

Qualified Health Plan Issuer Application Instructions

Plan Year 2025

June 2024

PY2025 QHP Instructions: Revisions

Changes made after initial document posting are listed by section.

Section	Change
2B: Interoperability	Updated screenshots 2B-5 and 2B-6 to reflect changes to UI text references to relevant CFR.

Terminology Guide

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

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

Abbreviation	Term
U.S.C.	<i>United States Code</i>
USP	United States Pharmacopeia

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Introduction: Qualified Health Plans for PY2025

As defined in the Affordable Care Act (ACA), a qualified health plan (QHP) is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits (EHBs), follows established limits on cost sharing, and meets several other requirements to display for consumers selecting insurance plans on [HealthCare.gov](https://www.healthcare.gov). This document is addressed to issuers who intend to submit a completed QHP Application for plan year (PY) 2025 certification.

Overview of the QHP Certification Process

Issuers must complete and submit a QHP Application that includes all plans they intend to offer on the Federally-facilitated Exchange (FFE) each year. During the annual application and certification process, issuers ensure the plans they submit comply with the ACA and all applicable regulations. The Centers for Medicare & Medicaid Services (CMS) recommends reading all applicable published guidance, including the following items that can be found on the [Center for Consumer Information and Insurance Oversight \(CCIIO\) website](https://www.cms.gov/CCIIO):

- The yearly *Letter to Issuers* provides guidance on offering QHPs, including stand-alone dental plans (SADPs), in the FFEs and in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs).
- The annual *Notice of Benefit and Payment Parameters (Payment Notice)* sets new standards to improve consumers' Exchange experience.
- The *Market Stabilization Final Rule of 2017*, the *ACA Exchange and Insurance Market Standards for 2015*, and *Beyond Final Rule of 2014* provide additional relevant guidance and regulations.
- The *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2025 Benefit Year* guidance sets payment parameters.

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

QHP Application Submission Process

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

In PY2025, the deadline for submitting the QHP Application Rates Table Template is later than the general QHP Application initial submission deadline. Issuers will submit a complete QHP Application—except for the Rates Table Template and on-Exchange marketing URLs (Summary of Benefits and Coverage [SBC], Plan Brochure, Payment, Network, Formulary)—by the initial submission deadline. Issuers may submit the Rates Table Template by the initial submission deadline, but no later than the secondary deadline. These deadlines can be found in the [PY2025 QHP Data Submission and Certification Timeline bulletin](https://www.cms.gov/CCIIO).

CMS relies on systems that automate the data collection and validation process. The systems issuers will use to submit their QHP Application materials depend on the Exchange model the issuer's state uses. Review the list of [Submission Systems](https://www.cms.gov/CCIIO) for information on which system an issuer should use to file their QHP Applications and supporting data.

If an issuer is applying for QHP certification in a state that does not perform plan management functions, they must submit their QHP Applications in the Health Insurance Oversight System (HIOS) Marketplace Plan Management System (MPMS) Module.

Some FFE states that do not perform plan management functions may choose to collect plan data, which could include copies of the QHP templates, in both HIOS and in the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF). If an issuer's state collects some plan data via

SERFF, the issuer must also submit their complete QHP Application in HIOS. CMS does not receive issuer plan data from SERFF for FFE states.

If an issuer's state performs plan management functions, they should submit QHP Applications in SERFF in accordance with state and CMS review deadlines. The state will transfer all QHP Application data as specified in state guidance.

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

SADP Issuers

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

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

Issuers should use HIOS or SERFF as applicable to their state to complete the relevant application sections and templates.

HIOS

Issuers must register in HIOS to obtain a HIOS Issuer Identifier (ID) and record issuer administrative contact information. Refer to the [HIOS Quick Reference Guide](#) and the [HIOS Portal User Manual](#) for more information on registering and navigating through the portal. Within HIOS there are several modules used to submit and review application data.

- The **Marketplace Plan Management System (MPMS) Module** is where FFE issuers submit plan benefit, rating, and business data to CMS. All QHP applicants, including issuers in states performing plan management functions and State-based Exchange on the Federal Platform (SBE-FP) states, access the Plan Validation Workspace in MPMS and submit URL and interoperability data to this module. MPMS comprises the following components:
 - **Home Page:** This is where issuers can access announcements pertaining to applications and metrics about any applications started.
 - **Plan Validation Workspace:** This is where issuers can upload QHP templates for validation and receive validation results at any time, including before submitting a QHP Application. Issuers in states performing plan management functions and SBE-FP states have access to the workspace to validate data before submitting a QHP Application in SERFF.
 - **QHP Applications:** This is where issuers can create new QHP Applications, update applications, submit applications to CMS for review, receive review results for several application areas, and make corrections as needed throughout the certification process.
 - **Application Tools:** This section consists of three pages.
 - **Application Materials:** This is where issuers may download application materials such as the prepopulated Plan ID Crosswalk Template.
 - **Issuer Details:** This is where issuers can update their Machine-Readable Index URLs.
 - **Plan Preview:** This is where issuers view PY2025 plan and issuer data as it will display in Plan Compare on [HealthCare.gov](#) if the issuer plans to offer QHPs or on-Exchange SADPs.

- **Plan Finder Module:** This is where issuers submit, review, and modify administrative data. Refer to the [HIOS Plan Finder – Issuer User Manual](#) for detailed instructions.
- **Unified Rate Review (URR) System Module:** This is where the URR is submitted for issuers in states without an Effective Rate Review Program and in states that do not have access to SERFF (currently OK, WY, and FL). Refer to the [Unified Rate Review System Module User Guide](#) for detailed instructions. A rate filing in SERFF automatically uploaded to the URR System Module of HIOS is considered as filed with CMS.

SERFF

If an issuer's state performs plan management functions or operates an SBE-FP, the QHP Application is submitted via SERFF and HIOS MPMS (see Section 1.1 [SERFF Issuers and MPMS] for additional detail on how SERFF issuers use MPMS). If an issuer's state has an Effective Rate Review Program, the rate filing (including the URR) is submitted via SERFF. Issuers should contact their state regulator for any additional application requirements. Questions related to SERFF functionality should be directed to the SERFF Help Desk at serffhelp@naic.org. For information about state systems, contact the relevant state.

Plan Management Community

Issuers use the Plan Management (PM) Community to review QHP Application data submitted to CMS and complete QHP certification–related activities, such as Final Issuer Plan Confirmation. The PM Community is also used to view the results of certain reviews.

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

QHP Application Sections, Associated Templates, and Supporting Documentation

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

Note: Not all QHP Application sections require the submission of supporting documentation or justifications. Table 1 lists the supporting documentation and justifications in each application section; it also includes a description of the files, the submission criteria that determine whether an issuer must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention issuers should use when naming the supporting documentation or justification.

Table 1. Required Materials

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

MPMS Group	Application Area	Required Materials
Plan Attributes	Plans & Benefits	◆ Plans & Benefits Template^a ◆ Plans & Benefits Add-In^a ◆ Plans & Benefits Add-In Change Log ◆ Standardized Plan Options Add-In ◆ Actuarial Value (AV) Calculator Screenshot ◆ Discrimination—Cost Sharing Outlier: Supporting Documentation and Justification ◆ EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification ◆ Unique Plan Design—Supporting Documentation and Justification ◆ Non-Standardized Plan Option Limit Exception Justification^b
	Prescription Drugs	◆ Prescription Drug Template ◆ Combined Prescription Drug Supporting Documentation and Justification ◆ Discrimination—Treatment Protocol Supporting Documentation and Justification ◆ Adverse Tiering Supporting Documentation and Justification
	Service Area	◆ Service Area Template^a ◆ Service Area Partial County Supplemental Response ◆ Evidence of state approval of the partial county (FFE issuers)
	Network ID	◆ Network ID Template ^a
	Essential Community Providers (ECPs)	◆ ECP data entered via MPMS user interface (UI) ^a
	Network Adequacy (NA)	◆ NA Template^a ◆ NA Justification Form (received and submitted via MPMS)^a
Plan Crosswalks	Plan ID Crosswalk	◆ Plan ID Crosswalk Template^c ◆ Plan ID Crosswalk Justification Form^b ◆ State Authorization documentation
Issuer Accreditation	Accreditation	◆ Responses to terms and conditions ◆ Quality Improvement Strategy (QIS) ◆ Accreditation Certificate
Transparency Data	Transparency in Coverage	◆ Transparency in Coverage Template ◆ Transparency in Coverage URL
Plan Rates	Rates Table	◆ Rates Table Template ^a
Issuer URLs	URL	◆ URLs for plan information ^a
HIOS Module	Application Area	Required Materials
Unified Rate Review Module	Unified Rate Review	◆ Unified Rate Review Template

^a Applicable to SADP issuers.

^b Collected via MPMS UI.

^c Applicable to returning issuers and new issuers receiving enrollees from a non-returning issuer.

Review Periods, Revision Process, and Certification

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

For the PY2025 QHP Application submission process, CMS will release review results to issuers in MPMS and the PM Community. These review results include required corrections that issuers need to make to their applications, a description of how to correct the errors, and the affected review area.

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

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

CMS certifies plans based on the information contained in the issuer application. After final submission, issuers must notify CMS and their state regulator if they intend to alter a QHP Application. CMS reserves the right to revisit the certification of any plan. CMS also reserves the right to decertify a plan during the plan year if it determines information in the relevant QHP Application is inaccurate, is incomplete, or does not meet certification standards or program requirements.

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

CMS certifies each plan’s compliance with QHP standards based on its review of the application and any information CMS receives from the applicable state regulator, including appropriate state approvals. Regardless of CMS determinations, issuers must comply with all applicable state and federal requirements.

New for PY2025

- There is a new Standardized Plan Option Limit Exclusion process. Issuers who submit more than two non-standardized plan options per product type, metal level, inclusion of dental or vision coverage, or service area combination will be required to submit a justification for each plan above the limit.
- Issuers will submit their ECP data via the MPMS UI rather than using a template. Issuers will be able to import the ECPs submitted in their PY2024 QHP application using their PY2024 ECP/NA Template (ECPs submitted through the PY2024 ECP Write-in Worksheet will not be imported) into their PY2025 QHP Application and can also export a file with the ECP details in the PY2025 QHP Application for offline review.
- Issuers will submit their NA data to MPMS using the NA Template. Issuers will be able to download a pre-populated NA Template from the Application Tools section of MPMS and will receive NA Justifications through MPMS rather than the PM Community.
- Issuers will submit their Plan ID Crosswalk data in MPMS rather than the PM Community. Returning issuers can download prepopulated Plan ID Crosswalk Templates from the Application Tools section of MPMS.
- The Master Review Tool has been renamed as the Data Consolidation Tool. The functionality and intended usage of the tool remain the same.

Review Tools

Review tools are provided to facilitate states’ review of issuer QHP Application data and help them identify errors that would require corrections. While all issuers may use the review tools, CMS requires that FFE issuers use the Plan Validation Workspace to validate their data and identify any errors that require correction before submission, as the Plan Validation Workspace performs additional validations that are not included in the public-

facing tools. For this reason, SERFF issuers are also required to use the Plan Validation Workspace before making their submission.

