Qualified Health Plan Issuer Application Instructions

Plan Year 2025

Extracted section:
Section 2E: Plans & Benefits

Section 2E: Plans & Benefits

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

- QHP
- SADP

See Appendix D for additional information.

1. Introduction

In the Plans & Benefits section of the Marketplace Plan Management System (MPMS), issuers enter plan data, list covered benefits with any quantitative limits or exclusions, and provide cost-sharing values and basic plan variation information for each submitted plan, 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.

2. Data Requirements

To complete this section, the following are needed:

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

3. Quick Reference

Key Changes for 2025

- There is new guidance relating to non-standardized plan option limits to ensure compliance with requirements at 45 CFR 156.202.
- There is new guidance related to how to enter certain telehealth benefit and cost sharing information:
  - For Section 2.24 on Covered Benefits, if the cost sharing of a benefit varies based on benefit setting, issuers must fill out the copay and coinsurance for the most common ***in-person*** setting for provision of that benefit and explain cost sharing for any less common settings in the *Benefit Explanation* field.
  - Also, issuers must explain any telehealth-specific benefit designs in the *Benefit Explanation* field of the Plans & Benefits Template, including any differences in cost sharing from in-person services as well as applicable limitations, virtual provider referral requirements, or other telehealth-specific benefit characteristics.
  - If a plan variant marketing name (PVMN) refers to telehealth or virtual care, issuers must explain this reference in the *Benefit Explanation* field.
- There is additional detail in the Plan Variant Marketing Name section to help issuers ensure that marketing names are correct and not misleading, in keeping with requirements at 45 CFR 225(c).

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. In the Plans & Benefits Template, issuers must assign a network, service area, and formulary ID (QHPs only) to each plan based on the IDs created in these three templates.

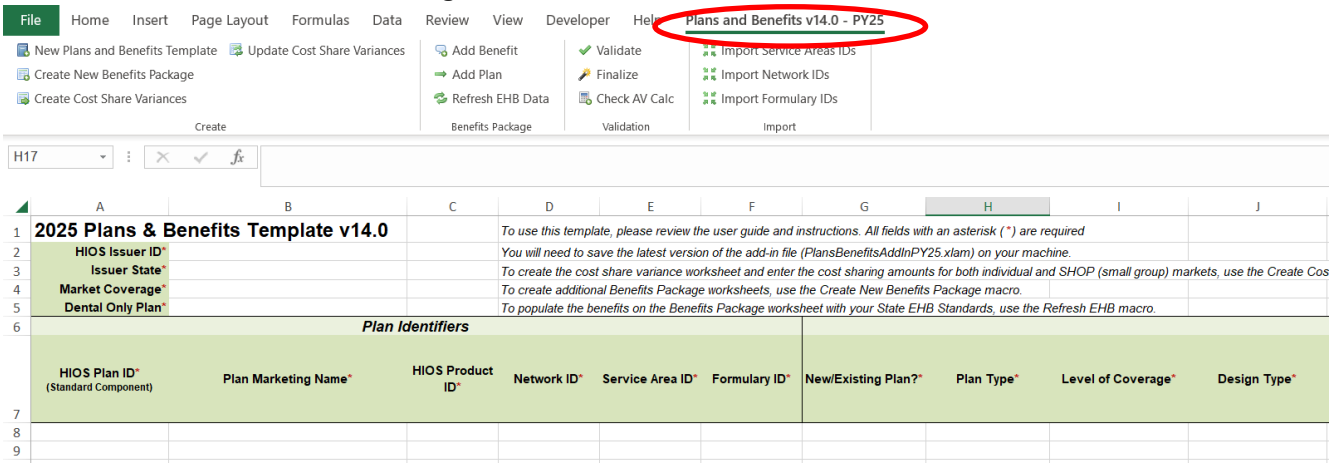
- Complete a separate Benefits Package worksheet for each unique benefits package the issuer wishes to offer. To create additional benefits packages, click Create New Benefits Package under the Plans & Benefits Add-In. *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, and *Dental Only Plan* will auto-populate.
- Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost sharing reduction (CSR) plan variation offered.
- 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 for in-person services. See Appendix A for how these values relate to AV.
- 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 in 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 asked to enable macros when the Plans & Benefits Template is opened, use **Options** on the Security Warning toolbar, and select **Enable this content**. The template will not recognize data entered before the macros were enabled. Any fields completed before enabling the macros will need to be reentered. Once macros are enabled, the **Plans and Benefits** ribbon should appear (Figure 2E-1) as a tab on the file's toolbar.

Figure 2E-1. Plans and Benefits Ribbon



Note: Before proceeding, download and use the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the QHP certification website.

When completing the Plans & Benefits Template, note the following special characters that are allowed in free text fields within the template. Entering other special characters will result in validation errors when uploading the template to MPMS.

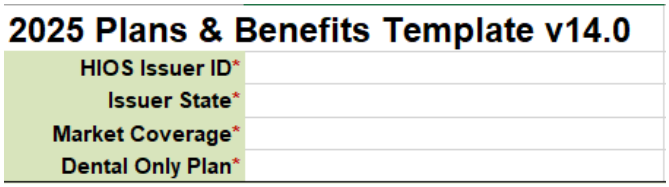
Valid Special Characters for Free Text Fields in the Plans & Benefits Template						
( ) (parentheses)	- (hyphen)	– (en dash)	, (comma)	. (period)	/ (slash)	& (ampersand)

Valid Special Characters for Free Text Fields in the Plans & Benefits Template						
$ (dollar sign)	: (colon)	; (semicolon)	% (percentage)	+ (addition sign)	< (less than)	> (greater than)
= (equal sign)	(space)	_ (underscore)	@ (at sign)	# (hashtag)	| (vertical bar)	\ (backslash)
! (exclamation point)	' (apostrophe/ single quote)	" " (quotation marks)	© (copyright)	® (registered trademark)	™ (trademark)	℠ (service mark)
[ ] (square brackets)						

4.1 General Information

Enter basic issuer information in the fields in the upper left portion of the Benefits Package worksheet (Figure 2E-2). After this information is entered in the first Benefits Package worksheet, it will auto-populate in any additional Benefits Package worksheets that are generated.

Figure 2E-2. Plans & Benefits Template



General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following: ◆ **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 *Benefits Package* 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: ◆ **Yes**—if this is a dental-only package. When **Yes** is selected, the template grays out areas that do not apply to stand-alone dental plans (SADPs) and prevents the fields from accepting data entry. ◆ **No**—if this is not a dental-only package.

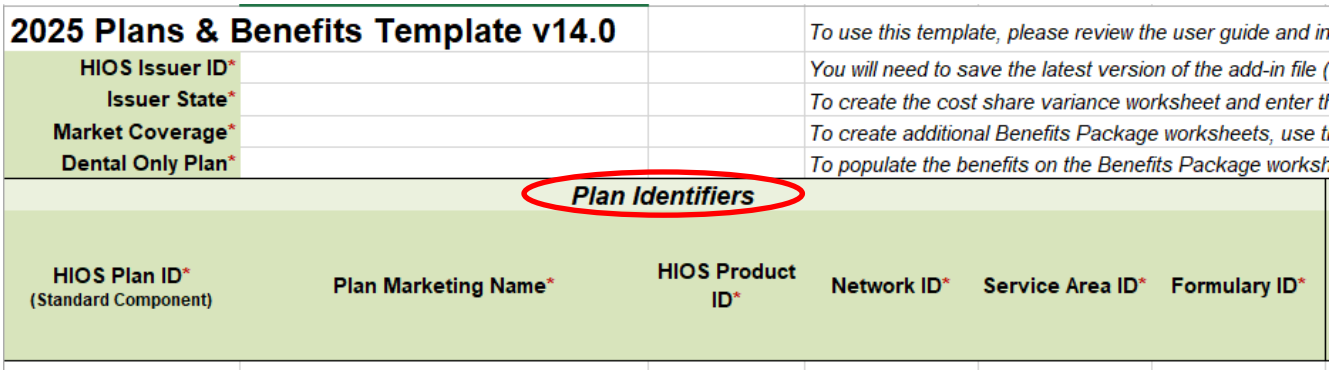
4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data for each plan, including its plan ID and the network, service area, and formulary (QHPs only) it uses (Figure 2E-3). Complete this section for each standard plan offered 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 each standard plan in the Benefits

Package worksheet is entered, the template will automatically create the necessary plan variations in the Cost Share Variances worksheet.

If no more empty rows for new plans are available, 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 2E-3. Plan Identifiers Section

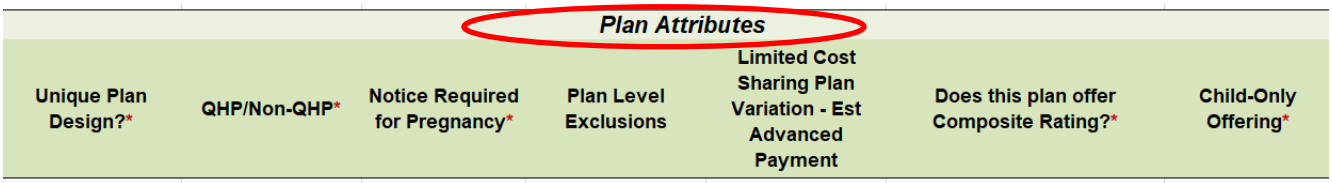


Plan Identifiers	Steps
HIOS Plan ID (Standard Component)*#	Enter the 14-character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name*#	Enter the plan marketing name at the standard plan level. Note: Issuers that want to add cost sharing and other benefit information to a plan marketing name can do so at the PVMN level. Any cost sharing or other benefit information in a PVMN must accurately reflect that plan variant's benefit information, and any references to telehealth or virtual services must be explained in the applicable Benefit Explanation section. (See Section 4.10 Plan Cost Sharing Attributes for additional guidance.)
HIOS Product ID*	Enter the 10-character, HIOS-generated product ID number.
Network ID*	Click **Import Network IDs** on the menu bar under the **Plans and Benefits** ribbon, select the Network ID Template Excel file 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, select the Service Area Template Excel file 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, select the Prescription Drug Template Excel file 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 2E-4).

