:</p> <ul style="list-style-type: none"> ◆ 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. <p>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.</p> <p>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.</p>
Out-of-network liability and balance billing	<p>Description:</p> <ul style="list-style-type: none"> ◆ 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. <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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.</p>
Enrollee claim submission	<p>Description:</p> <ul style="list-style-type: none"> ◆ An enrollee submits a claim instead of the provider, requesting payment for services received. <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. If your time limits vary by state, list out the states and their corresponding time limits. ◆ 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.

PY2024 URL Contents	Minimum Requirements
	<ul style="list-style-type: none"> ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. <p><u>Example of Acceptable Consumer-Facing Language:</u> 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. There are time limits on how long you have to submit claims, with details on the limit by state below. You can also check your specific plan's claims filing time limit information to determine the specific time limit for submitting your claim.</p> <p>Enrollee medical claim submission and claim filing time limit information: <u>State (Maximum Claim Filing Time Limit)</u> VT, NH, CT (90 Days) CA (90 Days) WA (180 Days)</p> <p>To file a claim, follow these steps:</p> <ol style="list-style-type: none"> 1. Complete a claim form [Include link to Claim Form]. 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	<p>Description:</p> <ul style="list-style-type: none"> ◆ If you are a QHP issuer, you must provide a grace period of 3 consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least 1 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). <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u> 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.</p> <p>If you are enrolled in an individual health care plan offered on the <i>Health Insurance Marketplace</i> 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,</p>

PY2024 URL Contents	Minimum Requirements
	<p>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.</p>
Retroactive denials	<p>Description:</p> <ul style="list-style-type: none"> ◆ A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment. <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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. 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.</p>
Recoupment of overpayments	<p>Description:</p> <ul style="list-style-type: none"> ◆ If you overbill an enrollee for a premium, they may use recoupment of overpayments to obtain a refund. <p>Provide:</p> <ul style="list-style-type: none"> ◆ Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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.</p>
Medical necessity and prior authorization timeframes and enrollee responsibilities	<p>Description:</p> <ul style="list-style-type: none"> ◆ 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. <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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.</p> <p>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.</p>

PY2024 URL Contents	Minimum Requirements
<p>Drug exception timeframes and enrollee responsibilities (not required for SADPs)</p>	<p>Description:</p> <ul style="list-style-type: none"> ◆ 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). <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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.</p> <p>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.</p> <p>An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:</p> <p>[Request Form Link] [Address] [Phone] [Fax].</p> <p>For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request.</p> <p>For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request.</p> <p>For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request.</p> <p>For external review of expedited exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request.</p> <p>To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.</p>
<p>Explanation of benefits (EOB)</p>	<p>Description:</p> <ul style="list-style-type: none"> ◆ 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. <p>Provide:</p> <ul style="list-style-type: none"> ◆ 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. <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>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.</p> <p>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.</p>

PY2024 URL Contents	Minimum Requirements
Coordination of benefits (COB)	<p>Description:</p> <ul style="list-style-type: none"> ◆ COB allows an enrollee who is covered by more than one plan to determine which plan pays first. <p>Provide:</p> <ul style="list-style-type: none"> ◆ An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). <p><u>Example of Acceptable Consumer-Facing Language:</u></p> <p>Coordination of benefits (COB) is required when you are covered under one or more additional 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 COB can be found in your benefit booklet.</p>

Once you have entered your Transparency in Coverage URL, click the “Save” button to ensure no data are lost.

This concludes the Transparency in Coverage section of the QHP Application Instructions.

Section 2L: Rates Table

1. Introduction

In the Rates Table section of MPMS, enter rate information for each plan you offer in a Rating Area. If you offer both medical and dental plans and if you submit your QHP Application in HIOS, you must submit a single Rates Table Template that contains rate data for all your plans (QHPs and stand-alone dental plans [SADPs]).

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

- QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2024

- ◆ There are no key changes to the 2024 Rates Table Template.

Tips for the Rates Table Section

- ◆ Use separate worksheets in the Rates Table Template for medical plans and dental plans.
- ◆ Use separate worksheets for Individual Market plans and Small Business Health Options Program (SHOP) plans.
- ◆ For Individual Market plans, the rate effective date must be January 1, 2024.
- ◆ 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 is bound to a separate effective date range. If you submit SHOP trended quarterly rates, you must submit a separate worksheet for each date range that a set of rates will be effective.
- ◆ If you submit in HIOS, you must submit a single Rates Table Template that contains rate data for all your plans (QHPs and SADPs) in MPMS. If you submit via the System for Electronic Rates & Forms Filing (SERFF), this requirement does not apply.

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

Complete the Rates Table Template using the steps outlined below to provide rate information. You cannot validate until all required fields are completed.

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID .
Rate Effective Date	<p>Enter the rate effective date as mm/dd/yyyy.</p> <p>For Individual Market plans, the rate effective date must be 01/01/2024.</p> <ul style="list-style-type: none"> ◆ 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. If you submit SHOP trended quarterly rates, you must submit a separate worksheet for each date range that a set of rates will be effective.

Rates Table Template	Steps
	<ul style="list-style-type: none"> ◆ If you submit a SHOP quarterly rate change, you must submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable data 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 must not change or delete rates from the template for any current or previous quarter during the data change window. For example, during the submission for updated second-quarter SHOP rates, the first-quarter rates must 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	<p>Enter the rate expiration date as mm/dd/yyyy.</p> <ul style="list-style-type: none"> ◆ For Individual Market plans, the rate expiration date must be 12/31/2024. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (03/31/2024, 06/30/2024, 09/30/2024, and 12/31/2024).
Rating Method	<p>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 on the State Specific Rating Variations page.</p>
Add Sheets	<p>Click Add Sheet to add additional worksheets for the following:</p> <ul style="list-style-type: none"> ◆ To separate SHOP plans with different rate effective and expiration dates. All plans on a single worksheet <u>must</u> have the same rate effective and rate expiration dates. ◆ To separate Individual Market plans and SHOP plans. ◆ To separate medical plans and dental plans. ◆ To separate plans that use age-based rating and family-tier rating. ◆ To separate by rating area.
Plan ID	<p>Enter the 14-character alphanumeric HIOS-generated plan ID (e.g., 12345AZ1234567) that identifies the plan associated with the rates in that row.</p>
Rating Area	<p>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 on the State Specific Geographic Rating Areas page. If a set of rates is 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.</p>
Tobacco	<p>If you use age-based rates, select from the following to indicate whether rates vary based on tobacco use:</p> <ul style="list-style-type: none"> ◆ Tobacco User/Non-Tobacco User—if rates differ 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.¹ <p>QHPs rating by tobacco use may not apply tobacco rating to individuals age 0–20, for 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 <i>Individual (non-tobacco) Rate</i> and <i>Individual Tobacco Rate</i>. This entry will prevent application of unique tobacco rating to an underage enrollee.</p> <p>To offer small-group market medical plans (including SHOP QHPs) with tobacco rating, you 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 your Plans & Benefits Template. If you do not offer such a wellness program, the small-group market medical plan cannot rate for tobacco use.</p>

¹ 42 U.S.C. 300gg—Fair Health Insurance Premiums.

Rates Table Template	Steps
	<ul style="list-style-type: none"> ◆ No Preference—if the rate applies to tobacco and non-tobacco users. No separate rates are submitted for tobacco and non-tobacco users.
Age	<p>If you use age-based rates, the template will automatically generate a row for each age band from 0–14 through 64 and over.</p> <ul style="list-style-type: none"> ◆ If you elect to rate by tobacco use and enter the non-tobacco rates first for the underage age bands of 0–14 through 20, the worksheet will auto-populate the tobacco-rate for each band with the non-tobacco rate. ◆ If the issuer is in a state that does not permit rating for age or tobacco use and that 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	<ul style="list-style-type: none"> ◆ Enter the individual rate that applies to the plan ID. Market rules limit individual rate variation based on age to 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 your state’s age-rating curve if it is within the 1:3 market rule. A list of states using state-specific age curve variations is available on the State Specific Rating Variations page. Note: QHPs and SADPs must enter a value above \$0.00 for all age bands under the Individual Rate column unless you responded Allows Child-Only under <i>Child-only Offering</i> in 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 <i>Individual Tobacco Rate</i> 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 <i>Individual Tobacco Rate</i> to avoid applying tobacco rating to underage enrollees. For QHPs, tobacco rating cannot be applied to individuals age 0–20, for whom the sale and use of tobacco products is prohibited under federal law.
Family Tier	<p>If your state does not permit rating for age or tobacco use and has established uniform family tiers and corresponding multipliers, or if you are issuing SADPs and selected Family-Tier Rates in <i>Rating Method</i>, enter the individual rate in <i>Individual Rate</i>. Selecting Family-Tier Rates will also generate the following family tier columns:</p> <ul style="list-style-type: none"> ◆ <i>Individual Rate</i> (required): Enter the rate of an individual primary subscriber. ◆ <i>Couple</i> (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. ◆ <i>Primary Subscriber and One Dependent</i> (required): Enter the rate for a primary subscriber with one dependent. ◆ <i>Primary Subscriber and Two Dependents</i> (required): Enter the rate for a primary subscriber with two dependents. ◆ <i>Primary Subscriber and Three or More Dependents</i> (required): Enter the rate for a primary subscriber with three or more dependents. ◆ <i>Couple and One Dependent</i> (required): Enter the rate for a couple with one dependent. ◆ <i>Couple and Two Dependents</i> (required): Enter the rate for a couple with two dependents. ◆ <i>Couple and Three or More Dependents</i> (required): Enter the rate for a couple with three or more dependents. <p>Note: A dependent is defined as any dependent relationship you allow 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.</p>

See Figure 2L-1 for an example of a completed Rates Table Template when **Age-Based Rates** is selected.