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

Using This Document

This document uses screenshots and written guidance to explain each step required to complete the PY2025 QHP Application. Hyperlinks throughout the document will direct issuers to external content that may be needed to complete the application.

Bolded text indicates items and information that are used, entered, or selected from a drop-down menu or via a button, such as the option **Yes** to indicate agreement with an attestation.

Italicized text indicates the names of fields into which information is entered, such as *HIOS Issuer ID*. *Italicized text* may also be used to indicate document titles, such as the *HHS Notice of Benefit and Payment Parameters for 2025*.

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

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

The remainder of this document will serve as step-by-step instructions for completing the PY2025 QHP Application, navigating through MPMS, and identifying specific policy and submission criteria for each section.

1. Using the Marketplace Plan Management System Module

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

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

After linking the validated templates to the corresponding application section, any necessary supporting documents can then be submitted. Once each section in a group is completed, that application group can be submitted to CMS for review.

Application sections will display one of the following statuses:

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

Each application grouping will display one of the following statuses:

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

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

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

1.1 SERFF Issuers and MPMS

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

- Use the Plan Validation Workspace
- Create a QHP Application
- Review and verify Administrative data
- Submit responses to Interoperability Questions, Interoperability URL, and Interoperability Justification, if necessary

- Submit Non-Standardized Plan Option (NSPO) Exception Justification
- Submit ECP data
- Submit NA data and retrieve and submit NA Justifications
- Submit Plan ID Crosswalk data
- Submit Transparency in Coverage URL
- Submit On-Exchange Marketing URLs.

SERFF issuers are required to use the Plan Validation Workspace in MPMS to validate templates before submitting them to SERFF. The Plan Validation Workspace will identify validation errors and allow the issuer to correct data before SERFF submission, perform cross validations on the data, and provide validation warnings regarding data issues that will not prevent submission, but that may need additional attention from issuers to resolve. While SERFF Validate & Transform has been enhanced for PY2025, it will identify only validation errors. Thus, issuers are required to use the Plan Validation Workspace to ensure receipt and review of their validation warnings.

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

Note that the successful transfer of data to HIOS from a SERFF state does not complete submission of the application to CMS. Once the state successfully completes a plan transfer, SERFF issuers must also cross validate and submit the applicable sections in MPMS to finish the application process.

2. Completing the QHP Application

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

Section 2A: Administrative

1. Introduction

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

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

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

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

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 QHP Application.

Tips for the Administrative Section

- ◆ Issuers will review the Administrative data within the Marketplace Plan Management System (MPMS) to determine if required fields are missing.
- ◆ Ensure the individual managing the issuer's Administrative data has the Submitter role in HIOS.
- ◆ Ensure the *Issuer Marketplace Information* fields in HIOS are completed (not the *Issuer General Information* fields).

Additional Resources

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

4. Detailed Section Instructions

Once in MPMS, navigate to the Administrative section in the QHP Application. The section will identify whether the issuer has missing fields and explain whether the missing fields are required (errors) or optional (warnings). Issuers must make any required corrections within HIOS Plan Finder. Changes made to the HIOS Plan Finder will refresh and be displayed in MPMS.

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

This concludes the Administrative section of the QHP Application Instructions.

Section 2B: Interoperability

1. Introduction

Per the Interoperability and Patient Access Final Rule published on May 1, 2020, applicable QHP issuers must comply with all provisions detailed in [45 Code of Federal Regulations \(CFR\) 156.221](#), which requires the implementation and maintenance of a patient access application programming interface (API) and related documentation by July 1, 2021.

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

- QHP
- See Appendix D for additional information.

These requirements only apply to issuers on the Federally-facilitated Exchanges (FEEs), including FEEs in states which conduct plan management activities. Issuers in State-based Exchanges on the Federal Platform, or that only offer stand-alone dental plans (SADPs), or plans in the Federally-facilitated Small Business Health Options Programs are not required to respond to these questions.

In the Interoperability section of MPMS, regulated issuers are required to provide responses to four questions related to the requirements detailed in the regulation. Each question relates to a specific component of the regulation (see Table 2B.1 for additional information). If an issuer answers “No” to any question, they must download and complete the Interoperability Justification Form to explain the root cause for non-compliance, the impact on enrollees, and plans to achieve compliance.

2. Data Requirements

To complete this section, the following are needed:

1. Information confirming issuer compliance with the requirements specified at 45 CFR 156.221(a) through (g) on which the issuer can base its answers to Questions 1–4.
2. A live URL that links to the required content specified at 45 CFR 156.221(d).
3. A live URL that links to the required content specified at 45 CFR 156.221(g).
4. Information about why the issuer is not compliant with the requirements specified at 45 CFR 156.221(a) through (g) if the issuer answers “No” to any of the Interoperability Questions.
5. [Interoperability Justification Form](#). Only required if the issuer responds “No” to any of the Interoperability Questions.

3. Quick Reference

Key Changes for 2025

- ◆ Revised Correction Codes for the Interoperability URLs related to the accessibility and required content specified at 45 CFR 156.221(d) and 45 CFR 156.221(g).
- ◆ Issuers can provide only one URL in response to Question 3.
- ◆ Issuers can provide only one URL in response to Question 4.
- ◆ Issuers must use the updated Interoperability Justification Form if answering “No” to any question.

Tips for the Interoperability Section

- ◆ Verify that URLs for Questions 3 and 4 are active and link to the required content.
- ◆ Ensure that the content available via the URL submitted for Question 3 meets the requirements of 45 CFR 156.221(d). The presence of keywords is not sufficient to meet the regulatory requirements.
- ◆ Ensure that the content available via the URL submitted for Question 4 meets the requirements of 45 CFR 156.221(g).
- ◆ Provide URLs that link directly to the required content for Question 3 and Question 4.
- ◆ Verify that any links within the URLs submitted for Questions 3 and 4 are active if the issuer relies on those links to meet regulatory requirements.
- ◆ Check that special effort, such as a sign-in or registration, is not required to access the content specified in Question 3 and Question 4.
- ◆ Submit the Interoperability Justification Form if answering “No” to any question.

Additional Resources

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

4. Detailed Section Instructions

Issuers are required to answer four “Yes” or “No” questions in the Interoperability section related to key provisions of the Interoperability and Patient Access Rule (45 CFR 156.221). Figures 2B-1 through 2B-4 show each question displayed in the Marketplace Plan Management System (MPMS).

Question 3 and Question 4 require the issuer to provide a URL that links to content specified at [45 CFR 156.221\(d\)](#) and [45 CFR 156.221\(g\)](#), respectively. CMS assesses both the accessibility and the content of the submitted URLs against the regulatory requirements. Therefore, it is critical that issuers ensure that each URL submitted is active, otherwise CMS will not be able to assess issuer compliance and a correction code will be assigned. Additionally, issuers must provide URLs that do not require special effort to access—issuers may not require a sign in, registration, username, or password to access the URLs. Issuers should also ensure that any links to required content within the submitted URLs remain functional.

Issuers that respond “No” to any question will be automatically directed to the Justification submission screen (see Figure 2B-5). Issuers directed to the Justification submission screen must download and complete the Interoperability Justification Form, to provide the following details required by [45 CFR 156.221\(h\)](#):

- The reasons why the issuer cannot reasonably satisfy all the 45 CFR 156.221 requirements for the upcoming plan year (the root cause).
- The impact of non-compliance upon issuer’s enrollees.
- The current or proposed means of providing the required 45 CFR 156.221 health information to issuer’s enrollees.
- Issuer’s solutions and a timeline to achieve compliance with all the 45 CFR 156.221 requirements.

Information about each question and the Justification Form is included in Table 2B-1, along with links to the detailed regulatory requirements and supporting information to help the issuer complete the Interoperability section.

Table 2B-1. Descriptions of Required Components and Supporting Information for Interoperability Submission

Interoperability Component	Supporting Information
Question 1: Has the issuer fully implemented a secure API that both:	• A secure API and its necessary features are detailed in 45 CFR 156.221(a) and 45 CFR 156.221 (c).

Interoperability Component	Supporting Information
- Allows all enrollees to access their claims and encounter information through a third-party application of the enrollee's choice, and - Meets the standards of Health Level 7 [HL7] Fast Healthcare Interoperability Resources [FHIR] Release 4.0.1?	Issuers are urged to refer to the "Best Practices for Payers and App Developers" document, which can be found in CMS' Interoperability Guidance. Issuers' use of this document is not required. The document provides valuable implementation and testing guidance for issuers building secure, standards-based APIs. The document is subject to change; issuers using the document should check regularly for any updates.
Question 2: Has the issuer ensured inclusion of all information detailed in 45 CFR 156.221 (b) in the content made accessible via the API?	Issuer's URL must include the following content: - Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are being appealed, and provider remittances and enrollee cost sharing pertaining to such claims, no later than 1 business day after a claim is processed. - Encounter data from capitated providers, no later than 1 business day after data concerning the encounter is received by the QHP issuer. - Clinical data, including laboratory results, if the QHP issuer maintains any such data, no later than 1 business day after data is received by the issuer.
Question 3: Has the issuer published on an easily accessible website and/or through publicly accessible hyperlink(s) information to support third party application use of the API, as detailed in 45 CFR 156.221(d)?	The issuer must demonstrate compliance by making, at minimum, the following information available on their website: - API syntax, function names, required and optional parameters and their data types, return variables and their types/structures, and exceptions and exception handling methods and their returns. - The software components and configurations an application must use to successfully interact with the API and process its responses. - All applicable technical requirements and attributes for an application to be registered with any authorization server deployed in conjunction with the API. Issuers can demonstrate compliance by linking directly to the required standards on an external website, for example ALL the following required API Interoperability Standards: USCDI, at 45 CFR 170.213 FHIR Release 4.0.1 HL7 FHIR US Core IG STU 3.1.1 HL7 SMART App Launch Framework IG 1.0.0 OpenID Connect Core 1.0. Issuers can also link directly to the recommended Implementation Guides (IGs), which include the following: CARIN for Blue Button IG Version STU 2.0.0 Da Vinci PDex IG Version STU 2.0.0 Da Vinci PDex U.S. Drug Formulary IG Version STU 2.0.1. If the issuer chooses to link directly to a required standard or IG to demonstrate compliance with the interoperability requirements, the issuer must ensure that link remains active and points to the required content. More information about the required standards and recommended IGs is available here.

Interoperability Component	Supporting Information
Question 4: Has the issuer published educational resources about health information privacy and security, including the information detailed in 45 CFR 156.221(g) , on a website easily accessible to enrollees?	Issuer's website's content must include educational resources about health information privacy and security, explaining at a minimum: 1. General information on steps the individual may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and 2. An overview of which types of organizations or individuals are and are not likely to be Health Insurance Portability and Accountability Act (HIPAA)–covered entities, the oversight responsibilities of the Office for Civil Rights and the Federal Trade Commission, and how to submit a complaint to the U.S. Department of Health and Human Services (HHS) Office for Civil Rights (OCR) and the Federal Trade Commission (FTC) as described in 45 CFR 156.221. Issuers are urged to refer to the “Best Practices for Payers and App Developers” document, which can be found in CMS’ Interoperability Guidance. Issuers’ use of this document is not required. The document provides valuable implementation and testing guidance for issuers building secure, standards-based APIs. The document is subject to change; issuers using the document should check regularly for any updates.
Interoperability Justification Form	Issuers that answered “No” to any of the four Interoperability Questions must download the Interoperability Justification Form, complete the form in its entirety and upload it through MPMS to satisfy the requirements of 45 CFR 156.221(h).