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



Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following: ◆ **New**—if this is a new plan that was not offered last year. This includes any plan offered last year that is not considered to be the "same plan" as described in 45 CFR 144.103. New plans should use a new plan ID that was not used for the 2024 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 the same plan ID that was used for the 2024 plan year.
Plan Type*#	Select the plan type that best corresponds to plan definitions provided in state law or regulations in the issuer's state. Plan type selections must be consistent with the issuer's state form-filing submissions. Choose from the following: ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point of service) ◆ EPO (exclusive provider organization). Note: The plan type for a plan in the *Benefits Package* tab must match the plan type for the product in HIOS.
Level of Coverage^*#	Select the metal level of the plan based on its actuarial value (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 (ACA). Choose from the following: ◆ **Bronze**—AV of 60 percent ◆ **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 *Level of Coverage* 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: ◆ **Low**—AV of 70 percent ◆ **High**—AV of 85 percent.

Plan Attributes	Steps
Design Type*	If the plan is not following a standardized plan option, select "Not Applicable." SADPs and SHOP plans also should select "Not Applicable" for this field. If the plan is following a standardized plan option and is being offered through an FFE or SBE-FP, excluding the FFEs of Delaware or Louisiana, select "Design Type 1." If the plan design is following a standardized plan option and is being offered through the FFEs in Delaware or Louisiana, select "Design Type 2." If the plan is following a standardized plan option and is being offered through the SBE-FP in Oregon, select "Design Type 3." 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 the corresponding silver plan variations must follow the cost sharing structure for their respective CSR standardized plan designs. For more information on the standardized plan design and populating plans' cost sharing using the SPOs Add-In, see Section 5.12.
Unique Plan Design	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: ◆ **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 **Yes** is selected 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 not unique.
QHP/Non-QHP*	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: ◆ **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.
Notice Required for Pregnancy	Indicate whether consumers or providers must notify the issuer of a pregnancy before pregnancy benefits are covered. Choose from the following: ◆ **Yes**—if a notice is required before pregnancy benefits are covered. ◆ **No**—if a notice is not 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 PY2025. As specified in the *2015 HHS Notice of Benefit and Payment Parameters*, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost sharing plan variations.
Does this plan offer Composite Rating?	Select **No** for this field. This field is not applicable for PY2025.

Plan Attributes	Steps
Child-Only Offering*	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. Choose from the following: ◆ **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 not 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 *Child-Only Offering*. Enter the 14-character plan ID for the corresponding child-only plan if this plan does not allow child-only enrollment. The entered plan ID must correspond to a plan in which the *Child-Only Offering* is **Allows Adult and Child-Only** or **Allows Child-Only** and must have the same selection for *Level of Coverage* as the allows adult-only plan for which you are entering data.
Tobacco Wellness Program Offered	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: ◆ **Yes**—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. ◆ **No**—if the plan does not offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter **No** if either of the following applies: ▪ The plan is offered in the Individual Market. ▪ The plan is offered in the SHOP Market and does not rate for tobacco use.
Disease Management Programs Offered#	Indicate whether the plan offers disease management programs. If the plan offers disease management programs, choose one or more of the following: ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure and High Cholesterol ◆ Low Back Pain ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs.
EHB Percent of Total Premium	Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). Note: This field is not applicable for SHOP Market plans or catastrophic plans. The *EHB Percent of Total Premium* field should be the multiplicative inverse of the URRT *Benefits in Addition to EHB* field when rounded to the fourth decimal point (e.g., 1 divided by *Benefits in Addition to EHB*). As part of the data integrity review, CMS will identify any mismatch between EHB percent of total premium and the multiplicative inverse of *Benefits in Addition to EHB* for a non-catastrophic Individual Market QHP and prompt the issuer to confirm that the submitted values for *EHB Percent of Total Premium* from the Plans & Benefits Template and *Benefits in Addition to EHB* from the URRT are correct.

Plan Attributes	Steps
	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] 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 the premium related to these services depends on whether the state makes these defrayal payments to the enrollee or to the issuer: In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer: ◆ The cost of the state-required benefit the state is defraying should not be factored into the calculation for the *EHB Percent of Total Premium* field on the Plans & Benefits Template and the cost of the state-required benefit should not be factored into the total premium from which the EHB percent of premium is calculated. ▪ Indicate in the *Benefits Information* 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 *EHB Variance Reason*. ▪ No warning error or any problem that would prevent validation of the Plans & Benefits Template will be experienced if coverage of the state-required benefit is excluded 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. In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee: ◆ The cost of the state-required benefit the state is defraying should not be included in the *EHB Percent of Total Premium* field on the Plans & Benefits Template. However, the cost of the state-required benefit should be included 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). ▪ The QHP issuer should also indicate in the *Benefits Information* 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 *EHB Variance Reason*. 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, issuers must handle the portion of the premium related to these services using one of the two methods described below: ◆ 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 (not 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.

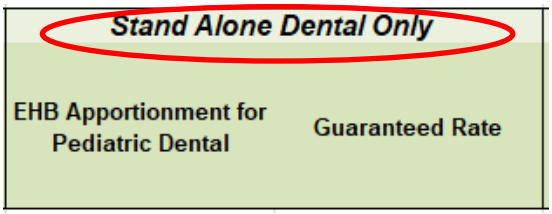
[1] 45 CFR 156.115(d).
[2] 45 CFR 155.170.
[3] 45 CFR 156.280(d).

Plan Attributes	Steps
	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. 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.

4.4 Stand-Alone Dental Only

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

Figure 2E-5. SADP-Only Fields



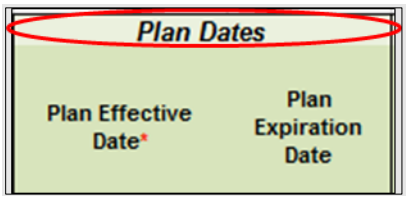
Stand-Alone Dental Only	Steps
EHB Apportionment for Pediatric Dental*	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies only to pediatric rates. If the rates are family-tiered, use the EHB percent 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. Note: This field is no longer applicable for SHOP Market plans.
Guaranteed Rate*	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 Rate" column on each *Benefits Package* tab of the Plans & Benefits Template. Select that this plan offers guaranteed rates. Choose the following: ◆ **Guaranteed Rate**—if the plan offers a guaranteed rate. SADP issuers must submit guaranteed rates. The template prevents selection of the discontinued option of Estimated Rate.

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

4.5 Plan Dates

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

Figure 2E-6. Plan Dates

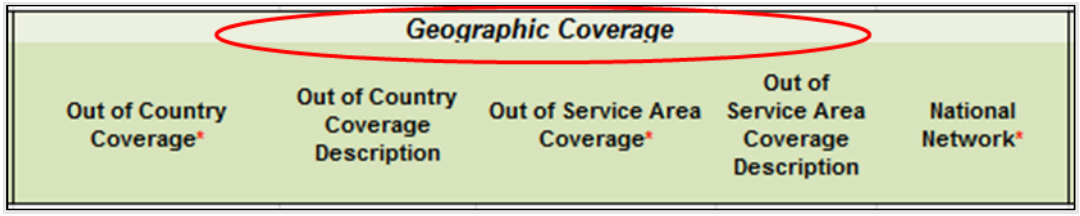


Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2025 plan year—even for existing plans offered on Exchange in 2024. Enter the effective date of the plan using the mm/dd/yyyy format. This must be 01/01/2025 for all plans that will be offered on the FFE and the 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 12/31/2025 for the Individual Market). FF-SHOP plans are effective for a 12-month plan year, so the plan expiration date must be 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 2E-7).

Figure 2E-7. Geographic Coverage Fields



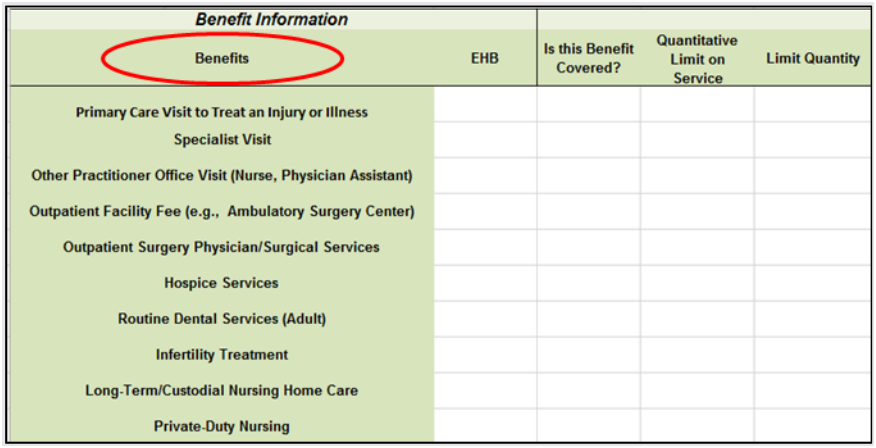
Geographic Coverage	Steps
Out of Country Coverage*	Indicate whether care obtained outside the country is covered under the plan. Choose from the following: ◆ **Yes**—if the plan covers care obtained out of the country. ◆ **No**—if the plan does not cover care obtained out of the country.
Out of Country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

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

4.7 Benefit Information

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

Figure 2E-8. Benefit Information Section



Benefit Information				
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.