Figure 2L-1. Rates Table Template (Age-Based Rates)

2024 Rates Table Template v13.0		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.			
Validate		If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
Finalize		If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
		If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
		To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
	HIOS Issuer ID*	12345			
	Rate Effective Date*	1/1/2024			
	Rate Expiration Date*	12/31/2024			
	Rating Method*	Age-Based Rates			
Add Sheet					
Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	
12345VA0001001	Rating Area 1	No Preference	0-14	10.00	
12345VA0001001	Rating Area 1	No Preference	15	11.00	
12345VA0001001	Rating Area 1	No Preference	16	12.00	
12345VA0001001	Rating Area 1	No Preference	17	13.00	

See Figure 2L-2 for an example of a completed Rates Table Template when **Family-Tier Rates** is selected.

Figure 2L-2. Rates Table Template (Family-Tier Rates)

2024 Rates Table Template v13.0		All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.			
Validate		If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
Finalize		If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
		If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
		To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
	HIOS Issuer ID*	12345			
	Rate Effective Date*	1/1/2024			
	Rate Expiration Date*	12/31/2024			
	Rating Method*	Family-Tier Rates			
Add Sheet					
Plan ID*	Rating Area ID*	Individual Rate*	Couple*	Primary Subscriber and One Dependent*	Primary Subscriber and Two Dependents*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Required: Enter the rate of a family based on a single parent with one dependent	Required: Enter the rate of a family based on a single parent with two dependents
12345VA0001001	Rating Area 1	10.00	20.00	30.00	40.00

After you enter all data, click **Save** to ensure no data are lost. Once the Rates Table Template is completed, you must validate, finalize, and upload it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate 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 reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved. The template will notify you when there are no errors with the callout box message "This Template is Valid!"
Finalize Template	Click Finalize in the template to create the .XML version of the template you will upload in the Plan Validation Workspace in MPMS.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	Upload the saved .XML file in the Plan Validation Workspace in MPMS and link the validated template to your application. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Rates Table section of the QHP Application Instructions.

Section 2M: URL Collection

1. Introduction

In the URL Collection section, you are required to submit URLs as part of their QHP Application. You must submit the following URLs: Summary of Benefits and Coverage (SBC), Plan Brochure, Enrollment Payment, Network, and Formulary. Note that SBC and Formulary Forms should also be uploaded to MPMS before the URL Submission Deadline. You must resubmit your forms whenever the forms are updated on the URL web page.

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

- QHP
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

1. HIOS Issuer ID
2. Summary of Benefits and Coverage (SBC) URLs
3. Plan Brochure URLs
4. Enrollment Payment URLs
5. Network URLs
6. Formulary URLs.

3. Quick Reference

Key Changes for 2024

- ◆ The *Market Type* and *Product Type* columns will be populated with N/A for all issuers. SERFF issuers no longer need to specify the Market Type and Product Type for the URL.
- ◆ Transparency in Coverage URLs will be submitted in the Transparency in Coverage section of MPMS. Refer to the Transparency in Coverage instructions for further detail.

Tips for the URL Collection Section

- ◆ Verify that URLs are functional before you submit them.
- ◆ All URLs submitted via the MPMS (SBC, Plan Brochure, Payment, Network, Formulary) should be submitted by September 20, 2023. All URLs must be active and directly route consumers to the appropriate document by the deadline for returning signed QHP Certification Agreements.
- ◆ Please note that the URL requirements described here apply only to on-Exchange plans; URLs for off-Exchange plans should still be submitted to the Rate & Benefits Information System (RBIS).

Additional Resources

- ◆ There are no supporting documents for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

The Generate URL Template page (Figure 2M-1) will display when you log into the MPMS. Select one or more URL types (Formulary, Network, Payment, Plan Brochure, SBC) that you wish to pre-populate in the generated URL Template and select the Generate and Download URL Template button. If your Product Offering is set to SADPs Only, the Formulary URL will not appear as an option.

Figure 2M-1. Generate URL Template

[Return to Application Overview](#)

URL

Generate populated URL Template.

Select one or more URL types that you wish to pre-populate in the generated URL template. You can populate this template to submit new URLs or edit existing URLs that were previously submitted.

Select All

Formulary

Network

Payment

Plan Brochure

SBC

[Generate and Download URL Template](#)

Figure 2M-2. URL Template File

HIOS Issuer ID:	11104							
GENERATED 2021-12-14T12:24:48								
URLs can be edited only with the New URL column (cannot be changed by making edits to the Current URL column). For more details and instructions please reference the user guide that can be downloaded from the UI.								
URL Type	URL ID	Market Type	Product Type	Current URL	New URL	Current Technical POC Email	New Technical POC Email	
Machine-Readable	11104	N/A	N/A	http://www.machine-readableURL.com/index.json		useremail@yopmail.com		
Transparency in Coverage	11104	N/A	N/A	http://url.com		N/A	N/A	
Summary of Benefits and Coverage	11104IN0010001-01	N/A	N/A	http://url.com		N/A	N/A	
Plan Brochure	11104IN0010001-01	N/A	N/A	http://url.com		N/A	N/A	
Payment	11104IN0010001	N/A	N/A	http://url.com		N/A	N/A	
Network	INN001	N/A	N/A	http://url.com		N/A	N/A	
Formulary	INF001	N/A	N/A	http://url.com		N/A	N/A	

After populating your URL Template, upload it to MPMS by selecting the “Upload” link as shown in Figure 2M-3. The system will validate that any Issuer URL Template File you upload is properly formatted and contains acceptable values. If an uploaded template contains no errors, a message of “No Errors Found” will display in the Validation Status field. If errors were identified, you must correct them and reupload the template. If a template passes all validations, the URL updates will be stored in the system.

Figure 2M-3. Upload URL Template File

Upload URL template.

Upload URL templates here. Uploading a new completed URL template will edit existing URLs.

Document Type	File Name	Validation Status	Uploaded By	Action
URL	PY24_URL.xlsx	No Errors Found	Dannie Greer 01/22/2022 12:56 PM	Upload

Once URLs are uploaded, you may edit URLs individually by searching for the URL Type and a URL ID (Figure 2M-4). To use the search function, enter search parameters by selecting a URL type in the drop-down menu, entering a URL ID, and selecting the Search button. You can enter a full or partial string of a URL ID to find a specific URL or leave the search field blank to return all URLs for the selected type. The MPMS will perform the same validations for URL updates submitted via the Search & Update URLs Section as for those submitted via the Issuer URL Template File.

You can also delete a URL in this section. However, the delete option is enabled only for SBC, Network, and Formulary URL types associated to off-Exchange plans. The checkbox is disabled for On-Exchange URLs and is always enabled for all Payment and Plan Brochure URLs, whether they are on- or off-Exchange because these two URL types are optional.

Figure 2M-4. Search & Update URLs Section

Edit single URLs.
 Edit URLs one at a time by searching for either or both the URL Type and URL ID.

URL Type **URL ID**

URL Type	URL ID	Current URL	New URL	Delete
Plan Brochure	10055TX0010002-00	www.google.com	<input type="text"/>	
Plan Brochure	10055TX0010002-01	www.google.com	<input type="text"/>	
Plan Brochure	10055TX0010002-02	www.google.com	<input type="text"/>	

If you offer QHPs, you must submit Network and SBC URLs. If you offer stand-alone dental plans (SADPs), you must submit Network URLs.

Note: The Upload URL Template File section will return errors unless you submit all required URLs for each URL ID that is present in the MPMS for that URL type. For example, if you submit one Network URL when there are two Network URL IDs in the MPMS, the system will return an error because a required URL is missing.

URL Collection Process	Steps
Access the MPMS	Log into the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal and select the MPMS application on the My Portal page.
Upload URL data into the MPMS	In the Generate URL Template File section of the URL Data page, choose the URL types you intend to upload.
	Select Generate and Download URL Template .
	Copy all new URL data into the Issuer URL Template File under <i>New URL</i> and save the template as a .CSV file.
	Upload the completed .CSV version of the Issuer URL Template File into the Upload Issuer URL Template File section of the URL Data page.
Updating previously submitted URL data	In the Search & Update URLs section of the URL Data page, enter search criteria, such as the URL type and relevant ID, to locate the previously submitted URL.
	Enter the updated URL under <i>New URL</i> .
	Click Save to ensure changes are retained.