Figures 2B-1 through 2B-6 display the Interoperability Questions and Justification Form.

Figure 2B-1. Interoperability Question 1

Interoperability

Applicants must respond to all questions in order to complete an issuer application and participate in the FFE.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2025-09	2025	10333 - AK - Test Issuer	QHP & SADP	Individual & SHOP

[← Return to Application Overview](#)

Interoperability
Introduction

☒ Question 1

☐ Question 2

☐ Question 3

☐ Question 4

☐ Justification

1. Has the issuer fully implemented a secure API that both:

- Allows all enrollees to access their claims and encounter information through a third-party application of the enrollee's choice and
- Meets the standards of Health 7® [HL7] Fast Healthcare Interoperability Resources® [FHIR] Release 4.0.1?

☒ Yes

☐ No, I will submit the Justification Form at the end of this section

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[Save](#)

[Save and Next](#)

Figure 2B-2. Interoperability Question 2

Interoperability

Applicants must respond to all questions in order to complete an issuer application and participate in the FFE.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2025-09	2025	10333 - AK - Test Issuer	QHP & SADP	Individual & SHOP

[Return to Application Overview](#)

Interoperability
Introduction

☒ Question 1

☒ **Question 2**

☐ Question 3

☐ Question 4

☐ Justification

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

☒ Yes

☐ No, I will submit the Justification Form at the end of this section

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[Save and Next](#)

Figure 2B-3. Interoperability Question 3

Interoperability

Applicants must respond to all questions in order to complete an issuer application and participate in the FFE.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2025-09	2025	10333 - AK - Test Issuer	QHP & SADP	Individual & SHOP

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Interoperability
Introduction

☒ Question 1

☒ Question 2

☒ **Question 3**

☐ Question 4

☐ Justification

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

☒ Yes

☐ No, I will submit the Justification Form at the end of this section

You must provide an active URL (that is, a live, functioning link) that directly links to the required information without preconditions or additional steps.

Active URL

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[Save](#)

[Save and Next](#)

Figure 2B-4. Interoperability Question 4

Interoperability

Applicants must respond to all questions in order to complete an issuer application and participate in the FFE.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333AK-2025-09	2025	10333 - AK - Test Issuer	QHP & SADP	Individual & SHOP

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Interoperability Introduction

Question 1

Question 2

Question 3

Question 4

Justification

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

☒ Yes

☐ No, I will submit the Justification Form at the end of this section

You must provide an active URL (that is, a live, functioning link) that directly links to the required information without preconditions or additional steps.

Active URL

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Figure 2B-5. Interoperability Justification Form Submission

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Interoperability Introduction

Question 1

Question 2

Question 3

Question 4

Justification

Interoperability Justification Form Required

Per the Interoperability and Patient Access Final Rule published on May 1, 2020, applicable QHP issuers must comply with all provisions detailed in 45 Code of Federal Regulations (CFR) [156.221](#), which requires the implementation and maintenance of a patient access application programming interface (API) and related documentation by July 1, 2021.

QHP issuers that answered "No" to any of the four Interoperability Questions must complete the [Interoperability Justification form](#) in its entirety as required by [45 CFR 156.221 h\(1\)](#). Please refer to the Qualified Health Plan Issuer Instructions, Section 2B: Interoperability, for detailed instructions about how to access, complete and submit the form. The Interoperability Justification Form asks the issuer to answer the following questions:

1. The reasons why the Issuer cannot reasonably satisfy all the 45 CFR 156.221 requirements for the upcoming plan year (the root cause).
2. The impact of non-compliance upon issuer's enrollees.
3. The current or proposed means of providing the required 45 CFR 156.221 health information to issuer's enrollees.
4. Issuer's solutions and a timeline to achieve compliance with all the 45 CFR 156.221 requirements.

Justification Documents

Document Type	File Name	Uploaded By	Action
Interoperability Justification	—	—	Upload

Issuers can download the Interoperability Justification Form (Figure 2B-6) from the [Interoperability page](#) of the QHP certification website.

Figure 2B-6. Interoperability Justification Form

Interoperability Justification

Issuers must fill in the following information.

Issuer Name:

HIOS ID:

Instructions: Per the Interoperability and Patient Access Final Rule published on May 1, 2020, applicable QHP issuers must comply with all provisions detailed in 45 *Code of Federal Regulations* (CFR) 156.221, which require the implementation and maintenance of a patient access application programming interface (API) and related documentation by July 1, 2021.

This form is not required for QHP issuers:

- Meeting the requirements above, by having answered "Yes" to all four Interoperability Questions in the Marketplace Plan Management System (MPMS).
- In State-based Exchanges on the Federal Platform.
- Offering only Stand-Alone Dental Plans.
- Only offering plans in the Federally-facilitated Small Business Health Options Program.

QHP issuers that answered "No" to any of the four Interoperability Questions in MPMS must complete the Interoperability Justification form in its entirety as required by 45 CFR 156.221 h(1) and upload it through MPMS. Please refer to the Qualified Health Plan Issuer Instructions, Section 2B: Interoperability, for detailed instructions about how to upload the form.

1. The reasons why the Issuer cannot reasonably satisfy all the 45 CFR 156.221 requirements for the upcoming plan year (the root cause).

2. The impact of non-compliance upon issuer's enrollees.



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2025 QHP Application Instructions

3. The current or proposed means of providing the required 45 CFR 156.221 health information to issuer's enrollees.

4. Issuer's solutions and a timeline to achieve compliance with all the 45 CFR 156.221 requirements.



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2025 QHP Application Instructions

This concludes the Interoperability section of the QHP Application Instructions.

Section 2C: Program Attestations

1. Introduction

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

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

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

- QHP
- SADP

See Appendix D for additional information.

Issuers must respond to all attestations and save the section before being able to submit the group.

If the issuer is in a state that performs plan management functions, complete the [State Partnership Exchange Issuer Program Attestation Response Form](#) and submit it via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF).

Figure 2C-1. Program Attestations Application Section

Program Attestations

Applicants must agree to all attestations in order to complete an issuer application and participate in the FFE.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10055TX-2025-09	2025	10055 - TX - Union Security Insurance Company	QHP & SADP	Individual & SHOP

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Program Attestations Introduction

☒ QHP & SADP Attestation

☐ QHP Attestation

☐ SADP Attestation

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

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

☐ I agree the issuer will comply with the above statement.

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Save and Next

2. Data Requirements

To complete this section, the following is needed:

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

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 QHP Application.

Tips for the Program Attestations Section

- ◆ For HIOS submitting issuers, only those attestations that are applicable for the submitted plan types will be displayed (e.g., if only medical QHPs are offered for certification, only those attestations relevant for medical QHPs will be displayed).
- ◆ “Dual Issuer” refers to an issuer that offers both a medical QHP and a SADP under the same HIOS Issuer ID.
- ◆ The issuer must respond to all attestations.
- ◆ For HIOS submitting issuers, the issuer must agree with each attestation displayed.
- ◆ For issuers in states performing plan management functions:
 - Use the *State Partnership Exchange Issuer Program Attestation Response Form*.
 - If the issuer only offers medical QHPs for certification, respond **Not Applicable** to the attestations required in the SADP-only issuers subsection.
 - If the issuer only offers SADPs for certification, respond **Not Applicable** to the attestations required in the medical QHP-only issuers subsection.

Additional Resources

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

4. Detailed Section Instructions

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

Attestation Area	Steps
Attestations required of both medical QHP and SADP issuers	All issuers must agree with this attestation to offer certified medical QHPs or SADPs: ◆ All HIOS submitting issuers must check the box agreeing to comply. ◆ All issuers in states performing plan management functions must respond Yes.
Attestations required of medical QHP issuers only	Issuers applying for certification of medical QHPs must agree with this attestation to offer certified medical QHPs: ◆ HIOS submitting issuers offering medical QHPs must check the box agreeing to comply. ◆ Issuers in states performing plan management functions offering medical QHPs must respond Yes. If the issuer is not applying to offer medical QHPs, select Not Applicable.
Attestations required of SADP issuers only	Issuers applying for certification of SADPs must agree with these attestations to offer certified SADPs: ◆ HIOS submitting issuers offering SADPs must check the boxes agreeing to comply. ◆ Issuers in states performing plan management functions offering SADPs must respond Yes to each attestation. If the issuer is not applying to offer SADPs, select Not Applicable.

The specific attestations are shown below.

Attestation Area	Attestation
Attestations required of both medical QHP and SADP issuers	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 <i>Code of Federal Regulations</i> (CFR) Parts 153, 155, and 156.

Attestation Area	Attestation
Attestations required of medical QHP issuers only	Applicant agrees to adhere to all applicable requirements in 45 CFR Parts 146, 147, 155, and 156.
Attestations required of SADP issuers only	Applicant agrees to adhere to all of the certification standards and operational requirements applicable to applicant in 45 CFR Parts 155 and 156.

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

Section 2D: Business Rules

1. Introduction

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

2. Data Requirements

To complete this section, the following are needed:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 QHP Application.

Tips for the Business Rules Section

- ◆ Enter values for *HIOS Issuer ID* and *Medical, Dental, or Both?* before entering data for the rest of the template. All other fields are locked until you respond to *Medical, Dental, or Both?*
- ◆ All rules associated with Individual Market and Small Business Health Options Program (SHOP) Market plans must be entered in a single Business Rules Template.
- ◆ The first row of rules (row 10) is the base set of issuer business rules. Leave the product ID and plan ID fields blank in this row, but enter data for all subsequent columns. This row applies to all products and plans associated with the HIOS Issuer ID, including individual, SHOP, qualified health plan (QHP), and stand-alone dental plan (SADP) products and plans. Define how product or plan rules differ from the base set of issuer business rules in the subsequent rows, as applicable.
- ◆ **The template requires a data entry of Age on effective date for the field *How is age determined for rating and eligibility purposes?* for all Medical and Dental business rules. The template will auto-populate this value for the issuer-level business rule, and any product or plan-level rule.**

Additional Resources

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

4. Detailed Section Instructions

Note for issuers submitting via the System for Electronic Rates & Forms Filing (SERFF): Issuers must include all rating business rules associated with all plan IDs for QHPs, on-Exchange SADPs, off-Exchange SADPs, Individual Market plans, and SHOP Market plans that are being submitted for QHP certification in one Business Rules Template and submit that template in all SERFF binders. If more than one template is submitted through multiple different SERFF binders, each with different business rules, only the last template that the issuer's state transfers from SERFF to HIOS will be retained; business rules data from all other binders within the same SERFF transmission will be overwritten. CMS requires submission of one single identical Business Rules Template in all binders to avoid data overwrite issues.

Dual-product issuers submitting the Business Rules Template via multiple SERFF binders should set *Medical, Dental, or Both?* to **Both** in all submitted Business Rules Templates. Do not enter **Medical** for this field in one template version and **Dental** for this field in another template version.