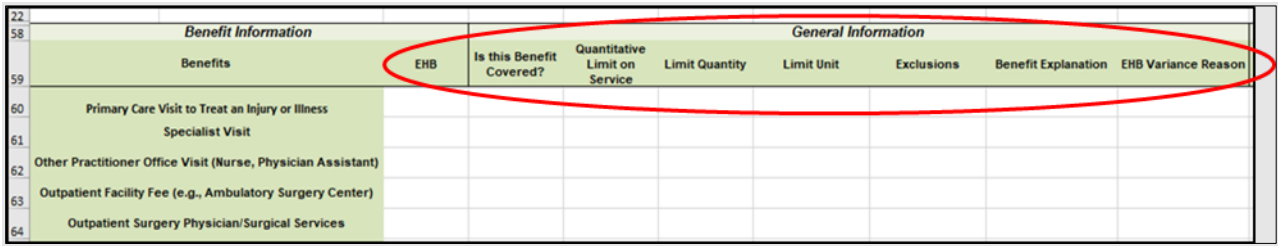
- Determine whether the benefit is listed in the drop-down menu; if it is, select it. If the benefit is not listed in the drop-down menu, click **Custom** and type in the new benefit name. New benefit names must be different from existing benefit names.
- A row for this benefit will appear below the last row in the Benefit Information section.

- If a benefit is added by mistake, 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 adding a benefit that is not found in the state's benchmark and not substituting it for an EHB found in the state's benchmark, select **Not EHB** as the EHB variance reason.
- If adding a benefit that is not found in the state's benchmark and substituting it for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the EHB variance reason.
- If 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 multiple cost sharing schemas are offered 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 2E-9).

Figure 2E-9. General Information Fields



General Information	Steps
EHB*	This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. This field is not editable. Note: Carefully review the benefits covered by the 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, update the Benefits Package worksheet, as needed, to accurately reflect your coverage of EHB benchmark benefits. See the instructions for the *EHB Variance Reason* field for more information on updating the Benefits Package worksheet.
Is this Benefit Covered?*	This field is auto-populated with **Covered** for benefits identified in the template as EHBs. If this field is changed to **Not Covered**, another benefit must be substituted in its place and the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification Form must be provided to support the actuarial equivalence of the substitution (see the *EHB Variance Reason* 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: ◆ **Covered**—if this benefit is covered by the plan. A benefit is considered covered if the cost of the benefit is covered via first-dollar coverage or in combination with a cost sharing mechanism (e.g., copays, coinsurance, or deductibles).

General Information	Steps
	◆ **Not Covered**—if this benefit is not 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?*	Complete this field if **Covered** is selected in the *Is this Benefit Covered?* field. This field is auto-populated for EHBs. If this field is changed for an EHB, an EHB variance reason and supporting documents must be provided. For benefits that are not EHBs, choose from the following: ◆ **Yes**—if this benefit has quantitative limits. ◆ **No**—if this benefit does not have quantitative limits. Note: Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, combined limits may not be imposed 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, a separate limit for those benefits must be provided.
Limit Quantity*#	If **Yes** is selected for *Quantitative Limit on Service?*, complete this field. This field is auto-populated for EHBs. If this data element is changed, an EHB variance reason must be provided. 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).
Limit Unit*#	If **Yes** is selected for *Quantitative Limit on Service?*, complete this field. This field is auto-populated for EHBs. If this data element is changed, 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: ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year ◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. 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 *Limit Unit* field but will auto-populate in the *Benefit Explanation* field. 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

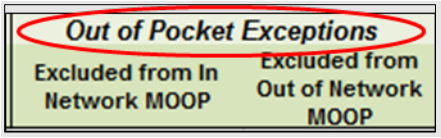
General Information	Steps
	therapy, and occupational therapy for rehabilitative services" will only appear in the *Benefit Explanation* field. Multiple limit units will not auto-populate. To implement multiple limits, complete the *Limit Quantity* and *Limit Unit* fields with the information that should be displayed on the Plan Compare function of the FFE website, then put all other quantitative limits in the *Benefit Explanation* 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 *Limit Unit* field, and **Two treatments per year** in the *Benefit Explanation* field. The message "Quantitative limit units apply, see EHB benchmark" may appear in the *Benefit Explanation* 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 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.
Exclusions*#	Enter any benefit-level exclusions. ◆ If particular services or diagnoses are covered only under some circumstances, list specific exclusions. ◆ If services or diagnoses are not excluded, leave this field blank.
Benefit Explanation*#	Enter any benefit explanations. Explain additional quantitative limits, link to additional plan documents, provide child-specific MOOP or deductible limits, detail descriptions of services provided, and describe alternate cost sharing structures if they depend on provider type or place of service, including virtual care and/or telehealth services. If the plan has different cost sharing for the virtual version of a benefit that can also be delivered in person, the issuer must note here that this is the case and specify the nature of the difference. For example: Virtual PCP visits $0 copay, In-person PCP visits $25 copay. If the plan requires a referral from a virtual provider for a beneficiary to access in-person services, the issuer must note here that this is the case, and specify where more information can be found. For example: Virtual PCP referral required to access in-person services; learn more in plan benefit brochure.
EHB Variance Reason*	If *Is this Benefit Covered?*, *Limit Units*, or *Limit Quantity* fields are changed, or if the issuer state's benchmark has an unallowable limit or exclusion under the ACA, complete this field. Select from the following EHB variance reasons if this benefit differs from the state's benchmark: ◆ **Not EHB**—if this benefit is not an EHB. ▪ If a new benefit not found in the state's benchmark is added, the *EHB* field will be blank and the EHB variance reason should be set to **Not EHB**. This benefit is not considered an EHB. ▪ If a benefit auto-populated as **Yes** in the *EHB* column, but CMS or the issuer's state have directed that the benefit should not be considered an EHB, set the EHB variance reason to **Not EHB**. This benefit is not considered an EHB. ◆ **Substituted**—if a benefit is included in the issuer state's EHB benchmark, the *EHB* field auto-populates as **Yes**. If a different benefit is substituted for an EHB, set the *EHB Variance Reason* to **Substituted** and *Is this Benefit Covered?* to **Not Covered**. The benefit substituted must be designated as an **Additional EHB Benefit**. ◆ **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 if 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 *EHB* column but is not an EHB in the alternate benchmark.

General Information	Steps
	◆ **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 *Is this Benefit Covered?* to **Covered** and set the variance reason to **Other Law/Regulation**. (State-required benefits that were enacted after December 31, 2011, are not 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 the dental EHB is only covered using a separate dental-only plan, set the EHB variance reason to **Dental Only Plan Available**. For example, if SADPs are offered to cover pediatric dental benefits, pediatric dental does not need to be covered 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.) 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, plan benefits may need to be conformed, 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. 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**.

4.9 Out of Pocket Exceptions

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

Figure 2E-10. Out of Pocket Exceptions

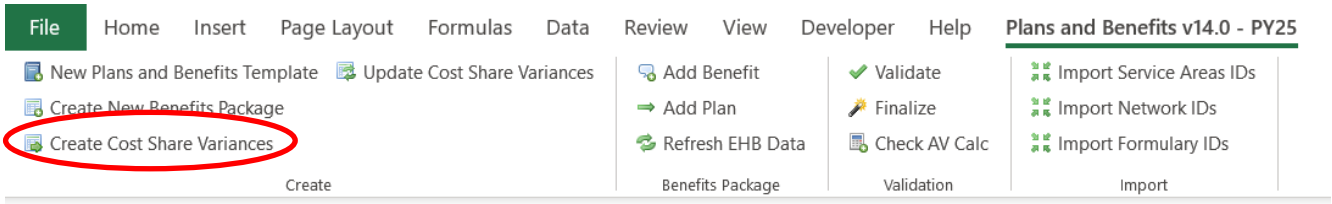


Out of Pocket Exceptions	Steps
Excluded from In Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits that are not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following: ◆ **Yes**—if this benefit is excluded from the in-network MOOP. ◆ **No**—if this benefit is not excluded from the in-network MOOP.

Out of Pocket Exceptions	Steps
Excluded from Out of Network MOOP*	Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following: ◆ **Yes**—if this benefit is excluded from the out-of-network MOOP. ◆ **No**—if this benefit is not excluded from the out-of-network MOOP.
◆ If the plans only have a combined (no separate, in-network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP*. ◆ If *Is this Benefit Covered?* is **Not Covered** or blank, leave the *Excluded from In Network MOOP* and *Excluded from Out of Network MOOP* fields blank. ◆ If the plans do not have an out-of-network MOOP, select **Yes** for *Excluded from Out of Network MOOP*.	

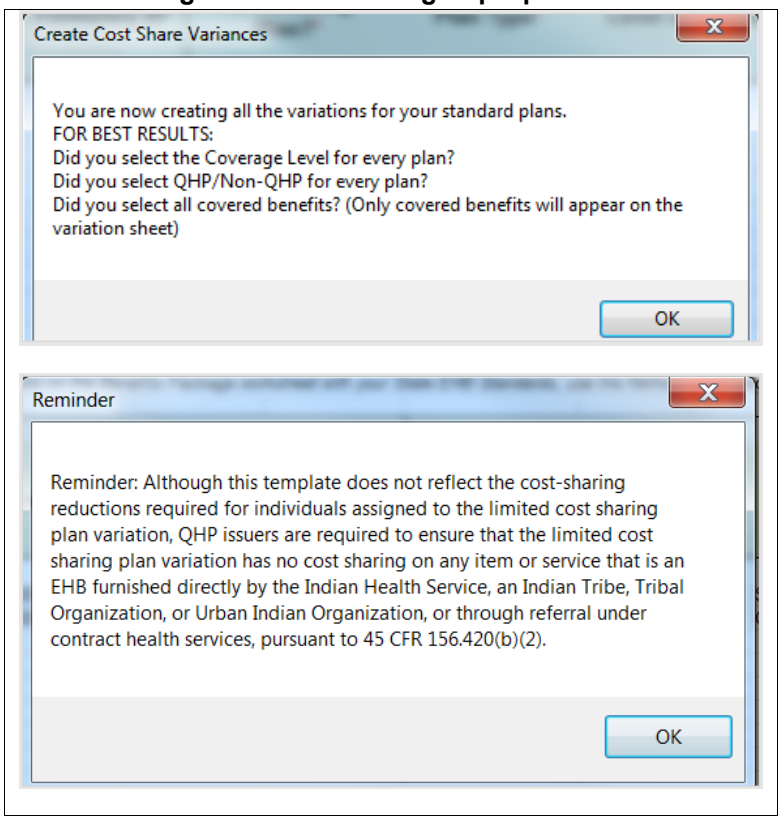
After the above benefit-related information is entered in the Benefits Package worksheet, click **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon (Figure 2E-11). The Cost Share Variances worksheet collects detailed cost sharing benefit design information for all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

Figure 2E-11. Create Cost Share Variances Button



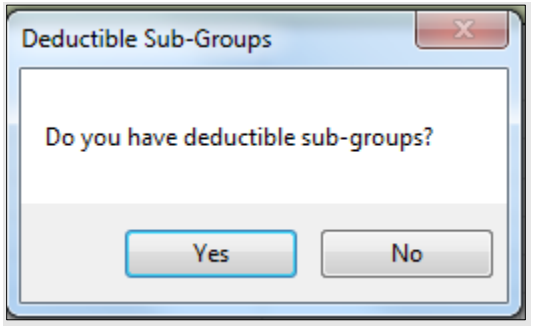
Click **OK** after reading the warnings (Figure 2E-12) and make any necessary changes.