This concludes the URL Collection section of the QHP Application Instructions.

Appendices

The appendices contain additional or more detailed information on completing and submitting the QHP Application.

[Appendix A: Actuarial Value Calculator](#)

[Appendix B: Plan ID Crosswalk](#)

[Appendix C: Supporting Documentation](#)

[Appendix D: Review Tools](#)

[Appendix E: Understanding Issuer Types](#)

[Appendix F: Network Adequacy Standards](#)

[Appendix G: Standardized Plan Option Requirements](#)

Appendix A: Actuarial Value Calculator

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 Actuarial Value Calculator (AVC) developed and made available by the U.S. 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 you with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. When you submit your QHP Application, HHS recalculates this value to validate that your plan designs meet AV requirements.¹ This section describes how cost-sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AVC.

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

- QHP
- See Appendix E for additional information.

2. Data Requirements

To complete this section, you will need the following:

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

3. Quick Reference

Key Changes for 2024

- ◆ In the 2024 AVC, copays paid during the deductible phase for services that aren't subject to the deductible will no longer accrue to the deductible. These copays will still, however, be counted toward the maximum out-of-pocket (MOOP).

Tips for Using the AVC

- ◆ If you are having difficulty matching AVs from the Plans & Benefits Template to the stand-alone AVC, follow the instructions on troubleshooting in Section 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 you understand the AVC's assumptions and to 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.²
- ◆ 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).

Additional Resources

- ◆ Download the [Final 2024 Standalone AVC](#).
- ◆ There are no supporting documents for this section.
- ◆ There are no instructional videos for this section.
- ◆ There are [templates](#) for this section.

¹ For additional information on the AVC, see the AVC Methodology at <https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>.

² These notes include things such as how the special cost-sharing provisions are being engaged in the calculations.

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 does not run for SADP-only Plans & Benefits Templates. 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, you do not need to address the error to validate the template if your AV falls within the relevant de minimis range. We recommend you run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that your submissions include the AV Calculator Output Number for plans that do not generate an error in the standalone 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	
<p>The Check AV Calc procedure on the Plans and Benefits ribbon allows the user to calculate AVs for all applicable plans.</p>	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 Check AV Calc . The Check AV Calc procedure will prompt you to select the file location of the standalone AVC. Use a clean copy of the AVC file that does 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 you will need to close all of the messages to finish the Check AV Calc procedure.
	Step 3	<ul style="list-style-type: none"> • A prompt will appear asking if you would like to save the screenshots. • Select Yes if you wish to save screenshots. 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 you do not wish to save screenshots. 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 <i>AV Calculator Output Number</i> field (column F in the Cost Share Variances worksheet) will be updated with the AV from the AVC. The <i>AV Calculator Output Number</i> field will remain blank if an error prevents an AV from being calculated.
	Step 5	If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, you must rerun the procedure so that the AVs in <i>AV Calculator Output Number</i> 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 you select 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 you will need to close all messages to finish the Check AV Calc procedure.

Check AV Calc	Steps	
For Unique Plan Designs: Upload screenshot into Marketplace Plan Management System (MPMS). ³	Step 7— (Optional)	If you submit a unique plan design, upload a screenshot of the standalone AVC with the Plan Name , Plan ID , and HIOS Issuer ID fields filled in as a supporting document, and include the plan ID (standard component) and date in the file name. You will upload the screenshot in the Plans & Benefits section of your application.

4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the application should include the [Unique Plan Design—Supporting Documentation and Justification Form](#) to certify 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.⁴ For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under 45 CFR 156.135(b), try to use the integrated version of the AVC before reverting to using the unique plan design option.

For plans compatible with the AVC, you must always use an actuarially justifiable process when inputting your plan designs into the AVC.⁵ 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 you can replicate the results of the standalone AVC using the Plans & Benefits Template and its **Check AV Calc** procedure.
 - a. If you cannot replicate the standalone AVC results because of the design of the Plans & Benefits Template, but the AVs obtained from the standalone AVC and via the Plans & Benefits Template both fall within the relevant de minimis range for the plan’s metal level or CSR variation, you do not need to designate the plan as a unique plan design. Instead, set the *Unique Plan Design* field 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 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. Upload a screenshot of the standalone AVC with the *Plan Name*, *Plan ID*, and *HIOS Issuer ID* fields filled in as a supporting document, 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 you may not be able to match AVs between the Plans & Benefits Template and the AVC, such as in the following examples:

1. One or more benefits apply a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AVC.⁶

³ You can use the standalone AVC to test plan designs, but you 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, you should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

⁴ When submitting a plan with a unique plan design, consult state guidance and complete the Unique Plan Design—Supporting Documentation and Justification Form in accordance with the applicable state processes.

⁵ For additional guidance, see the [May 16, 2014, CMS Frequently Asked Questions on Actuarial Value](#).

⁶ For more information, please refer to the AVC User Guide located in the first tab of the AVC.

- One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but you do not wish to split the benefits into their component parts during the coinsurance phase. For instance, the X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components and the 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 benefits can be split into Outpatient Facility and Outpatient Professional components.

4.2 Differences between Standalone AVC and Plans & Benefits Template

The screenshot feature 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, select **Yes** after a prompt appears asking if you want to save the AVC screenshots, then select the location you want the screenshots to be saved. Once the **Check AV Calc** procedure has finished, you can open the folder and use the automatically generated screenshots to compare with those manually created in the standalone AVC. This side-by-side comparison will help you determine if the cost-sharing structure has been entered and applied as intended.

Table A-2 describes the steps you 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 line-by-line to identify the difference that 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 you 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 **Check AV Calc** in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, you could open the screenshot file created by the **Check AV Calc** macro and the standalone AVC. 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) would show 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. Resolve this discrepancy 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

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$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

Type of Benefit	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input checked="" type="checkbox"/>	<input type="checkbox"/>		\$30.00

5. Field Mapping

This section describes how the **Check AV Calc** procedure automatically maps data from the Plans & Benefits Template into the AVC. 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* field in the Plans & Benefits Template is mapped to the *Desired Metal Tier* field in the AVC.

Expanded Bronze Plans: The AVC includes an option for you to indicate that you are running an expanded bronze plan as finalized in the [HHS Notice of Benefit and Payment Parameters for 2018](#). The expanded bronze plan option in the AVC allows you to calculate the AV for bronze plans that meet certain requirements, allowing you 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, non-preventive service 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. You must ensure your bronze plan meets these requirements if you use the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is -2 percentage points and +5 percentage points. Please see the AVC Methodology and the *HHS Notice of Benefit and Payment Parameters for 2024* 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, *Desired Metal Tier* depends on the AV level of the variation. *Desired Metal Tier* for silver plan variances is set to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation. *Desired Metal Tier* must be set to **Bronze** for expanded bronze plans.

De Minimis Range: In April 2022, the Centers for Medicare & Medicaid Services (CMS) released the HHS Notice of Benefit and Payment Parameters for 2023 Final Rule, which amends the de minimis variation range for the AV level of coverage in 45 CFR 156.140(c). For plan years beginning on or after January 1, 2023, 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 -2 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 -2 percentage points and +5 percentage points. In addition in 45 CFR 156.200, HHS limited the de minimis range to +2 percentage points for individual market silver QHPs (individual market on-Exchange silver plans).

5.2 Health Savings Account (HSA)/Health Reimbursement Arrangement (HRA) Options

If **Yes** is entered in *HSA/HRA Employer Contribution* 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 HSA/HRA input fields in the Plans & Benefits Template and Figure A-5 shows the corresponding input fields in the AVC.

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?	<input checked="" type="checkbox"/>
Annual Contribution Amount:	\$500.00

5.3 Tiered Network Options

The AVC can accommodate plans using up to two tiers of in-network services. You may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, 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.⁷

If *Multiple In Network Tiers?* is set 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 tiered 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?	<input checked="" type="checkbox"/>
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the **Not Applicable** option, you 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 sharing and uses the Copay—In Network (Tier 1) and Coinsurance—In Network (Tier 1) values when mapping

⁷ For more information on this option, please refer to the AVC Methodology and AVC User Guide.