Complete the Business Rules Template using the steps outlined below. This template cannot be validated until all required fields are completed.

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

- QHP
- SADP

See Appendix D for additional information.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Medical, Dental, or Both?	Select one of the following from the drop-down menu: ◆ Medical—if entering rating business rules for medical plans only. ◆ Dental—if entering rating business rules for dental plans only. ◆ Both—if entering rating business rules for medical and dental plans within the template. A value for this field must be entered before proceeding. All other fields are locked until a response is provided to <i>Medical, Dental, or Both?</i>
Product ID	For products with rules that differ from those entered in row 10, enter the 10-character (e.g., 12345AZ123) HIOS-generated product ID that identifies the product that will be associated with the rules defined in that row. ◆ If a product ID is entered, the rules defined in that row will be applied to all plans associated with that product ID. All other products will use the rules associated with either the HIOS Issuer ID in row 10 or a different product ID rule. ◆ If a product ID is <u>not</u> entered, the rules associated with the HIOS Issuer ID in row 10 will be used.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (e.g., 12345AZ1234567) that identifies the plan that will be associated with the rules in that row. ◆ If a plan ID is entered, the rules defined in that row will be applied to that plan ID only. All other products and plans will use the rules associated with the HIOS Issuer ID rule, product ID rule, or a different plan ID rule. ◆ If a plan ID is <u>not</u> entered, the rules for the product ID associated with that plan ID will be used. If a product ID rule is also not entered, the rules associated with the HIOS Issuer ID in row 10 will be used.
Medical or Dental Rule?	Select whether the business rule in the template row applies to medical or dental plans. The drop-down options are: ◆ Medical ◆ Dental. The allowed value for this field depends on the response to <i>Medical, Dental, or Both?</i>: ◆ If Medical is entered, the issuer-level row (row 10) for <i>Medical or Dental Rule?</i> defaults to Medical. Only a value of Medical may be entered for any subsequent rule. ◆ If Dental is entered, the issuer-level row for <i>Medical or Dental Rule?</i> defaults to Dental. Only a value of Dental may be entered for any subsequent rule. ◆ If Both is entered, the issuer-level row for <i>Medical or Dental Rule?</i> defaults to Medical. Either Medical or Dental may be entered for any subsequent rule and there must be at least one medical rule and one dental rule within the template.
What is the maximum number of rated underage dependents on this policy?	Select the maximum number of rated underage dependents from the drop-down menu. A rated underage dependent is defined as age 0–20. A QHP cannot rate more than the three oldest covered children when determining the total family premium.¹ This rule does not apply to SADPs, who have the option to enter a value of “Not Applicable.” If a response of Medical is provided for <i>Medical or Dental Rule</i>, the following are allowed: ◆ 1 ◆ 2 ◆ 3. If a response of Dental is provided for <i>Medical or Dental Rule</i>, the following are allowed: ◆ 1 ◆ 2

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

Business Rules Template	Steps
	◆ 3 ◆ Not Applicable. Note: Not Applicable means that a dental plan associated with the business rule has no maximum number of rated underage dependents on a policy. This option is not available to medical plans.
Is there a maximum age for a dependent?	Set the maximum age for a dependent for purposes of eligibility at policy issuance or renewal. The maximum age for a dependent applies only to the dependent relationships of Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter. Choose from the following: ◆ Yes—if selected, a pop-up will allow the user to enter the maximum age for a dependent. QHP issuers must enter a minimum value of 25 for a medical business rule. SADP issuers must enter a minimum value of 18 for a dental business rule. ◆ Note: The age entered is inclusive <u>through</u> that age. For example, entering a value of 25 means the issuer is offering to provide coverage through age 25, up to age 26. ◆ Not Applicable—if selected, then there is no maximum age and the dependent is allowed to enroll regardless of age as long as he or she meets the other eligibility rules. ◆ Market rules require QHP issuers that cover child dependents to make such coverage available for children until they attain age 26.² Note: Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 18.
How is age determined for rating and eligibility purposes?	◆ Upon entry of the issuer-level rule and any product or plan-level rule, the template will auto-populate the following value, which defines the method for calculating an enrollee's age for rating and eligibility purposes. ◆ Age on effective date—return the rate based on the consumer's age on the effective date. This option must be selected for all Medical and Dental business rules. ▪ The template prevents selection of the following discontinued options: Age on January 1 of the effective date year, Age on insurance date (age on birthday nearest the effective date), or Age on January 1 or July 1. Note: Market rules require QHPs to select Age on effective date.³ SADPs are also required to select Age on effective date.⁴
How is tobacco status returned for subscribers and dependents?	Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following: ◆ Applicable [x] months—if selected, a pop-up will ask for the number of months used to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than 6 months.⁵ SADP issuers are not subject to the look-back period. Rates will be tobacco or non-tobacco depending only on whether an enrollee indicates that he or she was an active tobacco user within the last [x] months (tobacco rate) or not an active tobacco user within the last [x] months (non-tobacco rate). In addition, if the enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used. ◆ Not Applicable—if selected, tobacco and non-tobacco rates are not separate. If rates are calculated by adding up individual rates, the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and non-tobacco rates for individuals who qualify for the non-tobacco rate. For states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, tobacco rates are not applicable.

² 45 CFR 147.120.

³ 45 CFR 147.102(a)(1)(iii).

⁴ Final HHS Notice of Benefit and Payment Parameters for 2024

⁵ 45 CFR 147.102(a)(1)(iv).

Business Rules Template	Steps
What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	◆ Select the relationships that are allowable when returning rates and if the dependent must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of the primary subscriber or dependent. Choose from the following: ▪ Self (selected by default) ▪ Spouse ▪ Child ▪ Stepson or Stepdaughter ▪ Grandson or Granddaughter ▪ Brother or Sister ▪ Life Partner ▪ Nephew or Niece ▪ Collateral Dependent ▪ Ex-Spouse ▪ Foster Child ▪ Ward ▪ Sponsored Dependent ▪ Other Relationship ▪ Other Relative. ◆ For each relationship selected, indicate Yes or No whether the dependent is required to live in the same household as the primary subscriber: ▪ Yes—the dependent must live in the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ▪ No—the dependent may live in or outside the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ▪ Market rules require the entry of No for the household residency requirement for child dependents for QHP products and plans that cover child relationships. This rule applies to Child, Foster Child, and Stepson or Stepdaughter relationships. ◆ Select Life Partner to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Relationships are not differentiated by sex. If a plan covers spouses and life partners, same-sex and opposite-sex spouses and life partners are covered.

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

Figure 2D-1. Sample Business Rules Template

2025 Business Rules Template v14.0

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

Enter the Issuer Rule on the first row (no Product ID or Plan ID).

For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.

For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule.

Issuer level rule will apply only to plan type indicated in cell C10.

Product ID	Plan ID (Standard Component)	Medical or Dental Rule?*	What is the maximum number of rated underage dependents on this policy?	Is there a maximum age for a dependent?	How is age determined for rating and eligibility purposes?	How is tobacco status determined for subscribers and dependents?	What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
		Medical	3	25	Age on effective date	6	Self, Yes; Spouse, Yes; Child, No; Stepson or Stepdaughter, No; Grandson or Granddaughter, No; Brother or Sister, Yes; Life Partner, Yes; Nephew or Niece, Yes
12345VA001		Dental	Not Applicable	18	Age on effective date	Not Applicable	Self, Yes; Spouse, Yes; Child, Yes; Stepson or Stepdaughter, Yes; Grandson or Granddaughter, Yes; Brother or Sister, Yes; Life Partner, Yes; Nephew or Niece, Yes

After you enter all data, click **Save** to ensure no data are lost. Once the Business Rules Template is completed, it must be validated, finalized, and uploaded into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the template to create the .XML file of the template that will need to 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.

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

Section 2E: Plans & Benefits

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.

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

- QHP
- SADP

See Appendix D for additional information.

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 PY2025 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)
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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)	SM (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

2025 Plans & Benefits Template v14.0	
HIOS Issuer ID*	
Issuer State*	
Market Coverage*	
Dental Only Plan*	

General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which 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 <i>Benefits Package</i> tab must match the Market Coverage for that plan stored in HIOS.
Dental-Only Plan*	Indicate whether the plans contained in the template are dental-only plans. Choose from the following: ◆ 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 <u>not</u> a dental-only package.

4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data for each plan, including its plan ID and the network, service area, and formulary (QHPs only) it uses (Figure 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

2025 Plans & Benefits Template v14.0		
HIOS Issuer ID*		To use this template, please review the user guide and in
Issuer State*		You will need to save the latest version of the add-in file (
Market Coverage*		To create the cost share variance worksheet and enter th
Dental Only Plan*		To create additional Benefits Package worksheets, use th
		To populate the benefits on the Benefits Package worksh
Plan Identifiers		
HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID* Network ID* Service Area ID* Formulary ID*

Plan Identifiers	Steps
HIOS Plan ID (Standard Component)*#	Enter the 14-character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name**	Enter the plan marketing name at the standard plan level. Note: Issuers that want to add cost sharing and other benefit information to a plan marketing name can do so at the 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						
Unique Plan Design?*	QHP/Non-QHP*	Notice Required for Pregnancy*	Plan Level Exclusions	Limited Cost Sharing Plan Variation - Est Advanced Payment	Does this plan offer Composite Rating?*	Child-Only Offering*

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following: ◆ 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 <u>not</u> 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 <u>the same</u> 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 <i>Benefits Package</i> 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 <i>Level of Coverage</i> field. Selecting High or Low will allow the template to validate for PY2024. The selection will not display to issuers in Plan Preview or to consumers in Plan Compare, as described in 45 CFR 156.140: ◆ 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 <u>not</u> 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 <u>not</u> required before pregnancy benefits are covered.
Plan Level Exclusions*	Enter any plan-level exclusions.
Limited Cost Sharing Plan Variation—Est. Advance Payment	Leave this field blank. This data element is not required for PY2025. As specified in the <i>2015 HHS Notice of Benefit and Payment Parameters</i> , beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost sharing plan variations.
Does this plan offer Composite Rating?	Select No for this field. This field is not applicable for 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 <u>not</u> allow child-only enrollment. Children may enroll for this plan, but an adult must be the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Do not select this option for SADPs, which must be available to child-only subscribers. ◆ Allows Child-Only—if the plan is a child-only plan that allows only child subscribers. Do not select this option for catastrophic plans.
Child-Only Plan ID	Required if Allows Adult-Only is entered in <i>Child-Only Offering</i>. Enter the 14-character plan ID for the corresponding child-only plan if this plan does <u>not</u> allow child-only enrollment. The entered plan ID must correspond to a plan in which the <i>Child-Only Offering</i> is Allows Adult and Child-Only or Allows Child-Only and must have the same selection for <i>Level of Coverage</i> as the allows adult-only plan for which you are entering data.
Tobacco Wellness Program Offered	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 <u>not</u> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter No if either of the following applies: ▪ 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 <i>EHB Percent of Total Premium</i> field should be the multiplicative inverse of the URRT <i>Benefits in Addition to EHB</i> field when rounded to the fourth decimal point (e.g., 1 divided by <i>Benefits in Addition to EHB</i>). As part of the data integrity review, CMS will identify any mismatch between EHB percent of total premium and the multiplicative inverse of <i>Benefits in Addition to EHB</i> for a non-catastrophic Individual Market QHP and prompt the issuer to confirm that the submitted values for <i>EHB Percent of Total Premium</i> from the Plans & Benefits Template and <i>Benefits in Addition to EHB</i> from the URRT are correct.