Figure 2E-12. Warning Pop-Up Boxes



After the warnings are addressed, the following series of questions regarding deductible sub-groups appears (Figure 2E-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. Issuers are not required to use deductible sub-groups.

Figure 2E-13. Deductible Sub-Groups



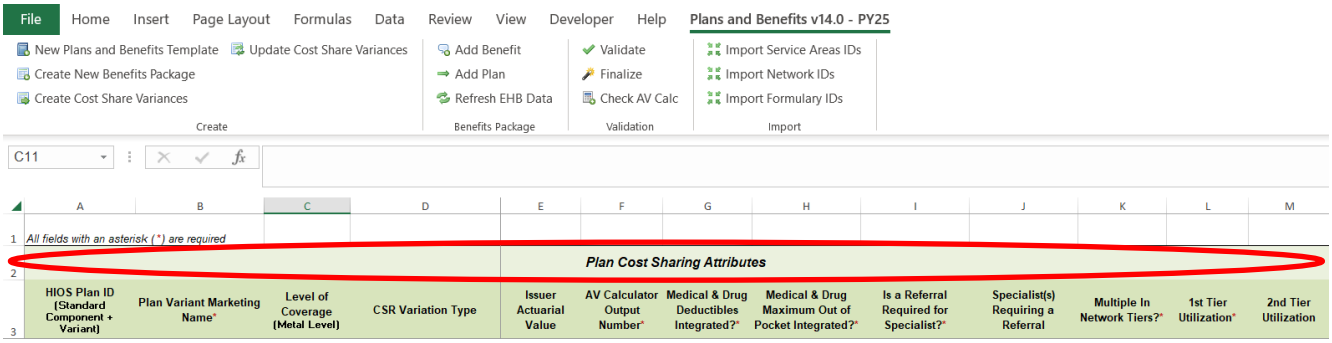
1. Do you have any deductible sub-groups?
   a. **Yes**—if the plan contains deductible sub-groups.
   b. **No**—if the plan does not contain deductible sub-groups.
2. If **Yes** is selected for the previous question, the following questions will appear:
   a. How many deductible sub-groups do you have?
      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 the deductible sub-groups. A different name must be used for each sub-group.

A new Cost Share Variances worksheet is created for each Benefits Package worksheet (Figure 2E-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 2E-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 submitted, but CSRs do not apply to SADPs.

Plan Cost Sharing Attributes	Steps
HIOS Plan ID*	The HIOS-generated number auto-populates for each cost sharing plan variation. ◆ Standard plans to be offered on the Exchange have a plan ID variant suffix of "−01," and standard plans to be offered 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"). ▪ 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"). ▪ 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. Any references to cost sharing or other benefit information must be adjusted 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. If the marketing name includes references to virtual care or telehealth services, these references must be explained in the applicable *Benefit Explanations* field.
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*	If **Yes** is entered for *Unique Plan Design* in the Benefits Package worksheet, enter the AV. This applies to health plans that indicate they are a unique plan for AV purposes. 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.
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?^	Indicate whether the plan's 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: ◆ **Yes**—if the medical and drug deductibles are integrated. If **Yes** is entered, 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 not integrated. If **No** is entered, do not enter information in the Combined Medical & Drug Deductible section (4.18).
Medical & Drug Maximum Out of Pocket Integrated?^	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: ◆ **Yes**—if the medical and drug MOOPs are integrated. If **Yes** is entered, 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 not 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?	Indicate whether consumers must be referred to see a specialist. Choose from the following: ◆ **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 *Is a Referral Required for a Specialist?*

Plan Cost Sharing Attributes	Steps
Multiple In Network Tiers?^*	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: ◆ **Yes**—for multiple in-network provider tiers. Enter Tier 1 information in the *In Network* and *In Network (Tier 1)* sections and Tier 2 information in the *In Network (Tier 2)* sections. ◆ **No**—if there are not multiple in-network provider tiers. If this response is selected, information in the *In Network (Tier 2)* sections cannot be entered will be grayed out and locked.
1st Tier Utilization^*	If responding **Yes** to *Multiple In Network Tiers?*, 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 responding **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 1st Tier Utilization.)
2nd Tier Utilization^*	If responding **Yes** to *Multiple In Network Tiers?*, enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked if responding **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 2nd Tier Utilization.)

4.10.1 Plan Variant Marketing Name

45 CFR 156.225(c), 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, do not omit material fact, and do not include content that is misleading. Issuers may, but are not required to, add cost sharing and 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:
  - PVMNs 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.
  - PVMNs that list cost sharing for a benefit that is subject to the deductible must also specify the deductible requirement in the marketing name.
  - If the plan has tiered benefits, the PVMN must match the highest cost sharing tier, list information for all tiers, or omit this information.
- 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). Cost sharing information in a PVMN must specify any benefits to which it applies, unless it applies to all plan benefits based on the Plans & Benefits Template.
- 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 ACA 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 (including spaces). Note that plan marketing names exceeding 100 characters may be truncated in parts of online Marketplace user interface (UI) displays and experiences for accessibility and will include an ellipsis or similar element to indicate that additional content would be available through an interaction.

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.

Terms such as "telehealth" and "virtual care" are allowed in the PVMN, but issuers must note any limitations and the benefit to which the telehealth-specific cost sharing applies. Issuers must also include an explanation of what these telehealth terms refer to in the Benefit Explanation section of the template, and state whether different cost sharing applies to the corresponding in-person service. Issuers are not expected to list telehealth versus in-person cost sharing for all plan variants in the Benefit Explanation section but should state if telehealth and in-person cost sharing are different for the applicable benefit and refer to where more detailed information is available (for example, in a plan brochure or SBC document).

4.11 Summary of Benefits and Coverage

4.11.1 Summary of Benefits and Coverage Scenario

Three SBC scenarios are completed 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 CCIIO 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 issuers Plans & Benefits Template to ensure data consistency. For more information on how to enter cost-sharing data into the Plans & Benefits Template, see Section 4.24 Covered Benefits. As noted in this section, 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, fill out the copay and coinsurance for the most common in-person setting for provision of that benefit. 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 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

Common Medical Event	SBC Form Benefit Name	Plans & Benefits Template Benefit Name
	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
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	N/A
	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 responding **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; complete section 4.15 only if responding **Yes**. Complete sections 4.16 and 4.17 only if responding **No** to *Medical & Drug Deductibles Integrated?*; complete section 4.18 only if you responding **Yes**. SADP-only issuers should 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

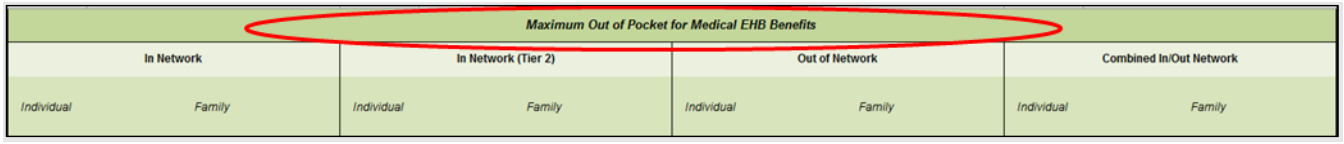
per-group amount and a per-person amount. The per-group amount is the total MOOP or deductible limit when accruing costs for all members in a family (i.e., any coverage other than self-only). The per-person amount is the MOOP or deductible limit that applies separately to each person in a family. The *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.
- The issuer must enter a per-person amount and per-group amount for MOOP and deductible; **Not Applicable** may not be entered 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 2E-15.

Figure 2E-15. MOOP Fields



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

[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 2025 Benefit Year*. Issuers must comply with policies that are incorporated into this guidance.

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

4.14 Maximum Out of Pocket for Drug EHB Benefits

Use this section to input MOOP values for drug EHBs only if the medical and drug MOOPs are not integrated (i.e., a response of **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; a response of **Yes** will cause this section to 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 not integrated, enter the dollar amount for *In Network Individual Maximum Out of Pocket for Drug EHB Benefits*.
In Network—Family#	If the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Maximum Out of Pocket for Drug EHB Benefits*.
In Network (Tier 2)—Individual^	If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the dollar amount for *In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits*. If there are not multiple in-network tiers, this field will be grayed out and locked. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* field.)
In Network (Tier 2)—Family	If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for *In Network (Tier 2) Family Maximum Out of Pocket for Drug EHB Benefits*. If there are not multiple in-network tiers, this field will be grayed out and locked. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
Out of Network—Individual	If the MOOPs are not integrated, enter the dollar amount for *Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits*.
Out of Network—Family	If the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.
Combined In/Out Network—Individual^#	If the MOOPs are not integrated, enter the *Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits*.
Combined In/Out Network—Family#	If the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.

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

Use this section to input MOOP values for medical and drug EHBs only if the medical and drug MOOPs are integrated (i.e., a response of **Yes** to *Medical & Drug Maximum Out of Pocket Integrated?*; a response of **No** will cause this section to 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 *Total In Network Individual Maximum Out of Pocket*.
In Network—Family#	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total In Network Family Maximum Out of Pocket*.