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 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 *In Network* is a dollar value (**\$X**), *In Network* is used for the AVC.
2. If *In Network* is set to **Not Applicable** and *Combined In/Out of Network* is a dollar value (**\$X**), *Combined In/Out of Network* is used for the AVC.
3. If the *In Network* and *Combined In/Out of Network* fields are set 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 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 set to **Not Applicable** and the *Combined In/Out of Network* field is 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. *In Network* is a dollar value, and *In Network (Tier 2)* is set to **Not Applicable**.
 - b. *In Network* is set to **Not Applicable**, and *In Network (Tier 2)* is a dollar value.
 - c. The *In Network*, *In Network (Tier 2)*, and *Combined In/Out of Network* fields are set 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 MOOP 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.
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 set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate MOOP 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 \$9,450. 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 2024 AVC, the MOOP limit and related functions have been set at \$9,450 to account for the annual limitation on cost sharing for PY2024. The 2024 annual limitation on cost sharing was specified in [Premium Adjustment Percentage](#), [Maximum Annual Limitation on Cost Sharing](#), [Reduced Maximum Annual Limitation on Cost Sharing](#), and [Required Contribution Percentage for the 2024 Benefit Plan Year](#). Refer to this guidance for final self-only coverage and other than self-only coverage amounts. If you are required to meet AV standards, you must comply with the limit established in the guidance and may not use the projected estimates stated in the 2024 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 set to **No** and *Medical & Drug Deductibles Integrated?* is set 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 you have 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 set 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.⁸ 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.

⁸ 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.

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 set 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.

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 you pay as the issuer. Thus, the coinsurance values entered into the AVC must be set 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 you will incur. 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 set 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 set 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	Tier 1			
	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Emergency Room Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
All Inpatient Hospital Services (inc. MHSU)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	<input type="checkbox"/>	<input type="checkbox"/>		\$20.00
Specialist Visit	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Imaging (CT/PET Scans, MRIs)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Speech Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Occupational and Physical Therapy	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preventive Care/Screening/Immunization	<input type="checkbox"/>	<input type="checkbox"/>	100%	\$0.00
Laboratory Outpatient and Professional Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
X-rays and Diagnostic Imaging	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Skilled Nursing Facility	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Outpatient Surgery Physician/Surgical Services	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Drugs	<input checked="" type="checkbox"/> All	<input checked="" type="checkbox"/> All		
Generics	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Non-Preferred Brand Drugs	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Specialty Drugs (i.e. high-cost)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		

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 Abuse 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%					
\$X Copay per Day after deductible	X% Coinsurance after deductible					
\$X Copay per Stay after deductible		Checked	Checked	(1-X)%	Blank	Unchecked
No Charge after deductible						
No Charge Not Applicable	X% Coinsurance after deductible					
\$X Copay per Day	X% Coinsurance after deductible					
\$X Copay per Stay						
\$X Copay with deductible	X%	Checked	Checked	(1-X)%	\$X	Unchecked
\$X Copay per Day with deductible	X% Coinsurance after deductible					
\$X Copay per Stay with deductible						
No Charge Not Applicable	No Charge after deductible					
No Charge after deductible	No Charge Not Applicable	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge after deductible					
\$X Copay after deductible	No Charge Not Applicable					
\$X Copay per Day after deductible	No Charge after deductible	Checked	Unchecked	Blank	\$X	Checked
\$X Copay per Stay after deductible						

Plans & Benefits Template		AVC				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X \$X Copay per Day \$X Copay per Stay	No Charge after deductible					
\$X Copay with deductible \$X Copay per Day with deductible \$X Copay per Stay with deductible	No Charge Not Applicable No Charge after deductible	Checked	Unchecked	Blank	\$X	Unchecked
No Charge Not Applicable	X%	Unchecked	Checked	(1-X)%	Blank	Unchecked
\$X \$X Copay per Day \$X Copay per Stay	X%	Unchecked	Checked	(1-X)%	\$X	Unchecked
No Charge Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X \$X Copay per Day \$X Copay per Stay	No Charge 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.⁹

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 the 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 AVC User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services, Imaging, Speech Therapy, Occupational Therapy and Physical 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 component and an Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AVC also allows you to indicate the cost sharing for Primary Care and 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 [AVC 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

⁹ The AVC User Guide can be found on the first tab of the AVC. 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.

coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

5.11 Benefit Categories¹⁰

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.

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
Preventive Care/Screening/Immunization ¹¹	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*

¹⁰ The 2024 AVC updates the factor applied to trend claims from 2018 to 2024. Spending was trended forward from 2018 to 2021 at an annual rate of 5.4 percent for medical and 8.7 percent for drug spending. The trend rate from 2021 to 2022 was revised to trend medical spending at 3.2 percent and drug spending at 4.55 percent. For 2022 to 2023, projection factors of 5.8 percent for medical costs and 8.7 percent for drug costs were selected, and for 2023 to 2024 we added projection factors of 5.4 percent for medical costs and 8.2 percent for drug costs. For information about the considerations of the new claims data, please refer to the [AVC Methodology](#).

¹¹ Section 2713 of the Public Health Service (PHS) Act, codified in 45 CFR 147.130, requires you 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 you 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.

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.

If you intend to use the *Maximum Number of Days for Charging an Inpatient Copay?* feature when filling out the standalone AVC, you 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, you need to follow the instruction in the first paragraph and select a cost-sharing option that includes the text “per day” to ensure the *Apply Inpatient Copay per Day?* checkbox is checked in the AVC mapping.

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?	<input checked="" type="checkbox"/>
# Days (1-10):	5

Figure A-20. Apply IP Copay Checkbox in AVC

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	<input type="checkbox"/>
Apply Inpatient Copay per Day?	<input checked="" type="checkbox"/>
Apply Skilled Nursing Facility Copay per Day?	<input type="checkbox"/>
Use Separate OOP Maximum for Medical and Drug Spending?	<input type="checkbox"/>
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	<input type="checkbox"/>
Desired Metal Tier	Silver <input type="button" value="v"/>

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.

If you intend to charge a skilled nursing facility copay per day, you should ensure you 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 AVC 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. You 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 AVC User Guide, the use of this option does not imply a benefit design for primary care visits after the initial copays have occurred. You 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?	<input checked="" type="checkbox"/>
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	<input type="checkbox"/>
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 Use 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)* in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the *Mental/Behavioral Health and Substance Use 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 Use Disorder Outpatient Services in the AVC is checked. Then, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)})]$ is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC.

In the following two scenarios, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)})]$ is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Use 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 Use 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 Use 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 Use 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 Use Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay after deductible	X%	Checked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
No Charge after deductible	X% Coinsurance after deductible					

Plans & Benefits Template— Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Use Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
No Charge 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% X% Coinsurance after deductible					
No Charge Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge Not Applicable No Charge after deductible					
\$X Copay after deductible	No Charge Not Applicable 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 No Charge after deductible					
No Charge 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 Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X	No Charge 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? <input checked="" type="checkbox"/>
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 via 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 PY2023 qualified health plan (QHP) plan ID and service area combinations to a PY2024 QHP plan ID. These data facilitate enrollment transactions from the Centers for Medicare & Medicaid Services (CMS) for enrollees in the Individual Market who did not actively select 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 PY2023.

The instructions for this section are the same for the following issuer types:

- HIOS
- SERFF
- SADP

See Appendix E for additional information.

2. Data Requirements

To complete this section, you 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 2024

- ◆ PY2024 Plan ID Crosswalk Template changed to include the PY2023 Network ID column that pulls in the Network ID from the Plans & Benefits Template import.

Tips for the Plan ID Crosswalk Section

- ◆ If you are submitting a QHP for the first time, you are not expected to submit a Plan ID Crosswalk Template.
- ◆ CMS has deferred the Federally-facilitated Small Business Health Options Program's (FF-SHOP's) ability to auto-renew employees for PY2024. Do not submit a Plan ID Crosswalk Template for FF-SHOP plans.
- ◆ Submit the Plan ID Crosswalk Template via the Plan Management (PM) Community. Import only one Plans & Benefits Template and one Service Area Template. Submit separate templates for SADPs.

Additional Resources

- ◆ There are [supporting documents](#) for this section.
- ◆ There are [instructional videos](#) for this section.
- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

You must submit evidence that your state has authorized you to submit your Plan ID Crosswalk Template no later than June 14, 2023. Provide evidence of state authorization, such as an email confirmation, via the PM Community.

States can review the Plan ID Crosswalk Template for compliance with Patient Protection and Affordable Care Act (PPACA) market reforms and will individually determine how they will review the Plan ID Crosswalk Template. For example, a state might review to confirm that the submitted Plan ID Crosswalk Template is consistent with state and federal requirements and matches the expectations of its form filing reviews.

CMS does not send Plan ID Crosswalk Templates to states, but your state regulators may ask you to provide this template in addition to your QHP Application (as part of the National Association of Insurance Commissioners' [NAIC's] System for Electronic Rates & Forms Filing [SERFF] binder, for example).

If you are in a state that does not enforce the PPACA market-wide requirements, submit the authorization form to your 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, beginning with the *2023 Plan Crosswalk* tab.