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 <u>should not</u> be factored into the calculation for the <i>EHB Percent of Total Premium</i> field on the Plans & Benefits Template and the cost of the state-required benefit <u>should not</u> be factored into the total premium from which the EHB percent of premium is calculated. ▪ Indicate in the <i>Benefits Information</i> field on the Plans & Benefits Template that the QHP covers the state-required benefit in question as a non-EHB. To add a benefit not already listed on the Plans & Benefits Template, click the Add Benefit button on the menu bar under the Plans and Benefits ribbon. Select Not EHB as the <i>EHB Variance Reason</i>. ▪ 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 <u>should not</u> be included in the <i>EHB Percent of Total Premium</i> field on the Plans & Benefits Template. However, the cost of the state-required benefit <u>should</u> 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 <i>Benefits Information</i> field on the Plans & Benefits Template that the QHP covers the state-required benefit in question as a non-EHB. ▪ To add a benefit not already listed on the Plans & Benefits Template, QHP issuers can click the Add Benefit button on the menu bar under the Plans and Benefits ribbon. QHP issuers should mark the benefit as Not EHB as the <i>EHB Variance Reason</i>. 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 (<u>not</u> offered in the FFE or in an SBE), the percentage of the premium associated with abortion services for which public funding is prohibited may be included in the EHB percentage.

¹ 45 CFR 156.115(d).

² 45 CFR 155.170.

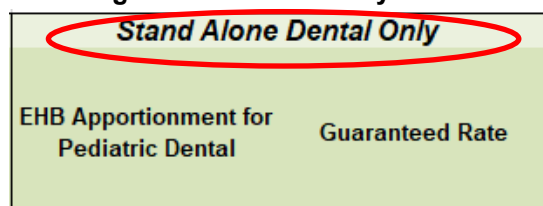
³ 45 CFR 156.280(d).

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 <i>Benefits Package</i> 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

The diagram shows a green rectangular box with a red oval around the top. Inside the box, the text "Plan Dates" is centered at the top. Below it, there are two fields: "Plan Effective Date*" on the left and "Plan Expiration Date" on the right.

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

The diagram shows a green rectangular box with a red oval around the top. Inside the box, the text "Geographic Coverage" is centered at the top. Below it, there are five fields: "Out of Country Coverage*" on the left, "Out of Country Coverage Description" in the middle-left, "Out of Service Area Coverage*" in the middle-right, "Out of Service Area Coverage Description" on the right, and "National Network*" on the far right.

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 <u>not</u> cover care obtained out of the country.
Out of Country Coverage Description*	If Yes is selected for the <i>Out of Country Coverage</i> 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 <u>not</u> cover care obtained outside the plan service area.
Out of Service Area Coverage Description*	If Yes for the <i>Out of Service Area Coverage</i> 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 <u>not</u> 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		Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
Benefits	EHB			
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.

- ## 4.8 General Information

Figure 2E-9. General Information Fields

[illegible]

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 <i>EHB Variance Reason</i> 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 <i>EHB Variance Reason</i> field). If a benefit is marked as Not Covered, it does not appear on the Cost Share Variances worksheet and the remaining fields for this benefit may be left blank. Choose from the following: ◆ 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 <u>not</u> covered by the plan. A benefit is considered not covered if the consumer is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service?*	Complete this field if Covered is selected in the <i>Is this Benefit Covered?</i> 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 <u>not</u> 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 <i>Quantitative Limit on Service?</i>, 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 <i>Quantitative Limit on Service?</i>, 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 <i>Limit Unit</i> field but will auto-populate in the <i>Benefit Explanation</i> 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

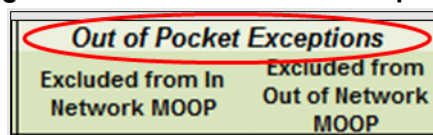
General Information	Steps
	therapy, and occupational therapy for rehabilitative services” will only appear in the <i>Benefit Explanation</i> field. Multiple limit units will not auto-populate. To implement multiple limits, complete the <i>Limit Quantity</i> and <i>Limit Unit</i> fields with the information that should be displayed on the Plan Compare function of the FFE website, then put all other quantitative limits in the <i>Benefit Explanation</i> field. For example, to enter the benefit “Outpatient Rehabilitative Services—90 days per year; two treatments per year,” you should enter 90 in the Limit Quantity field, Days per year in the <i>Limit Unit</i> field, and Two treatments per year in the <i>Benefit Explanation</i> field. The message “Quantitative limit units apply, see EHB benchmark” may appear in the <i>Benefit Explanation</i> field for benefits that do not have quantitative limits in the Benefits and Limits section of the Information on EHB Benchmark Plans page on the 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 <u>not</u> 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 <i>Is this Benefit Covered?</i>, <i>Limit Units</i>, or <i>Limit Quantity</i> 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 <u>not</u> an EHB. ▪ If a new benefit not found in the state’s benchmark is added, the <i>EHB</i> field will be blank and the EHB variance reason should be set to Not EHB. This benefit is <u>not</u> considered an EHB. ▪ If a benefit auto-populated as Yes in the <i>EHB</i> column, but 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 <u>not</u> considered an EHB. ◆ Substituted—if a benefit is included in the issuer state’s EHB benchmark, the <i>EHB</i> field auto-populates as Yes. If a different benefit is substituted for an EHB, set the <i>EHB Variance Reason</i> to Substituted and <i>Is this Benefit Covered?</i> 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 <i>EHB</i> 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 <i>Is this Benefit Covered?</i> to Covered and set the variance reason to Other Law/Regulation. (State-required benefits that were enacted after December 31, 2011, are <u>not</u> EHBs. Use Not EHB as the variance reason for such benefits.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan, and the state requires coverage only in the Individual Market. ◆ Additional EHB Benefit—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list, change the benefit to Covered, and choose Additional EHB Benefit as the EHB variance reason. For example, covered non-preferred brand drug benefits may not appear to be covered in the auto-populated table. This benefit is considered an EHB, and cost sharing values for the plan variations should be entered accordingly. ◆ Dental Only Plan Available—if a dental benefit auto-populates as Covered, but 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

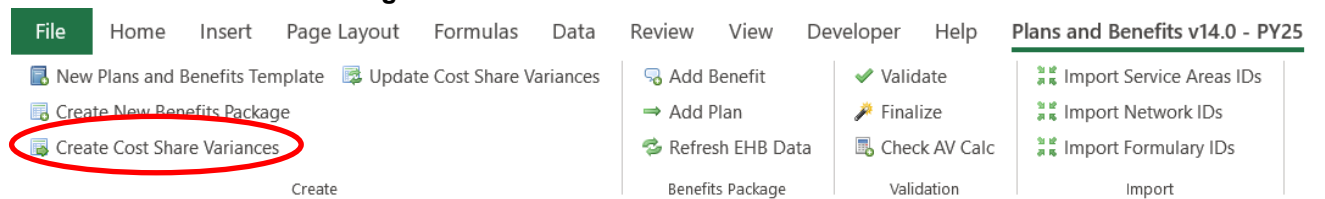


Out of Pocket Exceptions	Steps
Excluded from In Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits that are not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following: ◆ Yes—if this benefit is excluded from the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

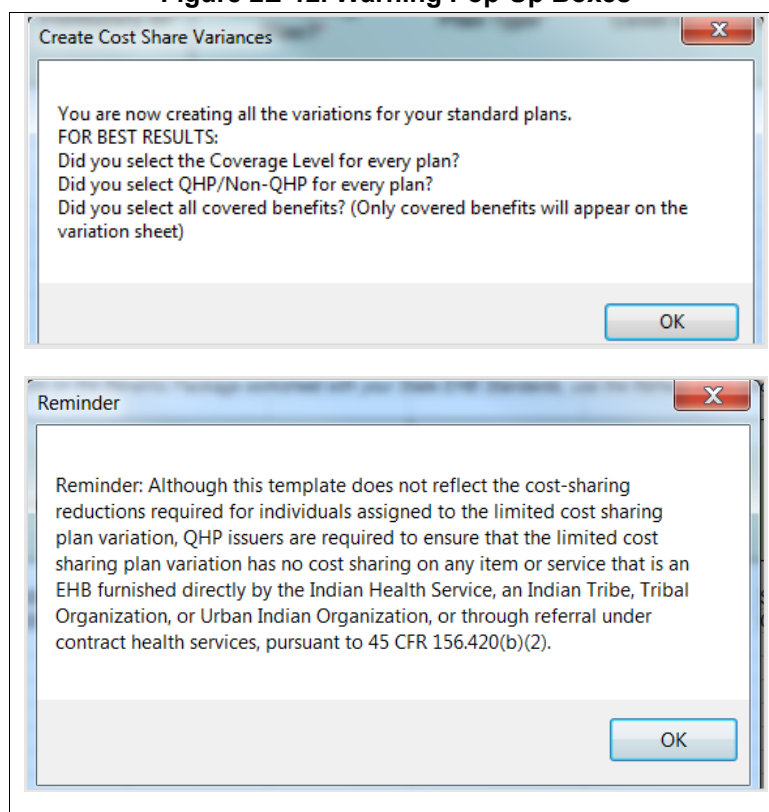
After the above benefit-related information is entered in the Benefits Package worksheet, click **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon (Figure 2E-11). The Cost Share Variances worksheet collects detailed cost sharing benefit design information for all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

Figure 2E-11. Create Cost Share Variances Button



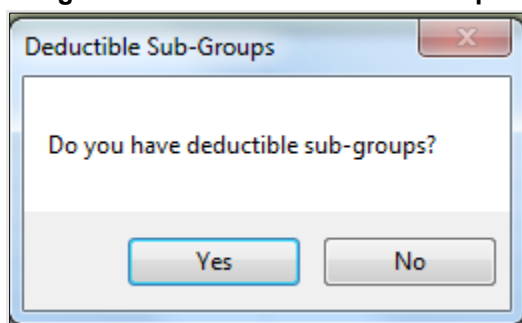
Click **OK** after reading the warnings (Figure 2E-12) and make any necessary changes.