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

4.16 Medical EHB Deductible

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

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

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., a response of **No** to *Medical & Drug Deductibles Integrated?*; a response of **Yes** will cause 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 not integrated, enter the dollar amount for *In Network Individual Drug EHB Deductible*.
In Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual^	If the deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for *In Network (Tier 2) Individual Drug EHB Deductible*. If there are not multiple in-network tiers, this field will be grayed out and locked. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* field.)
In Network (Tier 2)—Family	If the deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for *In Network (Tier 2) Family Drug EHB Deductible*. If there are not multiple in-network tiers, this field will be grayed out and locked. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
In Network (Tier 2)—Default Coinsurance^	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Default Coinsurance* field.)
Out of Network—Individual	If the deductibles are not integrated, enter the dollar amount for *Out of Network Individual Drug EHB Deductible*.
Out of Network—Family	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Drug EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *Combined In/Out of Network Individual Drug EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Drug EHB Deductible*.

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., a response of **Yes** to *Medical & Drug Deductibles Integrated?*; a response of **No** will cause this section to 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 *In Network Individual Combined Medical and Drug EHB Deductible*.
In Network—Family#	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *In Network Family Combined Medical and Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are integrated, this field must be completed 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 *In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible*. If there are not multiple in-network tiers, this field will be grayed out and locked.
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 *In Network (Tier 2) Family Combined Medical and Drug EHB Deductible*. If there are not multiple in-network tiers, this field will be grayed out and locked.
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 *Out of Network Individual Combined Medical and Drug EHB Deductible*.
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Combined Medical and Drug EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are integrated, enter the dollar amount for *Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Combined Medical and Drug EHB Deductible*.

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 2025 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 *In Network Individual MOOP for Dental EHB Benefits*.
In Network—Family*#	Enter the per-person and per-group dollar amounts for *In Network Family MOOP for Dental EHB Benefits*.
In Network (Tier 2)—Individual*^	Enter the dollar amount for *In Network (Tier 2) Individual MOOP for Dental EHB Benefits*.
In Network (Tier 2)—Family*	Enter the per-person and per-group dollar amounts for *In Network (Tier 2) Family MOOP for Dental EHB Benefits*.
Out of Network—Individual*	Enter the dollar amount for *Out of Network Individual MOOP for Dental EHB Benefits*.

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

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

4.21 Other Deductible

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

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

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

HSA/HRA Detail	Steps
HSA-Eligible^#	Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following: ◆ **Yes**—if the plan meets all HSA requirements. ◆ **No**—if the plan does not meet all HSA requirements. Note that **No** should be selected 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.
HSA/HRA Employer Contribution^	If the plan is 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: ◆ **Yes**—if the plan has an HSA/HRA employer contribution. ◆ **No**—if the plan does not have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount^	If responding **Yes** to *HSA/HRA Employer Contribution*, 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 *Federal Register* 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

4.23 AVC Additional Benefit Design

This section contains optional fields, which may be filled 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.

AVC Additional Benefit Design	Steps
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.

1. 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 in-person setting for provision of that benefit. Explain the cost sharing for any less common settings, and if applicable for telehealth 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. If a Specialist Visit could take place in an office setting or a hospital and the copay or coinsurance could differ depending on the location, input the cost sharing for the in-person location in which you expect enrollees to redeem the benefit most often.

   b. If a virtual Primary Care Visit would have a copay of $0, and an in-person visit would have a copay greater than $0, input the copay for the in-person visit in the copay field, and describe availability of $0 copay or otherwise discounted virtual visits in the *Benefit Explanation* field, with a reference as needed to where more detail on telehealth-specific cost sharing can be found.

2. If the plan does 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.

3. If the plan charges only a copay or a coinsurance for a benefit, enter **Not Applicable** for the one you do not charge. For example, if a plan charges 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 2025 template.

4. Set the "Multiple In Network Tiers?" drop-down menu option to "**Yes**" if the plan has multiple in-network tiers, and evaluate whether the following scenarios apply:

   a. If the plan has 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 the plan has multiple in-network tiers only for inpatient hospital covered benefits, 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.

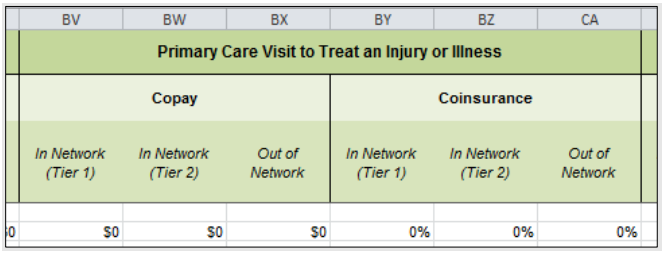
5. For further instructions on coordinating the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see 5.8 Suggested Coordination of Drug Data between Templates.

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

Figure 2E-16. Benefit Information Fields



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

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

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

Covered Benefits	Steps
Coinsurance—In Network (Tier 1)*^#	If an in-network coinsurance is charged, enter the percentage the consumer will pay in this field. If coinsurance is not charged, enter **Not Applicable** unless the plan has a Tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, 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 the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **Not Applicable**—the consumer only pays a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—In Network (Tier 2)*^#	If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay in this field. If a coinsurance is not charged, enter **Not Applicable** unless the plan has a Tier 2 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. For any benefit category that does not have tiers, enter **Not Applicable** in this field and in the *Copay—In Network (Tier 2)* 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: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, 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 the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network*#	If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If a coinsurance is not charged, enter **Not Applicable** unless the plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. If the plan does not cover this benefit out of network, enter **100%**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, 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 the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

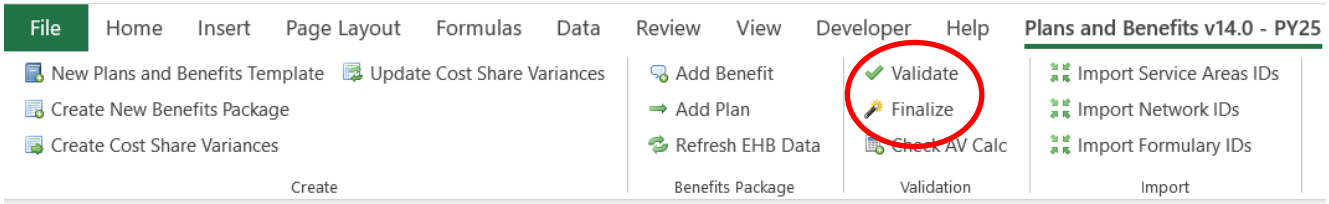
Covered Benefits	Steps
	◆ **Not Applicable**—the consumer pays only a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.25 Completed Plans & Benefits Template

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, it must be validated, finalized, and uploaded 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 that will be uploaded in the Plan Validation Workspace in MPMS.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file 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 the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

Figure 2E-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 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 2025 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.

   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.)

3. Family Deductible Requirements.[7] Ensure that the following limits are taken into consideration:

   a. Plans that allow multi-member enrollment (family plans) should 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.)

   c. For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, HealthCare.gov will not be able to display the total health and medical deductibles.

   d. For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, the per person in group deductible will display on HealthCare.gov.

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 a combination of both (deductibles combined, MOOPs separate OR deductibles

[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 2025 Benefit Year*.
[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 2025 Benefit Year*.

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 ACA and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can be offered only in the Individual Market.
2. They are permitted, but not required, to cover multi-person enrollment (families) when all members meet eligibility requirements for this type of plan.
3. They do not have multiple in-network tiers for EHBs.
4. They have integrated medical and drug deductibles.
5. They have integrated medical and drug MOOPs.
6. They have an in-network deductible and in-network MOOP equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the ACA 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 2025 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 benefits, 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 benefits must be provided 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.)

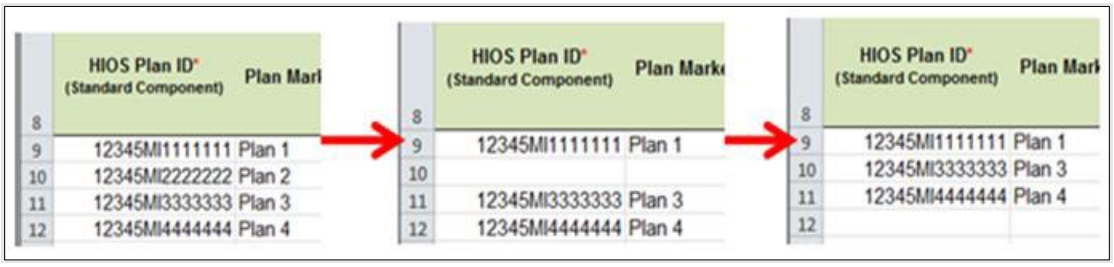
5.4 Editing the Template

The following should be kept in mind when changing the template:

1. If a benefit is added as an additional benefit by mistake, one of the following actions can be taken 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. To remove an additional benefit or change whether it is **Covered** on the Benefits Package worksheet after you create the Cost Share Variances worksheet, the entire Cost Share Variances worksheet must be deleted and a new one generated 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:
    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 2E-18) and click **Update Cost Share Variances**. For example, to delete Plan 2, 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 **Update Cost Share Variances** is clicked when there is an empty row between plans.

Figure 2E-18. Deleting a Plan



c. If any benefits package data for an existing plan are changed, only the following changes will be reflected on the Cost Share Variances worksheet when **Update Cost Share Variances** is clicked:

   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:

   i. Delete that plan on the Benefits Package worksheet, as explained previously, 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.

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 ACA 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 2025 Benefit Year* for an individual (self-only) and for a family (other than self-only).

[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.

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 ACA 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 2025 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 2E-1 explains when a benefit is considered an EHB based on different inputs.