2023 Plan Crosswalk Tab	Steps
Import 2023 Plans & Benefits and Service Area Template	<p>Click Import 2023 Plans & Benefits and Service Area Template to import the completed templates.</p> <p>The template will prompt you to select your completed 2023 Plans & Benefits and Service Area Templates. Before importing these templates, save them in the same folder; both must be uploaded at the same time. To select both files, click one template, then press and hold Ctrl on Windows or Cmd on macOS while clicking on the other template, and then click Open. Select exactly one of each type of template.</p> <p>The Plan ID Crosswalk Template will populate a list of PY2023 plan IDs and their associated service areas and network IDs on the <i>2023 Plan and Service Area Data</i> tab. Review this tab to ensure the data were accurately imported. After the PY2023 plan and service area data have been imported, the <i>2023 Plan Crosswalk</i> tab will be populated with all applicable issuer information as well as a row for each PY2023 plan ID.</p>
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 where you are offering coverage.
Market Coverage	<p>Ensure the template has accurately populated the market coverage from the drop-down menu.</p> <p>The FF-SHOP Exchange will not allow auto-renewals for PY2024, so this field will be hard coded to Individual.</p>
Dental Only	<p>Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental-only plans. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Yes—this template is for SADPs only. ◆ No—this template is for QHPs.
Crosswalk Level	<p>Select the level at which you would like to crosswalk each PY2023 plan from the drop-down menu. Choose from the following:</p> <ul style="list-style-type: none"> ◆ Crosswalking to the Same Plan ID: Select this option if you are crosswalking your PY2023 plan to the same plan ID for PY2024 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 PY2024 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 PY2023 plan to two or more PY2024 plan IDs. <p>Note: If your PY2023 plan covered the entire state, you will need to crosswalk the plan for every county in the state to PY2024 plan IDs.</p> <ul style="list-style-type: none"> ◆ Crosswalking at the ZIP Code level for one or more counties: Select this option if your service area changed for the upcoming year and you need to crosswalk your PY2023 plan to two or more PY2024 plan IDs for the same county. Selecting this option will require you to select the counties from the PY2023 plan's service area that will be crosswalked at the ZIP Code level. The remaining PY2023 service area will be crosswalked at the county level. <p>Note: Do not crosswalk at the ZIP Code level unless absolutely necessary.</p> <ul style="list-style-type: none"> ◆ Discontinue with no crosswalk: Select this option if you are discontinuing a PY2023 plan with no re-enrollment option for its enrollees. ◆ Plan withdrawn prior to certification: Select this option if the PY2023 plan was withdrawn from the Exchange before certification and has no enrollment. You should also select this option if the PY2023 plan ID listed on the template was not approved by the state or the Federally-facilitated Exchange (FFE) to be offered on the Exchange in PY2024.

2023 Plan Crosswalk Tab	Steps
Counties Crosswalked at ZIP Code Level	Select the counties in your PY2023 plan's service area that will be crosswalked at the ZIP Code level from the pop-up menu.

To complete the information on the *2024 Plan Crosswalk* tab, follow the steps in the table below.

2024 Plan Crosswalk Tab	Steps
Create "2024 Crosswalk Tab"	<p>Click Create "2024 Crosswalk Tab." This action creates the <i>2024 Plan Crosswalk</i> tab. The first four columns, 2023 HIOS Plan ID, County Name, Service Area ZIP Codes, and Crosswalk Level, and the last column, 2023 Network ID, will be auto-populated based on your entries in the <i>2023 Plan Crosswalk</i> tab. If you crosswalk at the plan ID, county level for one or more plans, a row will appear for each county that plan covered in PY2023. If you decided to crosswalk at the ZIP Code level for specific counties covered by a PY2023 plan, a row will appear for each combination of plan ID, county, and ZIP Code.</p> <p>Only click Create "2024 Crosswalk Tab" when you are sure the <i>2023 Plan Crosswalk</i> tab is complete. You cannot change a <i>2024 Plan Crosswalk</i> tab after it is created. Instead, you will need to click Create "2024 Crosswalk Tab" again, which will clear all data and begin a new copy of the <i>2024 Plan Crosswalk</i> tab. You can copy and paste your previously entered information into a separate workbook if you want to save your previous work.</p>
Crosswalk Reason	<p>Choose the reason for the crosswalk from the drop-down menu. Certain options will only be available for specific crosswalk levels. Table A-1 details crosswalk reason entries for each crosswalk level:</p> <ul style="list-style-type: none"> ◆ Renewing exact same product/plan combination (Same PY2023 plan ID): Select this option if you are crosswalking this plan ID/service area to the exact same HIOS Plan ID. The template will auto-populate the PY2024 Plan ID field with your PY2023 plan ID. Use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2024 plan year. You must comply with the "same plan" standards as defined in <i>45 Code of Federal Regulations (CFR) 144.103</i>. ◆ Renewing exact same product/plan combination (Different PY2024 plan ID): Select this option if you are crosswalking this plan ID/service area to the same product/plan combination but with a different PY2024 plan ID. If possible, you should use the same HIOS plan ID if the same plan ID/service area combination was available the previous year and remains available. If you are continuing a plan, but wish to crosswalk to a different HIOS plan ID, you must obtain approval from your state regulatory authority before you submit your Plan ID Crosswalk Template. You must comply with the "same plan" standards as defined in <i>45 CFR 144.103</i>. ◆ 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 on the FFE. If you select this option, you must use the same product ID that is embedded in the plan's 2023 plan ID. ◆ 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 PY2024 but will no longer offer any plans in part of the service area covered by the product in PY2023 and are crosswalking to a plan within a different product offered on the FFE. Select this reason for the portion of the service area where you no longer offer any plans under that product. If you select this option, you must crosswalk to a PY2024 plan ID with a different product ID from the PY2023 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 PY2023 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Do not enroll such plans into a plan offered off the Exchange. Selecting this option will disable the <i>2024 HIOS Plan ID</i> field.

2024 Plan Crosswalk Tab	Steps
	<ul style="list-style-type: none"> ◆ 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 PY2023 product is discontinued for PY2024 and enrollees in this plan and associated service area will be re-enrolled in a plan under a different product offered on the FFE. The entered PY2024 plan ID must have a different product ID, and you may not enter the discontinued PY2023 product ID for any other row under the PY2024 plan ID. Crosswalk any discontinued PY2023 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if you do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, we will crosswalk the discontinued plan to another product you offer under the same HIOS Issuer ID. ◆ Discontinuing product: no enrollment option: Select this option if a PY2023 product is discontinued for PY2024 and there is no enrollment option on the FFE for PY2023 enrollees in this plan ID/service area combination. Do not enroll pertinent plans into a plan offered off the Exchange. Selecting this option will disable the <i>PY2024 Plan ID</i> field. Under this option, you may not enter the discontinued PY2023 product ID for any other row under the PY2024 plan ID. You should crosswalk any discontinued PY2023 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if you do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, we will crosswalk the discontinued plan to another product you offer under the same HIOS Issuer ID.
2024 HIOS Plan ID	<p>Enter the PY2024 plan ID you would like to crosswalk your enrollees to for the row's PY2023 plan ID/service area. This field will be auto-populated when Renewing exact same product/plan combination (Same 2023 Plan ID) is chosen under <i>Crosswalk Reason</i>. This field will be disabled when Discontinuing product; no enrollment option or Continuing product; no plan available in the particular service area under that product; no enrollment option are chosen under <i>Crosswalk Reason</i>.</p> <p>Note: Only enter PY2024 plan IDs for plans that will be offered on the Exchange and are listed in the 2024 QHP Application. CMS will not accept any PY2024 plan IDs for plans only sold off the Exchange.</p>
Is this PY2024 Plan a Catastrophic or Child-Only Plan?	This field will default to No . Please select Yes if you are crosswalking a catastrophic or child-only plan.
PY2024 Plan ID for Enrollees Aging off Catastrophic or Child-Only Plan	If you respond Yes to <i>Is this PY2024 Plan a Catastrophic or Child-Only Plan?</i> , this field will allow you to enter a PY2024 plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2024 plan ID entered in this field.
Associated Policy Form Numbers and NAIC SERFF Tracking Numbers for Form Filings	<p>Complete the following optional data fields if directed to do so by your state regulator:</p> <ul style="list-style-type: none"> ◆ PY2023 Plan ID—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ PY2024 Plan ID—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ PY2024/23 Plan ID (catastrophic or child-only)—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings.

See Figure B-1 for a sample completed Plan ID Crosswalk Template.

Figure B-1. Sample Plan ID Crosswalk Template

Plan Crosswalk Template v13.0

Issuer Information	
HIOS Issuer ID	12345
Issuer State	VA
Market Coverage	Individual
Dental Only Plan	No

2023 HIOS Plan ID (Standard Component)	Crosswalk Level	Counties Crosswalked at Zip Level
Required	Required: Indicate whether you would like to crosswalk your 2023 to 2024 Plan IDs at the plan, county or zip code level.	Required if user indicates Crosswalked at the Zip Level for one or more counties.
12345VA1234567	Crosswalking to same Plan ID	
12345VA1234568	Crosswalking at the plan ID level	

Actions

- Import 2023 Plans & Benefits Template and Service Area Template**
Please save your completed 2023 Plans & Benefits Template and Service Area Template to a folder on your harddrive and then select the button below to import the data.

Import 2023 Plan & Benefits and Service Area Templates
- Create "2024 Crosswalk Tab"**
Select the button below to create the 2024 Crosswalk Tab based upon your entry.