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 <i>Benefit Explanations</i> 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 <i>Unique Plan Design</i> in the Benefits Package worksheet, enter the AV. This applies to health plans that indicate they are a unique plan for AV purposes. 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 <u>not</u> 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 <u>not</u> integrated. If No is entered, issuers should not enter information in the Maximum Out of Pocket for EHB and Drug Benefits (Total) section (4.15).
Is a Referral Required for a Specialist?	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 <u>not</u> required to see a specialist.
Specialist(s) Requiring a Referral#	Enter the types of specialists that require a referral if Yes is entered for <i>Is a Referral Required for a Specialist?</i>

Plan Cost Sharing Attributes	Steps
Multiple In Network Tiers?^*	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 <i>In Network</i> and <i>In Network (Tier 1)</i> sections and Tier 2 information in the <i>In Network (Tier 2)</i> sections. ◆ No—if there are <u>not</u> multiple in-network provider tiers. If this response is selected, information in the <i>In Network (Tier 2)</i> sections cannot be entered will be grayed out and locked.
1st Tier Utilization^*	If responding Yes to <i>Multiple In Network Tiers?</i>, enter the 1st Tier Utilization as a percentage. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. The field auto-populates to 100% if responding No to <i>Multiple In Network Tiers?</i> (All plan variations must match the standard plan 1st Tier Utilization.)
2nd Tier Utilization^*	If responding Yes to <i>Multiple In Network Tiers?</i>, enter the 2nd Tier Utilization as a percentage here. This cell will be grayed out and locked if responding No to <i>Multiple In Network Tiers?</i> (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

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

Use this section to input MOOP values for medical EHBs only if 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .
In Network—Family ^{^#}	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .
In Network (Tier 2)—Individual [^]	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Maximum Out of Pocket for Medical EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Maximum Out of Pocket for Medical EHB Benefits</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the MOOPs are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .
Out of Network—Family	If the MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for <i>Out of Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are <u>not</u> integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Maximum Out of Pocket for Medical EHB Benefits</i> .

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 <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Maximum Out of Pocket for Medical EHB Benefits</i> .

4.14 Maximum Out of Pocket for Drug EHB Benefits

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

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

Use this section to input MOOP values for medical and drug EHBs only if 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 <i>Total In Network Individual Maximum Out of Pocket</i> .
In Network—Family [#]	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total In Network Family Maximum Out of Pocket</i> .

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 <i>Total In Network (Tier 2) Individual Maximum Out of Pocket</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for the <i>Total In Network (Tier 2) Family Maximum Out of Pocket</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the MOOPs are integrated, enter the dollar amount for the <i>Total Out of Network Individual Maximum Out of Pocket</i> .
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total Out of Network Family Maximum Out of Pocket</i> .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are integrated, enter the dollar amount for the <i>Total Combined In/Out of Network Individual Maximum Out of Pocket</i> .
Combined In/Out Network—Family [#]	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the <i>Total Combined In/Out of Network Family Maximum Out of Pocket</i> .

4.16 Medical EHB Deductible

Use this section to input deductible values for medical EHBs only if 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 <u>not</u> integrated, enter the dollar amount for <i>In Network Individual Medical EHB Deductible</i> .
In Network—Family [#]	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Medical EHB Deductible</i> .
In Network—Default Coinsurance [^]	If the deductibles are <u>not</u> integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are <u>not</u> integrated, this field must be completed for the AV calculation if your plan uses the AVC.
In Network (Tier 2)—Individual [^]	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for <i>In Network (Tier 2) Individual Medical EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the deductibles are <u>not</u> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Medical EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Default Coinsurance [^]	If the deductibles are <u>not</u> integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Out of Network Individual Medical Deductible</i> .
Out of Network—Family	If the deductibles are <u>not</u> integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Medical EHB Deductible</i> .
Combined In/Out Network—Individual ^{^#}	If the deductibles are <u>not</u> integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Medical EHB Deductible</i> .

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

4.17 Drug EHB Deductible

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

4.18 Combined Medical and Drug EHB Deductible

Use this section to input deductible values for medical and drug EHBs only if the medical and drug deductibles are integrated (i.e., 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 <i>In Network Individual Combined Medical and Drug EHB Deductible</i> .
In Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>In Network Family Combined Medical and Drug EHB Deductible</i> .
In Network—Default Coinsurance [^]	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are integrated, 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 <i>In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Family	If the deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family Combined Medical and Drug EHB Deductible</i> . If there are not multiple in-network tiers, this field will be grayed out and locked.
In Network (Tier 2)—Default Coinsurance [^]	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked.
Out of Network—Individual	If the deductibles are integrated, enter the dollar amount for <i>Out of Network Individual Combined Medical and Drug EHB Deductible</i> .
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>Out of Network Family Combined Medical and Drug EHB Deductible</i> .
Combined In/Out Network—Individual ^{^#}	If the deductibles are integrated, enter the dollar amount for <i>Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible</i> .
Combined In/Out Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amounts for <i>Combined In/Out of Network Family Combined Medical and Drug EHB Deductible</i> .

4.19 Maximum Out of Pocket for Dental EHB Benefits

Use this section to input SADP MOOP values for dental EHBs. When entering the SADP MOOP values, ensure that the values are equal to or below the required limits for one covered child and two or more covered children as specified in [Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 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 <i>In Network Individual MOOP for Dental EHB Benefits</i> .
In Network—Family ^{**}	Enter the per-person and per-group dollar amounts for <i>In Network Family MOOP for Dental EHB Benefits</i> .
In Network (Tier 2)—Individual ^{*^}	Enter the dollar amount for <i>In Network (Tier 2) Individual MOOP for Dental EHB Benefits</i> .
In Network (Tier 2)—Family [*]	Enter the per-person and per-group dollar amounts for <i>In Network (Tier 2) Family MOOP for Dental EHB Benefits</i> .
Out of Network—Individual [*]	Enter the dollar amount for <i>Out of Network Individual MOOP for Dental EHB Benefits</i> .

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

4.20 Dental EHB Deductible

Use this section to input deductible values for dental EHBs. The deductible value may not be higher than the MOOP value. Using the drop-down menus, enter the appropriate values for the individual and family deductibles for EHBs in the following areas on the template.

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

4.21 Other Deductible

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

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

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

HSA/HRA Detail	Steps
HSA-Eligible ^{^#}	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 <u>not</u> 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 <u>not</u> have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount [^]	If responding Yes to <i>HSA/HRA Employer Contribution</i> , enter a numerical value representing the employer contribution amount to the HSA/HRA. Leave this field blank for Individual Market plans; the template does not permit an Individual Market plan to enter an HSA/HRA contribution amount. As discussed at 78 <i>Federal Register</i> 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

4.23 AVC Additional Benefit Design

This section contains optional fields, which 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%

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 <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if a coinsurance is charged. ◆ No Charge after deductible—after the consumer first meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 2)*^#	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 <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copay if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance, or this benefit does not have multiple tiers. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

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 <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 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 <i>Copay—In Network (Tier 1)</i> above. Choose from the following: ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for copayment if only a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copay is charged (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Day—the consumer pays a copayment per day (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay per Stay—the consumer pays a copayment per stay (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay per Day after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Stay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Day with deductible—after the consumer pays the copay per day, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ \$X Copay per Stay with deductible—after the consumer pays the copay per stay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit. For Inpatient Hospital Services and Skilled Nursing Facility covered benefits, <u>do not</u> copy and paste cost sharing values entered for other benefits (e.g., \$25 copay). Instead, enter values with the “per day” or “per stay” qualifiers. Copying and pasting any other cost sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.

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 <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ Not Applicable—the consumer only pays a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—In Network (Tier 2)*^#	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 <i>Copay—In Network (Tier 2)</i> field. This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following: ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ Not Applicable—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network**	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 <u>not</u> subject to the deductible). Note: Use Not Applicable, not No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible).

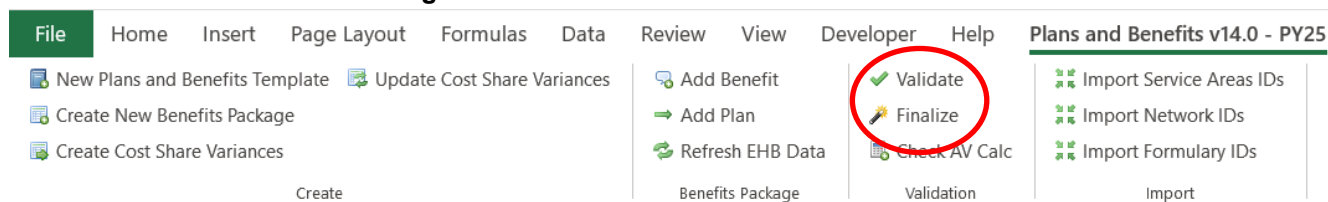
Covered Benefits	Steps
	◆ Not Applicable—the consumer pays only a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <u>not</u> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.25 Completed Plans & Benefits Template

After entering all data, including all Benefits Package and Cost Share Variances worksheets, click **Save** to ensure no data are lost. Once the Plans & Benefits Template is completed, 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

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI2222222	Plan 2
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10		
11	12345MI3333333	Plan 3
12	12345MI4444444	Plan 4

	HIOS Plan ID* (Standard Component)	Plan Mark
8		
9	12345MI1111111	Plan 1
10	12345MI3333333	Plan 3
11	12345MI4444444	Plan 4
12		

- 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 \leq \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 $Y\% \leq X\%$) ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% \leq X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% \leq X\%$) ◆ Not Applicable	◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% > X\%$)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ No Charge After Deductible ◆ Y% Coinsurance (all values) ◆ Y% Coinsurance After Deductible (all values)

Table 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 \leq \\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 \leq \\X) ◆ \$Y Copay After Deductible (when $\\$Y \leq \\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 \leq \\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 \leq \\X) ◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ No Charge ◆ Not Applicable	◆ \$Y Copay Per Day (when $\\$Y > \\X) ◆ \$Y Copay Per Stay (when $\\$Y > \\X) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay	◆ \$Y Copay Per Stay (when $\\$Y \leq \\X) ◆ \$0 Copay Per Day	◆ \$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 <i>Level of Coverage</i>	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 <i>Is This Benefit Covered?</i> value is Yes)	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit “Limits and Exclusions Apply” hyperlink displays when Explanation, 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
Health Savings Account Eligible Plan	HSA-Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template

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 <i>Medical & Drug Deductibles Integrated?</i> value is Yes , the text “Included with Medical” displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out of Pocket: In-Network—Individual Drug EHB Maximum Out of Pocket: In-Network—Family (When the <i>Medical & Drug MOOP Integrated?</i> value is Yes , the text “Included with Medical” displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral Required to See a Specialist	Plans & Benefits Template
Hospital-Based Services		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., hospital stay)	Inpatient Hospital Services (e.g., hospital stay)	Plans & Benefits Template
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
Coverage Examples		
Total Cost of Having a Baby	SBC Scenario—Having a Baby. Sum of the following data elements: ♦ Deductible ♦ Copayment ♦ Coinsurance ♦ Limit	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: ♦ Deductible ♦ Copayment ♦ Coinsurance ♦ Limit	Plans & Benefits Template
Total Cost of Treating a Simple Fracture	SBC Scenario—Treatment of a Simple Fracture. Sum of the following data elements: ♦ Deductible ♦ Copayment ♦ Coinsurance ♦ Limit	Plans & Benefits Template