Table 2E-1. EHB Designation

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

5.7 Successive Cost Sharing Guidance

As explained in 5.5 Requirements for 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 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, the cost sharing structures may not be changed 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 2E-2 through 2E-8 show compliant and noncompliant data entry options for cost sharing fields, as well as numerous examples.

Table 2E-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 ≤ $X)	◆ Not Applicable ◆ $Y (when $Y > $X)
Not Applicable	◆ Not Applicable	◆ $Y

Table 2E-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 2E-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)

First Plan (Lower AV) Coinsurance Value	Compliant Second Plan (Higher AV) Coinsurance Values	Noncompliant Second Plan (Higher AV) Coinsurance Values
X% Coinsurance	◆ No Charge ◆ Y% Coinsurance (when Y% ≤ 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% ≤ X%) ◆ Y% Coinsurance After Deductible (when Y% ≤ 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 2E-5. Examples of Compliant and Noncompliant Successive Cost Sharing Coinsurance Values

Plan	Coinsurance	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	0%	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	25%	Compliant
Higher AV Plan	20%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	25% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20%	
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 2E-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	◆ No Charge ◆ $0 Copay ◆ Not Applicable	◆ No Charge After Deductible ◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
No Charge After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ $0 Copay ◆ $0 Copay After Deductible ◆ Not Applicable	◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (when greater than 0) ◆ $Y Copay With Deductible (all values)
$X Copay	◆ No Charge ◆ $Y Copay (when $Y ≤ $X) ◆ Not Applicable	◆ No Charge After Deductible ◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ $Y Copay (when $Y ≤ $X) ◆ $Y Copay After Deductible (when $Y ≤ $X) ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (when $Y > $X) ◆ $Y Copay With Deductible (all values)
$X Copay With Deductible	◆ No Charge ◆ $Y Copay (when $Y < $X) ◆ $Y Copay With Deductible (when $Y ≤ $X) ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (when $Y > $X)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)

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

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

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

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

Table 2E-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	

Example	Copay	Compliance
Lower AV Plan	$40	Not Compliant
Higher AV Plan	$45	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay With Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay With Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	
Lower AV Plan	$40 Copay per Day	Compliant
Higher AV Plan	$30 Copay per Day	
Lower AV Plan	$40 Copay per Stay	Compliant
Higher AV Plan	$40 Copay per Stay	
Lower AV Plan	$40 Copay per Day	Not Compliant
Higher AV Plan	$35 Copay per Stay	
Lower AV Plan	$40 Copay per Day After Deductible	Compliant
Higher AV Plan	$30 Copay per Day	
Lower AV Plan	$40 Copay per Stay After Deductible	Compliant
Higher AV Plan	$40 Copay per Stay	
Lower AV Plan	$40 Copay per Day After Deductible	Not Compliant
Higher AV Plan	$35 Copay per Stay With Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	$35 Copay per Stay With Deductible	

5.8 Suggested Coordination of Drug Data between Templates

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

To support the AV calculations using the AVC, the Plans & Benefits Template contains four drug benefit categories that represent a typical four-tier drug design: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly

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

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, issuers are not required to submit a separate formulary in the Prescription Drug Template for plan variations.

Regardless of how each plan's cost-sharing data is translated 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 2E-9 and Table 2E-10 list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This list is not final and may change after these instructions are published, but issuers should use it as a reference while preparing their QHP Applications.

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

Plan Compare Label Name	Template Value	Data Source
Deductibles and Maximum Out of Pocket Rules	◆ If medical and drug amounts are integrated, the combined amount will display. ◆ If medical and drug amounts are not integrated, 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 + Prescription Drug) 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." ◆ For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, HealthCare.gov will not be able to display the total health and medical family per group deductibles. ◆ For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, the per person in group deductible will display on HealthCare.gov.	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

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

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

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

Plan Compare Label Name	Template Value	Template Source
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
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When the *Medical & Drug Deductibles Integrated?* 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 *Medical & Drug MOOP Integrated?* 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

Plan Compare Label Name	Template Value	Template Source
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
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, 2025. It covers most situations but is not exhaustive. This list is not final and may change after these instructions are published, but issuers should use it as a reference while preparing their QHP Applications.

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 **$0** or a positive dollar amount was entered 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.
- For the Primary care, Specialist care, Urgent care, Emergency room, and Outpatient mental health benefits, "per visit from day 1" will display in Plan Compare, Plan Summary Page, and Plan Details, if the Plans & Benefits Template indicates the benefit is available for a copay not subject to the deductible.
- Plan Compare will direct consumers to "View plan details for full list of benefits, limits, and exclusions" for the benefits listed in Plan Summary Page.

5.11 Troubleshooting the Plans & Benefits Add-In File

If the Plans & Benefits Add-In file is opened 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 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 downloading a new copy or version of the Add-In file, always choose the option to replace the old version.

If run-time errors are still encountered, 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 2E-19) > Manage: Excel Add-Ins > Go (Figure 2E-20) > uncheck Plansbenefitsaddin > OK (Figure 2E-21).
2. Verify that the **Plans and Benefits** ribbon is gone. Ensure that only the correct version of the Add-In file is saved on your computer.
3. Open the Plans & Benefits Template.
4. If the template opens the Add-In automatically after clicking **Enable Macros**, the template has successfully loaded the Add-In.

Figure 2E-19. Excel Options Window

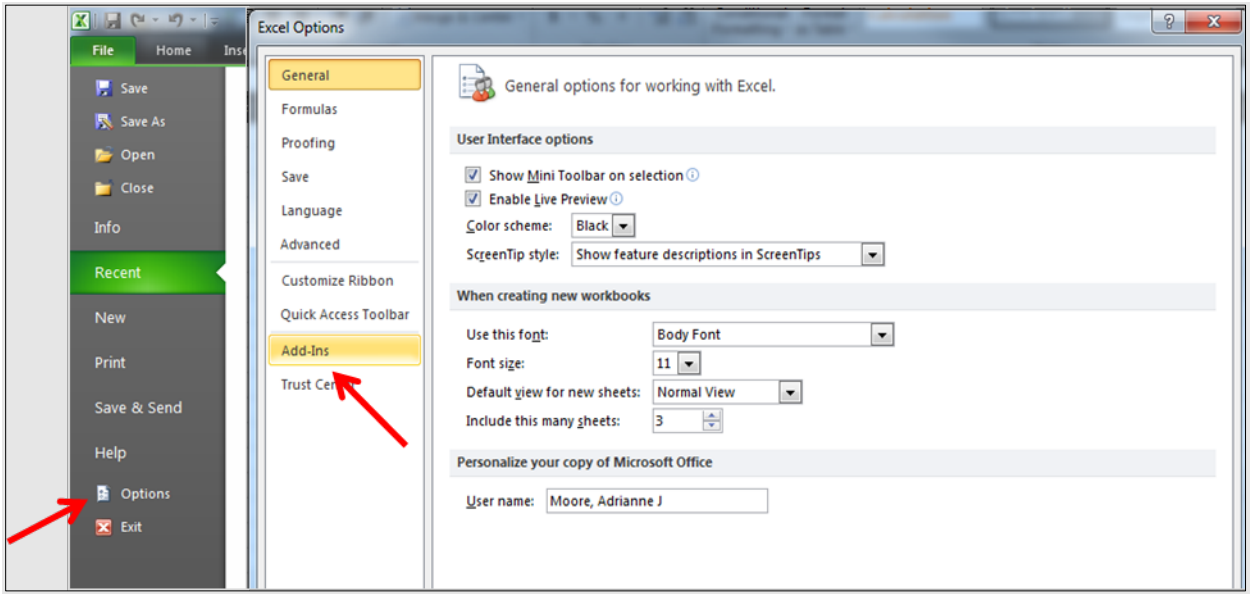


Figure 2E-20. Add-Ins Tab in Excel Options Window

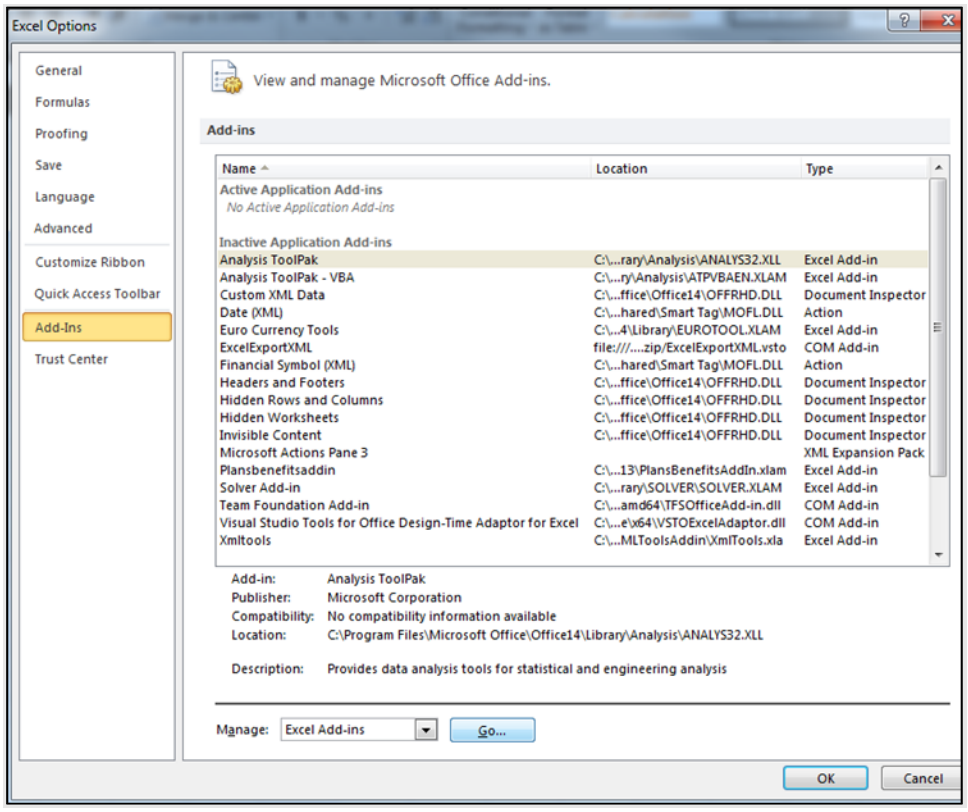
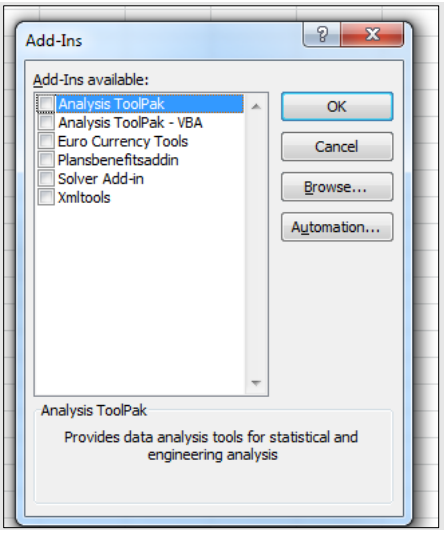


Figure 2E-21. Add-Ins Window



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 for 2023.
2. Standardized plan options simplify the consumer shopping experience by offering plans that are easier for consumers to 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.