Create "2024 Crosswalk Tab"
- Validate Data**
Select the button below to validate information entered into all tabs. **Warning:** Depending on data size, validation may take several minutes.

Validate
- Finalize Template**
Select the button below to export data to XML file.

Finalize

Table B-1 lists the crosswalk reason and PY2024 plan ID entry options for each crosswalk level.

Table B-1. Crosswalk Level, Reason for Crosswalk, and PY2024 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2024 HIOS Plan ID
Crosswalking to same plan ID	Renewing exact same product/plan combination (auto-populated) (same PY2023 plan ID)	Template auto-populates field with PY2023 plan ID
Crosswalking at the plan ID level	Renewing exact same product/plan combination (different PY2024 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2023 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 PY2023 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 PY2024 plan ID
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2023 plan ID
Crosswalking at the plan ID and county coverage level	Renewing exact same product/plan combination (same PY2023 plan ID)	Template auto-populates field with PY2023 plan ID
	Renewing exact same product/plan combination. (different PY2024 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2023 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 PY2023 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 PY2024 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	PY2024 HIOS Plan ID field is disabled
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2023 plan ID
	Discontinuing product; no enrollment option	PY2024 HIOS Plan ID field is disabled

Crosswalk Level	Crosswalk Reason	2024 HIOS Plan ID
Crosswalking at the ZIP Code level for one or more counties	Renewing exact same product/plan combination (same PY2023 plan ID)	Template populates field with PY2023 plan ID
	Renewing exact same product/plan combination (different PY2024 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2023 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 PY2023 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	PY2024 HIOS Plan ID field is disabled
	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 PY2024 plan ID
	Discontinuing product; no enrollment option	PY2024 HIOS Plan ID field is disabled
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2023 plan ID
Discontinue with no crosswalk	Discontinuing product; no enrollment option	PY2024 HIOS Plan ID field is disabled
	Continuing product; no plan available in the particular service area under that product; no enrollment option	PY2024 HIOS Plan ID field is disabled
Plan withdrawn prior to certification	Plan withdrawn prior to certification; no enrollment option	PY2024 HIOS Plan ID field is disabled

Once the Plan ID Crosswalk Template is completed, you must validate, finalize, and upload the files to the PM Community.

Template Validation	Steps
Validate Template	Click Validate on the <i>2024 Plan Crosswalk</i> tab. 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 reason for and cell location of each error. Correct any identified errors, and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize on the <i>2024 Plan Crosswalk</i> tab to create the .XML version of the template you will upload in the PM Community.
Save Template	Save the .XML template. We recommend you save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Follow the steps in Section 5. Submitting Plan ID Crosswalk Documents to upload the finalized template to the PM Community. Note: If you modify the .XML file name after finalization, we cannot process the template.

5. Submitting Plan ID Crosswalk Documents

You must submit your Plan ID Crosswalk Templates and associated documents via the PM Community.

Follow these steps to upload and submit the .XML version of the Plan ID Crosswalk Template, your required state authorization, and any justifications, if applicable:

Log into the PM Community and select **Plan ID Crosswalk Submission** from the top navigation bar, as shown in Figure B-2.

Figure B-2. PM Community Home Screen



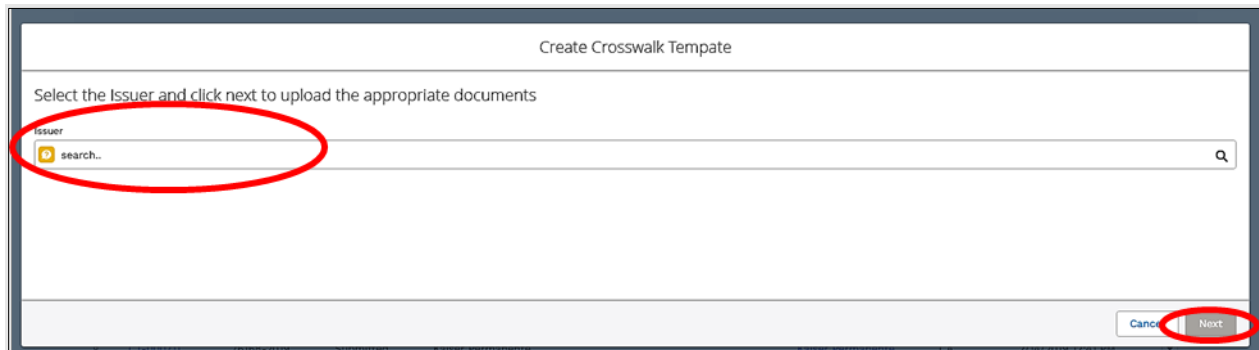
On the *Plan ID Crosswalk Submission* tab, click **New** on the right of the screen (Figure B-3).

Figure B-3. Plan ID Crosswalk Submission Page



In the Create Crosswalk Template Issuer Selection Window pop-up (Figure B-4), use the drop-down menu in the search bar to select the specific HIOS Issuer ID and the plan year for which you are uploading a crosswalk. For example, for HIOS Issuer ID **12345** and plan year **2024**, select **12345-2024**. Complete this process for each HIOS Issuer ID for which a Plan ID Crosswalk Template is being submitted. After you select a specific HIOS Issuer ID, click **Next** on the right of the screen.

Figure B-4. Create Crosswalk Template Issuer Selection Window



In the Create Crosswalk Template File Upload Window pop-up (Figure B-5), upload the following three file types, as necessary:

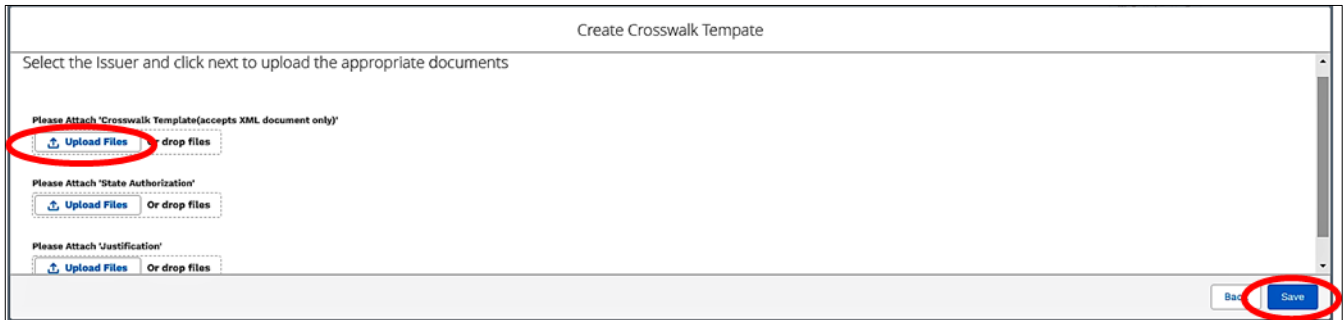
Crosswalk Template. Submit this template during the certification window in .XML format. No other file formats will be accepted. This file is created after you validate and finalize the Excel-based Plan ID Crosswalk Template.

State Authorization. Submit this file during the certification window in MS Word or PDF format. This file shows evidence that your state attests that they have seen and approved of your proposed plan crosswalks.

Justification. This file is optional and may be submitted in MS Word or PDF formats. If you have data issues, corrections, or variances from the required regulations in your template, you may upload a justification file explaining why you believe your crosswalk is compliant.

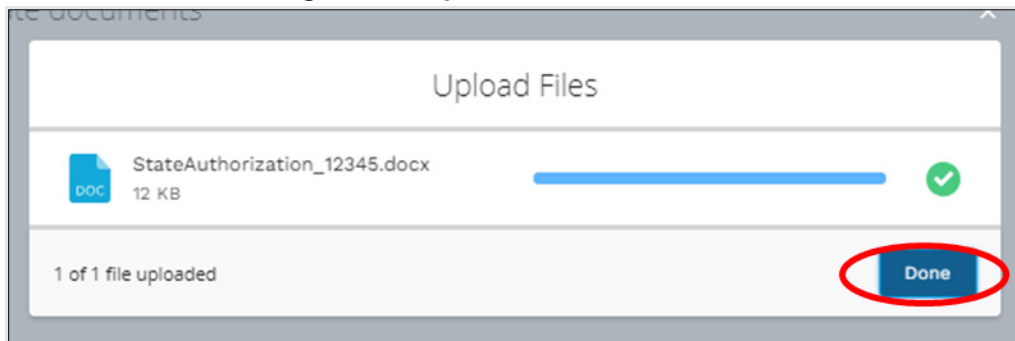
You may upload all files associated with multiple templates, state authorizations, or justifications for a single HIOS Issuer ID in a single submission (Figure B-5).