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

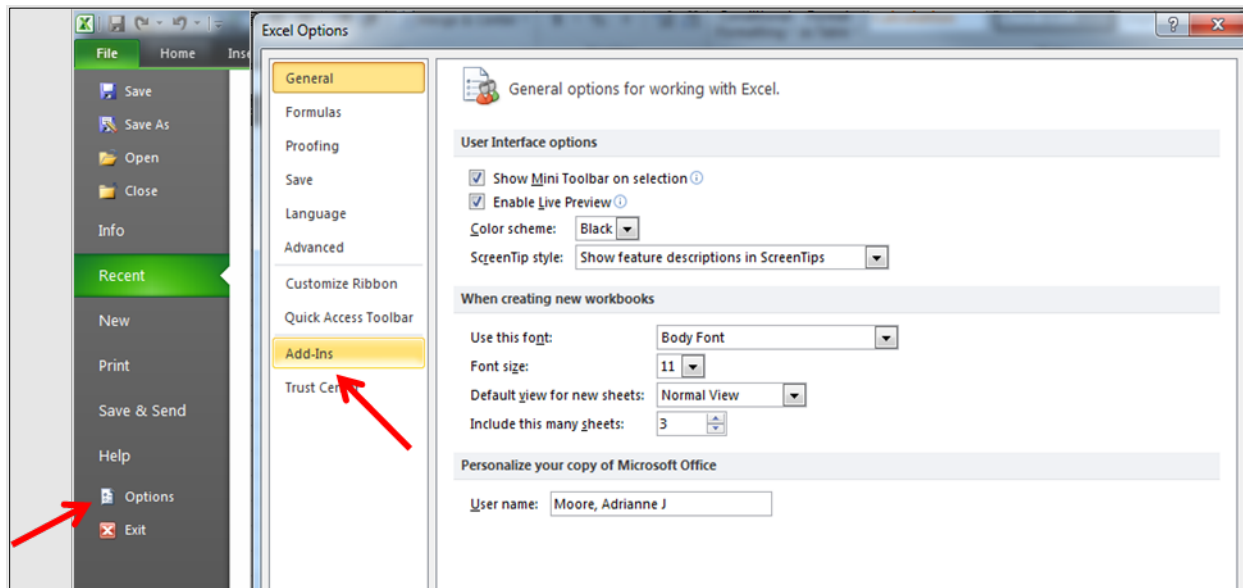


Figure 2E-20. Add-Ins Tab in Excel Options Window

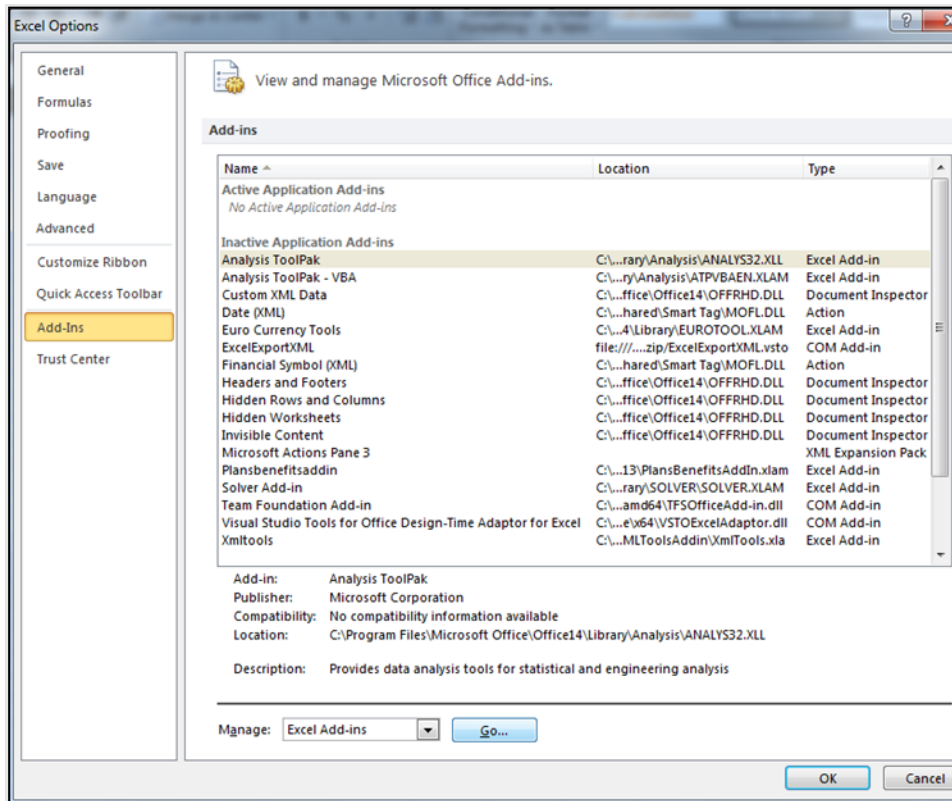
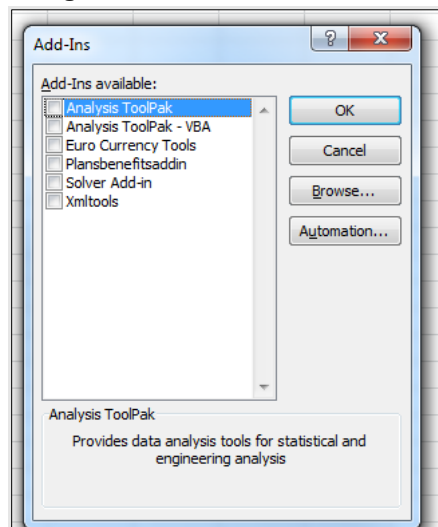


Figure 2E-21. Add-Ins Window



5.12 Standardized Plan Options and Corresponding Add-In File

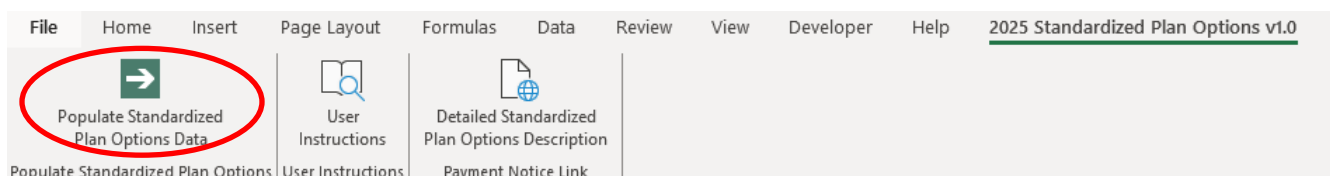
1. The SPOs Add-In file is provided to help users populate the cost sharing information for plans that are using standardized plan options. Details regarding the purpose and parameters of the standardized plan options are specified in 45 CFR 156.201 of the preamble to the Final HHS Notice of Benefit 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.

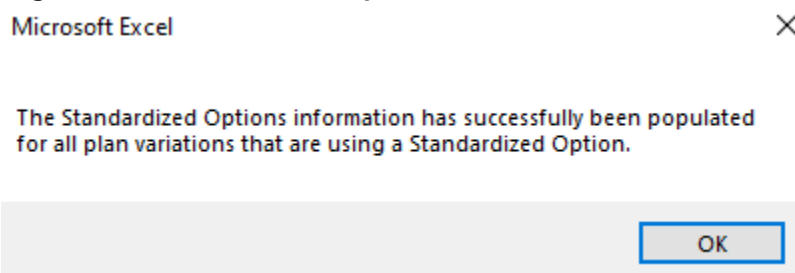
3. SPOs show the covered benefits and cost sharing amounts for each of the standardized plan options.
4. Populate the rest of the Benefits Package worksheet following the instructions detailed in Section 4 of these Plans & Benefits instructions. For details about the benefits and cost sharing expectations 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



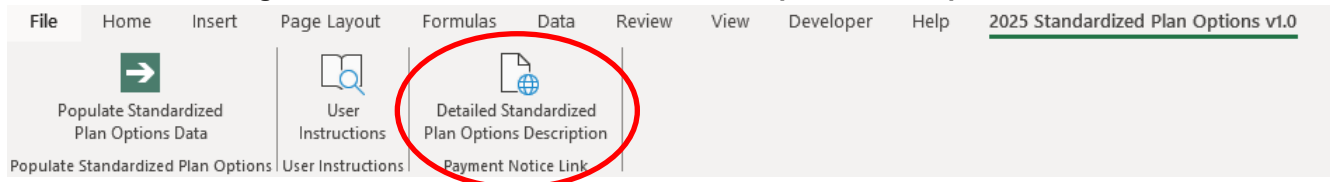
9. The SPOs Add-In file contains two buttons in addition to the main **Populate Standardized Plan Options Data** button.
 - a. The **User Instructions** button (Figure 2E-24) contains convenient abbreviated instructions similar to the instructions detailed here for reference while working in the Plans & 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 excluding Delaware, Louisiana, and Oregon, select "Design 1" from the drop down menu. To indicate that a plan is a standardized option in the States of Delaware and Louisiana, select "Design 2" from the drop down menu. To indicate that a is a standardized option in the State of Oregon, select "Design 3" from the drop down menu. Plans with a value of "Design 4", "Design 5", or "Not Applicable" in the "Design Type" column will not be treated as using a standardized option.
3)	The following benefits must be covered by any plan that is using a standardized option. Please ensure that all of these benefits are listed as "Covered" in the "Is this Benefit Covered?" field on all Benefits Packages that contain one or more plans using a standardized option. 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	Dental Check-Up for Children	Yes Covered
Specialist Visit	Yes	Covered	Rehabilitative Speech Therapy	Yes Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered	Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered	Well Baby Visits and Care	Yes Covered
Outpatient Surgery Physician/Surgical Services	Yes	Covered	Laboratory Outpatient and Professional Services	Yes Covered
Hospice Services	Yes	Covered	X-rays and Diagnostic Imaging	Yes Covered
Routine Dental Services (Adult)			Basic Dental Care – Child	Yes Covered
Infertility Treatment			Orthodontia – Child	Yes Covered
Long-Term/Custodial Nursing Home Care			Major Dental Care – Child	Yes Covered
Private-Duty Nursing			Basic Dental Care – Adult	
Routine Eye Exam (Adult)			Orthodontia – Adult	
Urgent Care Centers or Facilities	Yes	Covered	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*

Plan Cost Sharing Attributes											
HIOS Plan ID (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage (Metal Level)	CSR Tier Variational 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 Off Excl	60.00%	Yes	Yes	No		No	100%	
10333TX0050020-01	PB Med Indl 1	Bronze	Standard On Excl	60.00%	Yes	Yes	Yes	Podiatrist	No	100%	
10333TX0050020-02	PB Med Indl 1	Bronze	Zero Cog Plan V	100.00%	Yes	Yes	No		No	100%	

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)					
In Network		In Network (Tier 2)		Out of Network	
Individual	Family	Individual	Family	Individual	Family
\$2,403 \$7000 per person \$13000 per group	\$9,100 \$9100 per person \$18200 per group			\$2,403 \$7000 per person \$13000 per group	\$2,403 \$7000 per person \$13000 per group
\$0 \$0 per person \$0 per group	\$9,100 \$9100 per person \$18200 per group			\$0 \$0 per person \$0 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	
\$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		Out of Network	Coinsurance		
In Network (Tier 1)	In Network (Tier 2)		In Network (Tier 1)	In Network (Tier 2)	
\$50.00		\$50.00	75.00%		
No Charge after deductible		\$50.00	Not Applicable		
\$0.00		\$0.00	0.00%		
No Charge after deductible		\$50.00	Not Applicable		
\$50.00		\$0.00	Not Applicable		

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.

Section 2F: Prescription Drug

1. Introduction

In the Prescription Drug section of the Marketplace Plan Management System (MPMS), issuers will create cost sharing values for each tier of drug benefits and select the drugs that will be offered at each tier level. These instructions do not apply to stand-alone dental plan (SADP)—only issuers.