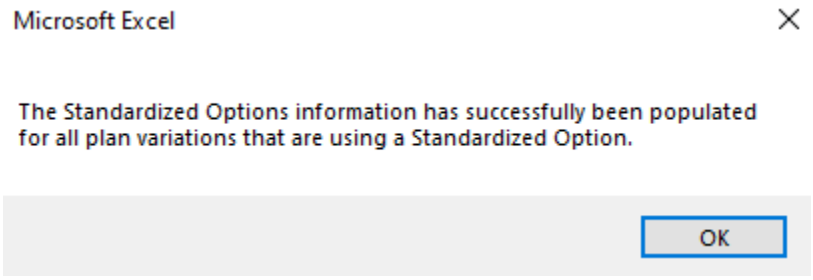
Each state has one set of standardized plan options with a specified MOOP, deductible, and cost sharing structure at each of the expanded bronze, silver, silver CSRs (73% AV, 87% AV, and 94% AV plan variations), gold, and platinum metal levels. HHS did not create standardized plan options for catastrophic 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 2025 (also found in Appendix F). 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, the Standardized Plan Add-In must be opened 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 2E-22).

Figure 2E-22. Populate Standardized Plan Data Button

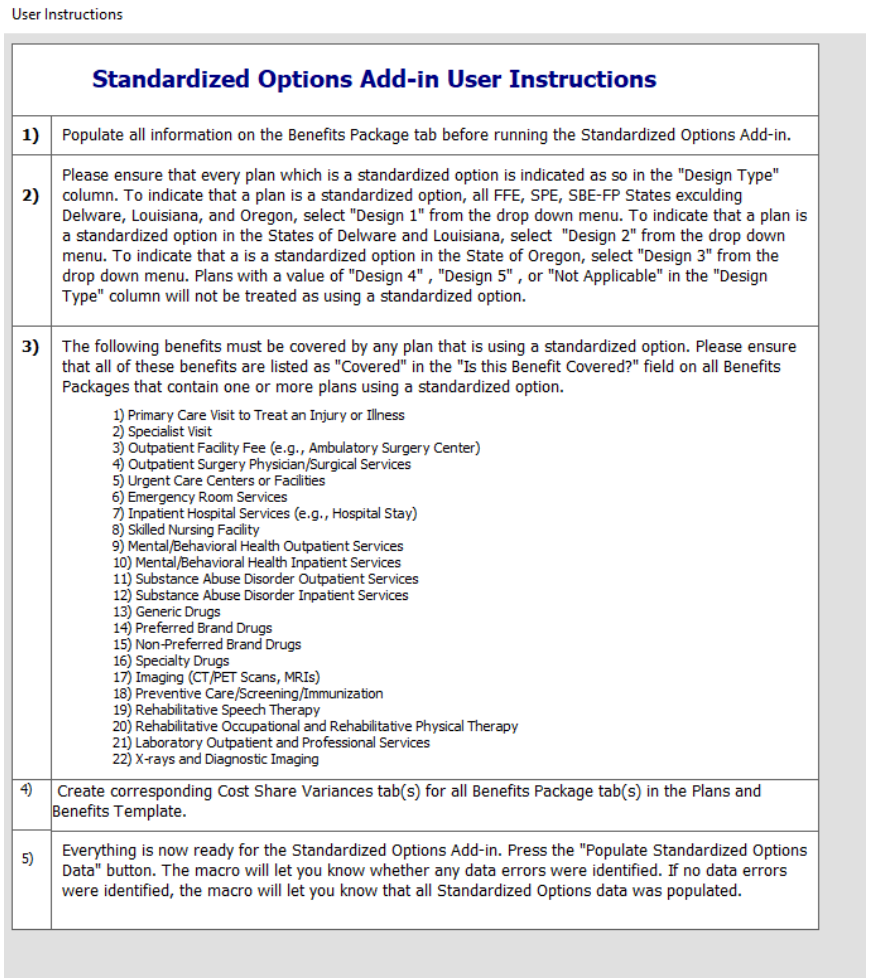
8. If everything runs correctly, the message in Figure 2E-23 will appear; otherwise, an error message will appear and indicate what needs to be corrected to proceed. After everything has been corrected, press the **Populate Standardized Plan Options Data** button again.
    a. The **Populate Standardized 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 Proposed HHS Notice of Benefit and Payment Parameters for 2025. Note: Issuers in the state of Oregon will encounter an error message indicating that the tool will not populate Oregon Standardize Plan Option Values.

Figure 2E-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 2E-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 2E-25) button hyperlinks to the Proposed HHS Notice of Benefit and Payment Parameters for 2025 for a detailed description of the standardized plan options purpose and parameters.

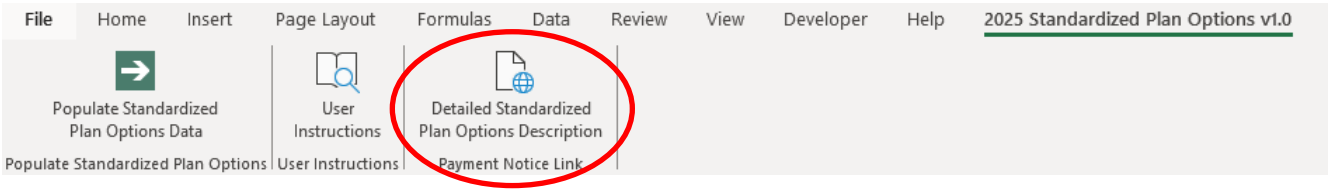
Figure 2E-24. User Instructions Button


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 exculding Delware, Louisiana, and Oregon, select "Design 1" from the drop down menu. To indicate that a plan is a standardized option in the States of Delware 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. 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 2E-25. Detailed Standardized Plan Options Description Button

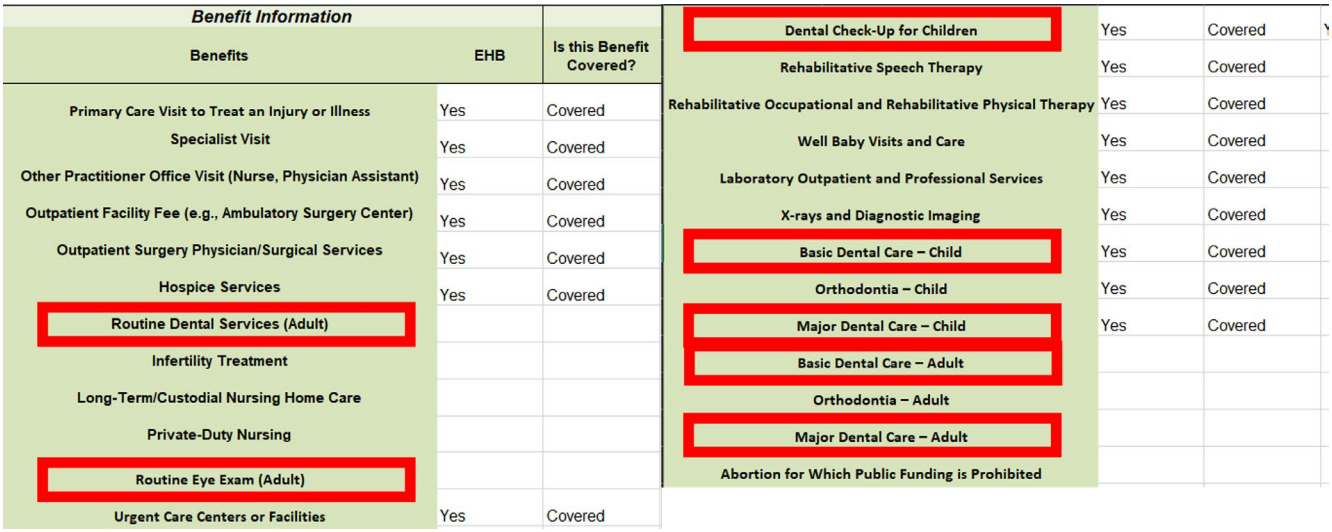


After all data is entered, click **Save** to ensure no data are lost.

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 easily and 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 2025. Under the requirements at 45 CFR 156.202, issuers are limited to offering two 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. For PY2025, issuers may offer up to two 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 2E-26).
3. 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).