Figure B-5. Create Crosswalk Template File Upload Window



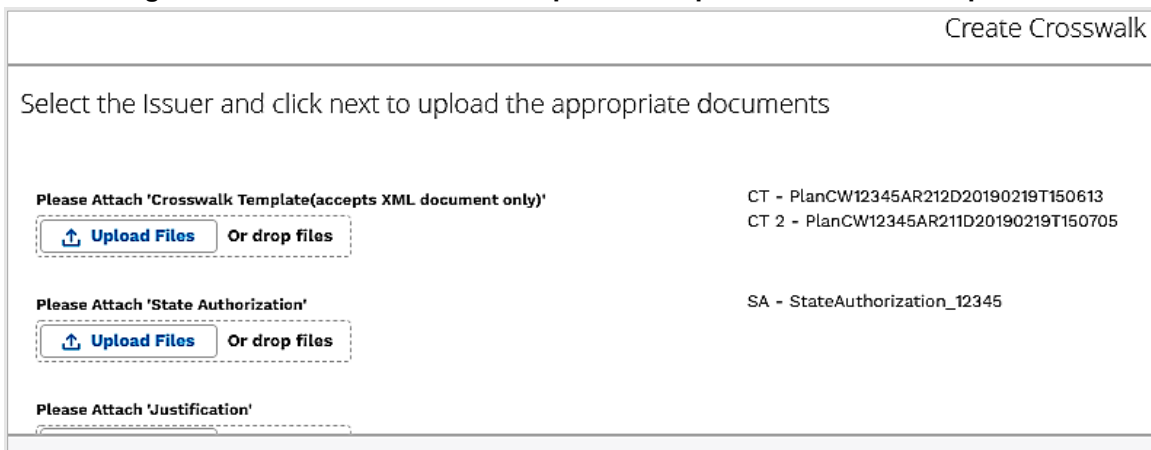
After uploading these files, you will see the Upload Files screen shown in Figure B-6. Click **Done** to continue.

Figure B-6. Upload Files Confirmation



The uploaded file names will appear on the Create Crosswalk Template window (Figure B-7).

Figure B-7. Create Crosswalk Template File Upload Window after Upload



After you've uploaded all required files, click **Save** in the bottom right of the window (Figure B-5).

After saving, the Plan ID Crosswalk Submission Window page will load (Figure B-8). Review the information and click **Submit Templates** in the top right of the screen to submit your templates and supporting documentation.

WARNING: If you upload or save files but do not click **Submit Templates**, CMS will not receive the files.

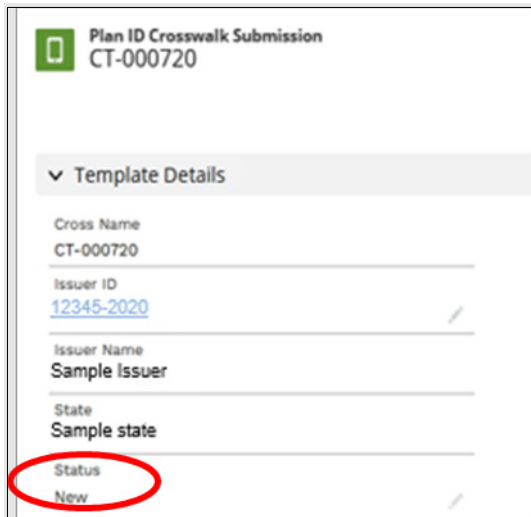
Figure B-8. Plan ID Crosswalk Submission Window



The screenshot shows the 'Plan ID Crosswalk Submission' window for ID CT-000720. In the top right corner, there are two buttons: 'Submit Templates' and 'View Files'. The 'Submit Templates' button is circled in red. Below the header is a 'Template Details' section with the following fields: Cross Name (CT-000720), Issuer ID (12345-2020), Issuer Name (Sample Issuer), State (Sample state), and Status (New).

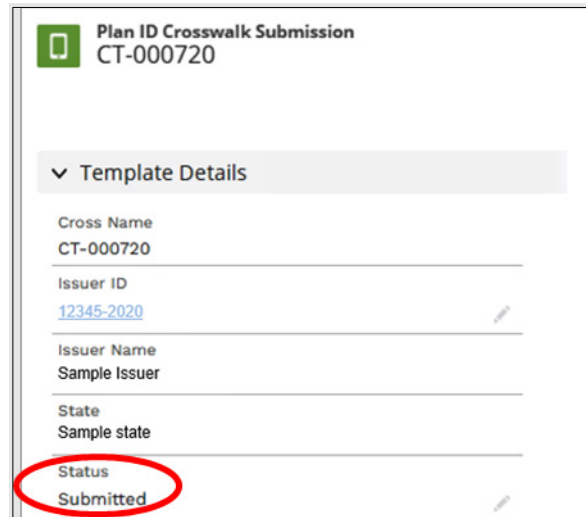
Figure B-9 shows a closer view of the left side of Figure B-8. The status says New, indicating that the files have not yet been submitted. After you click **Submit Templates**, the status will change to Submitted, as shown in Figure B-10 to indicate that all files have been transferred to us and the crosswalk upload process is complete.

Figure B-9. Screen before “Submit Templates” Is Clicked



This is a close-up of the 'Status' field in the 'Template Details' section. The status is 'New', which is circled in red.

Figure B-10. Screen after “Submit Templates” Is Clicked



This is a close-up of the 'Status' field in the 'Template Details' section. The status has changed to 'Submitted', which is circled in red.

To submit an updated Plan ID Crosswalk Template or State Authorization or to submit a new justification document, repeat this Plan ID Crosswalk submission process.

Appendix C: Supporting Documentation

You may be asked to submit supporting documentation and justifications as part of the Qualified Health Plan (QHP) Application process.

Note: Not all QHP Application sections require you to submit supporting documentation or justifications.

Table C-1 lists the supporting documentation and justifications for each application section. It describes the files, the criteria that determine whether you must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the suggested file-naming convention to use when naming the supporting documentation or justification.

Table C-1. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Submission Location	Suggested File Name
State Partnership Exchange Issuer Program Attestation Response Form	Provides program attestations if your state performs plan management functions and you are not able to respond to attestations via MPMS.	Required only if your state performs plan management functions (see Program Attestations section).	SERFF	[Issuer ID]_SPEissuer Attestations
Accreditation Certificate	Demonstrates that you are accredited.	You may choose to submit this certificate if you are accredited.	Accreditation	[Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes a payment structure that provides increased reimbursement or other market-based incentives to improve plan enrollee health outcomes. Access the QIS Guidance and QIS forms on the QIS page of the Centers for Medicare & Medicaid Services (CMS) website.	Required if you have issued QHPs on an Exchange for 2 or more consecutive years that offer family or adult-only medical coverage and meet the QIS minimum enrollment threshold in the Individual Market or Small Business Health Options Program (SHOP) Exchange. Review the QIS threshold in the QIS Technical Guidance and User Guide for the 2024 Plan Year. Issuer submission requirements are in the QIS Issuer List for the 2024 Plan Year.	Accreditation	If submitting an Implementation Plan: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP] If submitting a Progress Report: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[PR] If submitting a Modification Summary: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[MS]

Title	Description	Submission Criteria	Submission Location	Suggested File Name
ECP Justification Form	Explains why you are not meeting the ECP requirements and describes ongoing provider recruitment activities. If you receive a correction notice for not meeting one or more of the ECP standards, you must complete the required fields in the partially pre-populated ECP Justification Form generated by CMS (posted to the ECP/Network Adequacy Justifications tab of the PM Community) and submit via the PM Community.	We will notify you of any failure to meet one or more of the ECP standards by issuing a correction notice and partially pre-populated ECP Justification Form for you to complete and submit via the PM Community.	ECP/Network Adequacy Justifications tab of the PM Community	(Issuer ID)-ECP-(Plan Type)-(Round Abbreviation) Example for Issuer ID 12345 in the Initial Round that is a Medical QHP: 12345-ECP-MedQHP-IR. Example for Issuer ID 12345 in the Initial Round that is an SADP: 12345-ECP-SADP-IR. For Second Round use SR in place of IR and for Final Round, use FR.
Network Adequacy Justification Form	Explains why you are not meeting the network adequacy requirements and describes ongoing provider recruitment activities. If you receive a correction notice for not meeting one or more of the network adequacy standards, you must complete required fields within the partially pre-populated Network Adequacy Justification Form generated by CMS (posted to the ECP/Network Adequacy Justifications tab of the PM Community) and submit via the PM Community.	We will notify you of any failure to meet one or more of the network adequacy standards by issuing a correction notice and partially pre-populated Network Adequacy Justification Form for you to complete and submit via the PM Community.	ECP/Network Adequacy Justifications tab of the PM Community	(Issuer ID)-NA-(Round Abbreviation) Example for Issuer ID 12345 in the Initial Round: 12345-NA-IR. For Second Round use SR in place of IR and for Final Round, use FR.
Service Area Partial County Supplemental Response	Describes why you cannot serve an entire county.	Required if you request to serve only part of a county in a service area.	Service Area	[Issuer ID]_[State Abbreviation]_service_area_partial_county