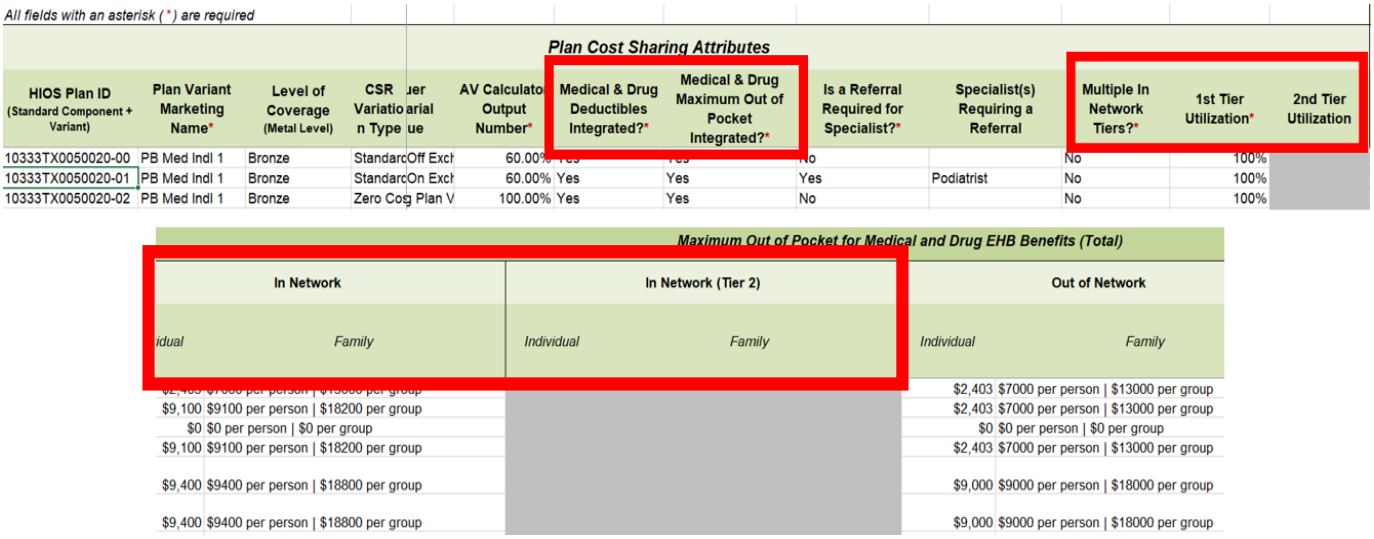
Figure 2E-26. Non-Standardized Plan Option Limits—Applicable Benefits for the Inclusion of Dental and/or Vision Benefits within the Plans & Benefits Template



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

4. More than two 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 two 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 2E-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 2E-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—Adult
        xii. Eyeglasses for Children.

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



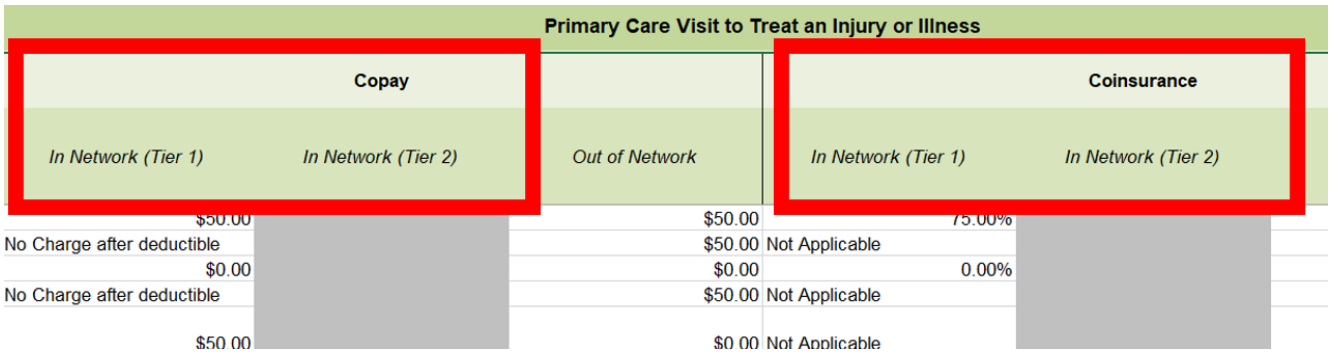
All fields with an asterisk (*) are required

HIOS Plan ID (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage (Metal Level)	CSR Variation Type	AV Calculator 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	60.00%	Yes	Yes	No		No	100%	
10333TX0050020-01	PB Med Indl 1	Bronze	Standard	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*
$9,100	$9100 per person | $18200 per group			$2,403	$7000 per person | $13000 per group
$9,100	$9100 per person | $18200 per group			$2,403	$7000 per person | $13000 per group
$0	$0 per person | $0 per group			$0	$0 per person | $0 per group
$9,100	$9100 per person | $18200 per group			$2,403	$7000 per person | $13000 per group
$9,400	$9400 per person | $18800 per group			$9,000	$9000 per person | $18000 per group
$9,400	$9400 per person | $18800 per group			$9,000	$9000 per person | $18000 per group

Figure 2E-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			Coinsurance	
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*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	

5. There may be no more than two 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 two non-standardized plan options (each with a distinct set of cost-sharing data), issuers may offer each one of those plans in eight variations based on the inclusion of dental and vision benefit coverage:
   a. No additional dental or vision benefit coverage.
   b. Pediatric dental benefit coverage.
   c. Adult vision benefit coverage.
   d. Adult dental benefit coverage.
   e. Pediatric dental and adult vision benefit coverage.
   f. Pediatric dental, adult dental, and adult vision benefit coverage.
   g. Adult dental and adult vision benefit coverage.
   h. Adult dental and pediatric dental benefit coverage.

5.14 Non-Standardized Plan Option Limit Exceptions Justifications

In PY2025, issuers that submit more than two non-standardized plan options per product network type, metal level, inclusion of dental and/or vision coverage, and service area combination must submit a justification for

each plan above the limit as specified at 45 CFR 156.202(d). To utilize this exceptions process, issuers must demonstrate that these additional non-standardized plan options offered beyond the limit have specific design features that would substantially benefit consumers with chronic and high-cost conditions. Issuers are limited to one exception per product network type, metal level, inclusion of dental and/or vision benefit coverage, and service area, for each chronic and high-cost condition.

The Non-Standardized Plan Option Limit Exceptions Justifications process has two components that issuers must successfully complete:

- The MPMS Justification Form
- The Actuarial Memorandum (uploaded as a PDF supporting document in the MPMS Justification Form).

5.14.1 MPMS Justification Form

CMS will automatically prompt issuers to submit justification forms for review if any application includes more than the two plans permitted by the two non-standardized plan limit.

In the justification, issuers must answer the following questions:

1. Identify the specific chronic and high-cost condition that the additional non-standardized plan option is designed to offer substantially reduced cost sharing for.
2. Identify which specific benefits in the Plans & Benefits Template are discounted to provide reduced treatment-specific cost sharing for individuals with the specified chronic and high-cost condition. These discounts must be relative to the treatment-specific cost sharing for the same corresponding benefits in your other non-standardized plan offerings in the same product network type, metal level, and service area. For the purposes of this standard, "treatment-specific cost sharing" are the costs for obtaining services that pertain to the treatment of a particular chronic and high-cost disease—but not the costs for obtaining services that do not pertain to the treatment of the relevant condition. The issuer must identify all services for which the benefits substantially reduce cost sharing in the Plans & Benefits Template. Note that these benefits must encompass a complete list of relevant services pertaining to the treatment of the relevant condition. For example, if you intend to offer a plan that is targeted to the treatment of diabetes, list only the benefits pertaining to the treatment of diabetes.
3. Explain how the reduced cost sharing for these services pertains to clinically indicated guidelines and a representative treatment scenario for the specified chronic and high-cost condition. Include any relevant studies, guidelines, or supplementary documents to support your application. For the purposes of this standard, a representative treatment scenario is an annual course of treatment for a chronic and high-cost condition. For example, if you listed benefits/services pertaining to the treatment of diabetes in the previous question, explain, or provide external reference to, a clinically indicated treatment scenario/guideline that recommends the use of those services in treatment of diabetes.

Refer to the MPMS User Guide for instructions on how to navigate to the justification form as well as additional details about how to use the Plan Validation Workspace, complete the sections of an application, and submit the application.

5.14.2 Actuarial Memorandum Instructions

Issuers must submit an actuarial memorandum for each justification submitted via MPMS (uploaded as a PDF). Issuers should format answers with the headers provided below and include answers and responses for all requirements provided.

Section 1. General Identification Section

Issuers will be responsible for providing the following information.

- Company Identifying Information
- Company Contact Information (i.e., who is providing the actuarial opinion, and how to contact the provider if there are questions related to the submission)
- Market for which the plans will be offered (i.e., Individual, Small Group, or both).

Section 2. Plan Identification

Issuers must answer the following questions in full.

- Confirm the plan IDs for which the justification is suitable.
  - Correctly identify the plan ID for which the reduced cost sharing is being demonstrated.
  - Correctly identify the plan ID that will establish the baseline for the cost sharing comparison.

Section 3. Demonstrating Reduced Cost Sharing

Issuers must provide the following information.

- Demonstrate how the out-of-pocket costs of services specifically referenced in Question 2 of the justification are at least 25% lower for an enrollee seeking treatment for this condition under the exception plan compared to at least one of the identified in-limit offerings in the same product network type, metal level, inclusion of dental and/or vision coverage, and service area combination. Provide this demonstration specifically in reference to the specific population that would be seeking treatment for that chronic and high-cost condition and not the general population. For example, if seeking to justify this plan for the population of individuals with diabetes, demonstrate that the out-of-pocket costs of diabetes-related treatment services are at least 25% lower over the course of the year for an enrollee in this plan compared to an in-limit offering.

Section 4. Actuarial Opinion and Signature

Issuers must include the following certification language and provide a dated signature that is consistent with the person or persons identified in Section 1. The opining actuary must be a member of the American Academy of Actuaries, in good standing, and have the education and experience necessary to perform the work.

- In my expert opinion as a certified actuary and member of the American Academy of Actuaries, this analysis was prepared in accordance with the appropriate Actuarial Standards of Practice (ASOPs) and the profession's Code of Professional Conduct. While other ASOPs apply, particular emphasis is placed on:
  - ASOP No. 8, *Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health Benefits*
  - ASOP No. 23, *Data Quality*
  - ASOP No. 41, *Actuarial Communications.*

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