Title	Description	Submission Criteria	Submission Location	Suggested File Name
Combined Prescription Drug Supporting Documentation and Justification	Explains why a correction was required in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count and how each is not discriminatory.	Required if we issue a correction in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count.	Prescription Drug	[Issuer ID]_[State Abbreviation]_combineddrug
Discrimination—Treatment Protocol Supporting Documentation and Justification	Explains why a drug list's outlying out-of-pocket cost is not discriminatory.	Required if we determine the out-of-pocket cost is an outlier.	Prescription Drug	[Issuer ID]_[State Abbreviation]_treatmentprotocol
Discrimination—Cost-Sharing Outlier: Supporting Documentation and Justification	Explains why outlying cost-sharing values should be allowed and are not discriminatory.	Required if we determine cost-sharing values are outliers at the national or state levels and you do not correct them. States determine the System for Electronic Rates & Forms Filing (SERFF) submission requirements.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_discrimination_cost_sharing
Discrimination—Adverse Tiering: Supporting Documentation and Justification	Explains why the prescription benefit covers all 1st line therapeutics and most or all drugs on the highest tier(s).	Required if we issue a correction in the review based on drug tier coverage.	Prescription Drug	[Issuer ID]_[State Abbreviation]_adversetiering
Unique Plan Design—Supporting Documentation and Justification	Describes why a plan qualifies as unique (why it is incompatible with the standard Actuarial Value Calculator [AVC]) and the methods used to calculate the actuarial value (AV).	Required if you respond Yes to <i>Unique Plan Design?</i>	Plans & Benefits	[Issuer ID]_[State Abbreviation]_unique_plan_design
EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification	Describes EHB compliance for issuers that opt to substitute benefits for EHBs.	You may submit this form or an alternative form to demonstrate EHB compliance. SERFF issuers are not required to submit this form.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_EHB_actuarial_equivalent

Title	Description	Submission Criteria	Submission Location	Suggested File Name
Interoperability Justification	Describes when Interoperability requirements will be met, how enrollees will be impacted by non-implemented requirements, and your plan for completing implementation.	Required if you respond No to any of the four Interoperability attestations.	Interoperability	[Issuer ID]_Interoperability Justification.pdf

Saving Supporting Documents

Save supporting documentation and justifications using the file-naming conventions in the last column of Table C-1. The following special characters are not allowed in the names of files uploaded to MPMS:

Invalid Characters in File Names for Upload to MPMS						
<	:	'	/	\		?
>	;	"	=	%	*	

The file name may include lowercase and uppercase letters. Its full path length must not exceed 255 characters if the file is being uploaded to MPMS. When uploading supporting documentation and justifications, use only the following document formats:

Valid Supporting Document Formats	
.doc	.docx
.jpg	.jpeg
.rtf	.pdf
.ppt	.pptx
.csv	.txt

Uploading Supporting Documents

When multiple plans in an application section use the same supporting documentation or justification reasoning, list all of the supported products and plans in the same uploaded document.

Appendix D: Review Tools

Although these review tools are available to run to identify and correct data errors, issuers must use the Plan Validation Workspace after populating templates because the templates cannot be linked to an application and submitted for CMS review until they pass all the validations that are conducted upon upload to the Plan Validation Workspace. SERFF issuers will also have access to the Plan Validation Workspace and should use it to validate data before submitting materials to SERFF. Table D-1 provides a high-level description of each tool's functionality.

Table D-1. High-Level Description of Each Tool's Functionality

Tool	Purpose
Data Integrity Tool ^a	Identifies critical data errors within and across templates. Provides immediate feedback about data to reduce issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports QHP and SADP data from most application templates. Conducts validations 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 a template.
Plan ID Crosswalk Tool ^a	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring that all counties in all Federally-facilitated Exchange (FFE) plans that were offered in 2023 are included in the crosswalk, the plans are crosswalked to valid 2024 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 <i>Code of Federal Regulations</i> (CFR) 155.335(j).
Master Review Tool ^a	Aggregates data from the Plans & Benefits, Service Area, Essential Community Provider (ECP)/Network Adequacy, and Prescription Drug templates and serves as a data input file to the other standalone tools.
Essential Community Providers Tool for Medical 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 checks 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. The tool also checks for satisfaction of the ECP category per county and Indian health provider contract offering requirements.
Essential Community Providers Tool ^a 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 checks 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. The tool also checks for satisfaction of the Indian health provider contract offering requirement.
Non-Discrimination Tool	Performs an outlier analysis for <i>QHP Discriminatory Benefit Design</i> as discussed in the final 2024 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 ^a	Runs four different checks (when they are applicable to the plan) for cost-sharing standards. This includes the 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) v8 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 27 USP classes.

Tool	Purpose
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.

^a Indicates tools that apply to SADP issuers.

Appendix E: Understanding Issuer Types

Your Qualified Health Plan (QHP) Application submission will differ based on whether you offer Medical QHPs, stand-alone dental plans (SADPs), or both plan types. Each section of this document indicates the type of issuers to which the information applies in a callout box, as shown in Figure E-1.

Figure E-1. Example Identification Box

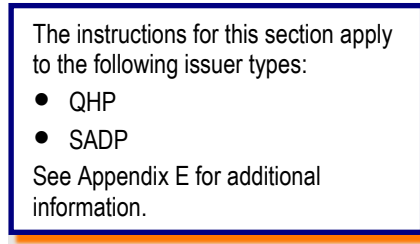


Table E-1 identifies how we categorize issuer types for this document.

Table E-1. Terms and Descriptions

Term	Description
QHP	Qualified health plan. As defined in Section 1301(a) of the Patient Protection and Affordable Care Act (PPACA), a QHP is an insurance plan that is certified by the Health Insurance Marketplace, provides Essential Health Benefits, follows established limits on cost sharing, and meets other requirements outlined within the application process.
SADP	Stand-alone dental plan. As defined in Section 1302(b)(1)(J) and Section 1311(b)(2)(B)(ii) of the PPACA, an SADP is an insurance plan that only provides limited scope dental benefits. SADPs provide dental benefits that are offered in a separate plan and are generally considered to be “excepted benefits” with varying applicable statutory and regulatory standards that differ from QHPs. SADPs are excepted from the insurance market reform provisions of the Public Health Service Act and the PPACA, including but not limited to: medical loss ratio standards; rating standards related to age, family size, rating area, and tobacco use; and guaranteed availability and guaranteed renewability standards.

Appendix F: Network Adequacy Standards

To count towards meeting the time and distance standards, individual and facility providers listed on the below tables must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available.

Table F-1. Time and Distance Standards for Individual Provider Specialty Types for Medical QHPs for Exchange PY2024 QHP Certification

Individual Provider Specialty Types	Maximum Time and Distance Standards ^a									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology—Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology—Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85

Individual Provider Specialty Types	Maximum Time and Distance Standards ^a									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Outpatient Clinical Behavioral Health (licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care–Adult	10	5	15	10	30	20	40	30	70	60
Primary Care–Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130

^a Time standard is measured in minutes. Distance standard is measured in miles.

Table F-2. Time and Distance Standards for Facility Specialty Types for Medical QHPs for Exchange PY2024 QHP Certification

Facility Specialty Type	Maximum Time and Distance Standards ^a									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Critical Care Services–Intensive Care Units (ICU)	20	10	45	30	160	120	145	120	155	140

Facility Specialty Type	Maximum Time and Distance Standards ^a									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

^a Time standard is measured in minutes. Distance standard is measured in miles.

Table F-3. Time and Distance Standards for SADPs for Exchange PY2024 QHP Certification

Individual Provider Specialty Type	Maximum Time and Distance Standards ^a									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

^a Time standard is measured in minutes. Distance standard is measured in miles.

Appendix G: Standardized Plan Option Requirements

Table G-1. 2024 Standardized Plan Options Set One
(For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	64.39%	70.01%	73.00%	87.03%	94.06%	78.02%	88.10%
Deductible	\$7,500	\$5,900	\$5,700	\$700	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,400	\$9,100	\$7,200	\$3,000	\$1,800	\$8,700	\$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$15*	\$30*	\$10*
Non-preferred Brand Drugs	\$100	\$80	\$80	\$60	\$50*	\$60*	\$50*
Specialty Drugs	\$500	\$350	\$350	\$250	\$150*	\$250*	\$150*

*Benefit category not subject to the deductible.

Table G-2. 2024 Standardized Plan Options Set Two (For Exchange Issuers in Delaware and Louisiana)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	64.39%	70.01%	73.00%	87.04%	94.08%	78.04%	88.11%
Deductible	\$7,500	\$5,900	\$5,700	\$700	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,400	\$9,100	\$7,200	\$3,000	\$1,900	\$8,700	\$3,200
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$5*	\$30*	\$10*
Non-preferred Brand Drugs	\$100	\$80	\$80	\$60	\$10*	\$60*	\$50*
Specialty Drugs	\$150	\$125	\$125	\$100	\$20*	\$100*	\$75*

*Benefit category not subject to the deductible.