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

- QHP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

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

3. Quick Reference

Key Changes for 2025

- ◆ After selecting a formulary ID on the Formulary Tiers tab, the associated Drug List ID field will automatically populate as drug list ID 1.
- ◆ The 1 Month Out of Network Retail Pharmacy Benefit Offered?, 3 Month In Network Mail Order Pharmacy Benefit Offered?, and 3 Month Out of Network Mail Order Pharmacy Benefit Offered? fields will no longer automatically populate as **No**.

Tips for the Prescription Drug Section

- ◆ RXCUIs should have one of the following term types (TTYs): semantic branded drug (SBD), semantic clinical drug (SCD), brand name pack (BPCK), or generic pack (GPCK).
- ◆ Set Tier Level equal to "NA" (not applicable) if the drug is not part of a given drug list.
- ◆ Each drug list may have only one tier structure, as indicated by number of tiers and drug tier types, and all formularies associated with each drug list must be identical. The .XML file generated from the template and submitted to MPMS includes only the Number of Tiers and Drug Tier Type fields for the first formulary associated with each drug list.
- ◆ If plans are offered in the Individual and Small Business Health Options Program (SHOP) Markets, you must create separate formulary IDs for each market, regardless of whether the formulary is intended to serve both markets. Issuers submitting via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF) must use the same Prescription Drug Template across all binders or ensure that no formulary IDs repeat across the binders.

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

The Drug Lists worksheet must be completed before filling out the Formulary Tiers worksheet in the template. See Figure 2F-1 for a sample completed Drug Lists worksheet.

Figure 2F-1. Drug Lists Worksheet

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

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

Drug List	Steps
RXCUI	When selecting RXCUIs to include, use the December 4, 2023, full monthly release of RxNorm data to find a list of valid RXCUIs. To download the file, a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account are needed. A license and account can be obtained at no charge by following the instructions at the National Library of Medicine. Application resources including the EHB RX Crosswalk, a reformatted RxNorm database, and state review tools can be found on the Review Tools page of the qualified health plan (QHP) certification website. RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK. The drug list should include all drugs on the issuer's formulary, even those that are not in a category or class identified in the summary of EHB benchmark information. This includes all drugs the issuer lists as "medical service drugs."
Tier Level	For each drug, select the RXCUI's cost-sharing tier level from the drop-down menu, or select "NA" if this drug is not part of the given drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following: ♦ Yes—if prior authorization is required. ♦ No—if prior authorization is <u>not</u> required. If Tier Level is "NA," leave this column blank.
Step Therapy Required	Indicate whether the plan requires the enrollee to try at least one other drug before the plan covers the given drug. Choose from the following: ♦ Yes—if step therapy is required. ♦ No—if step therapy is <u>not</u> required. If Tier Level is "NA," leave this column blank.

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

Figure 2F-2. Add Drug List Button

	A	B	C	D	E	F	G	H
1	Drug Lists	All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.						
2		Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.						
3		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.						
4		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.						
5		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).						
6		Drug List ID 1			Drug List ID 2			
7		RXCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required
8		Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required
9		405550	3 No	No		3 No	No	
10		405551	2 No	Yes	NA	1 No	No	
11		405552	1 No	No		1 No	No	
12		405553	1 No	No		1 No	No	

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

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

Figure 2F-3. Remove Drug List Button

	A	B	C	D	E	F	G	H
1	Drug Lists	All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.						
2		Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.						
3		After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.						
4		Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.						
5		Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).						
6		Drug List ID 1			Drug List ID 2			
7		RXCUI*	Tier Level*	Prior Authorization Required	Step Therapy Required	Tier Level*	Prior Authorization Required	Step Therapy Required
8		Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required
9		405550	3 No	No		3 No	No	
10		405551	2 No	Yes	NA	1 No	No	
11		405552	1 No	No		1 No	No	
12		405553	1 No	No		1 No	No	

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

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

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

Formulary Tiers	Steps
	◆ The 1 Month In Network Retail Pharmacy Copayment and 1 Month In Network Retail Pharmacy Coinsurance will both be automatically set to Not Applicable when this tier type is chosen. The remaining pharmacy benefit types cannot be edited.
Tier Cost Sharing	This section describes how to document the cost-sharing structure for each drug tier. The only columns that must be populated are <i>1 Month In Network Retail Pharmacy Copayment</i> and <i>1 Month In Network Retail Pharmacy Coinsurance</i>. The issuer must indicate whether each tier offers these types of pharmacy benefits, but should only complete the information for the other three pharmacy types if they apply to the given drug tier. The pharmacy benefits are as follows: ◆ 1 Month In Network Retail Pharmacy (Copayment & Coinsurance) ◆ 1 Month Out of Network Retail Pharmacy Benefit Offered? ◆ 1 Month Out of Network Retail Pharmacy (Copayment & Coinsurance) ◆ 3 Month In Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month In Network Mail Order Pharmacy (Copayment & Coinsurance) ◆ 3 Month Out of Network Mail Order Pharmacy Benefit Offered? ◆ 3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance).
Benefit Offered	Select Yes if the pharmacy benefit is offered for the corresponding tier. Otherwise, select No .
Copayment	Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following: ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use Not Applicable, <u>not</u> No Charge, for copayment if a coinsurance is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ \$X Copay after deductible—after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a coinsurance. The issuer may only select Not Applicable for coinsurance and copay if the drug tier type is Medical Service Drugs.
Coinsurance	Enter the coinsurance amount for the given pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following: ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Use Not Applicable, <u>not</u> No Charge, for coinsurance if only a copay is charged. ◆ No Charge after deductible—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible). ◆ X% Coinsurance after deductible—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ Not Applicable—the consumer pays only a copay. The issuer may only select Not Applicable for copay and coinsurance if the drug tier type is Medical Service Drugs.

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

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

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

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

If the issuer has used all seven available tiers, include the Zero Cost Preventive Drugs in the lowest-cost tier and clearly identify that these drugs are available at zero cost sharing in the plan brochures and on the formulary web page; all drugs within the same tier should have the same cost sharing. Alternatively, if one of the seven tiers is a Medical Service Drugs tier, remove the Medical Service Drugs tier and add a Zero Cost Preventive Drugs tier as the first tier.

If the issuer offers a tier with cost sharing of zero that is not a preventive tier, select either **No Charge** for copayment and **Not Applicable** for coinsurance or **Not Applicable** for copayment and **No Charge** for coinsurance in the Formulary Tiers worksheet. **Not Applicable** may only be used for copayment and coinsurance in a Medical Service Drugs tier.

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

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

After entering all data, click **Save** to ensure no data are lost. Once the Prescription Drug Template is completed, it must be validated, finalized, and uploaded it into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.

Template Validation and Submission Step	Step Description
Finalize Template	Click Finalize in the template to create the .XML file 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.

This concludes the Prescription Drug section of the QHP Application Instructions.

Section 2G: Service Area

1. Introduction

In the Service Area section of the Marketplace Plan Management System (MPMS), issuers identify the service areas associated with their qualified health plans (QHPs), stand-alone dental plans (SADPs), or both, by state and county. Issuers must submit the Service Area Template as part of their QHP Application.

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

- QHP
- SADP

See Appendix D for additional information.

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

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

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

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

2. Data Requirements

To complete the template for this section, the following are needed:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer state
3. Names and IDs for proposed service areas to be associated with the issuer's QHPs or SADPs
4. Names of counties that the issuer is applying to cover if the issuer does not include an entire state in a service area
5. ZIP Codes in any county that the issuer is applying to cover if the issuer does not include an entire county in a service area.

3. Quick Reference

Key Changes for 2025

- ◆ *Service Area Names* must be identical within the same *Service Area ID*.
- ◆ *Service Area Names* must be unique across *Service Area IDs*.

Tips for the Service Area Section

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

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

Tips for the Service Area Section

- ◆ If the issuer offers plans in the Individual and Small Business Health Options Program (SHOP) Markets, the issuer must create separate service area IDs for each market, regardless of whether the service area is intended to serve both markets.
- ◆ Issuers can make changes to their plan's service area after the initial submission deadline without first submitting a data change request (DCR) for Centers for Medicare & Medicaid Services (CMS) authorization. After the final submission deadline in the PY2025 QHP Data Submission and Certification Timeline bulletin, a DCR is required for any change to QHP data, including service area.

Additional Resources

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

4. Detailed Section Instructions

Follow these steps to complete the Service Area Template.

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

Valid Special Characters for Free Text Fields in the Service Area Template

() (parentheses)	- (hyphen)	, (comma)	. (period)	/ (slash)	\ (backslash)	& (ampersand)
\$ (dollar sign)	+ (addition sign)	' ' (apostrophe/ single quote)	_ (underscore)			

Service Area Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which the issuer intends to offer coverage using the drop-down menu.
Service Area ID	Click Create Service Area IDs at the top of the Service Area Template and enter the total number of desired service areas for the identified state. The template will generate and add the requested number of service area IDs to the <i>Service Area ID</i> drop-down menu. For example, if "3" is entered for the total number of service areas, the template automatically generates three service area IDs. If the proposed service area covers the entire state, request one service area. The service area ID consists of the state abbreviation plus an "S" and then a sequenced number (for example, AZS001 or AZS002). Note: If the issuer submits via SERFF, click Create Service Area IDs and enter the number of service area IDs the issuer needs to ensure that no two templates use the same service area ID. For example, if the Individual Market needs three service area IDs and the SHOP Market needs two service area IDs, enter "5" for the total number of service areas. Each plan can only be associated with one service area ID, but a service area ID can be associated with multiple plans. In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.
Service Area Name	Enter a name for the service area selected. Note: It may be helpful to name the service area so that it identifies a plan characteristic, such as health maintenance organization (HMO), or the plan name. Dual-product issuers must use the word "dental" in the name for their dental service area to distinguish the dental service area from the QHP service area.

Service Area Template	Steps
	The service area name will not display to the public on HealthCare.gov. However, the service area name will display in the Public Use Files.² Issuers will receive an error when validating the Service Area Template if the <i>Service Area Name</i> is not identical within the same <i>Service Area ID</i>. For example, the <i>Service Area Name</i> for county A must be identical for county B if both counties are included in AZS001. Issuers will also receive an error when validating the Service Area Template if the <i>Service Area Name</i> is not unique across <i>Service Area IDs</i>. For example, the <i>Service Area Name</i> of AZS001 must differ from the <i>Service Area Name</i> of AZS002.
State	Choose from the following: ◆ Yes—if the service area includes the entire state. No additional information is required for the identified service area. Add service areas until all service areas have been identified. ◆ No—if the service area includes only certain counties in the state. In the next step, county information must be provided for the identified service area. Add service areas and counties as appropriate until all service areas have been identified. Note: The same service area ID <u>cannot</u> be used for both a service area that covers the entire state <u>and</u> a service area that covers only certain counties in the state.
County Name	Use the drop-down menu to select the name of each county included in the identified service area if the identified service area was indicated to not cover the entire state. If a service area includes multiple counties, a new row must be added for each new county using the same service area ID and service area name. If the issuer's service area counties are not in the drop-down menu, contact the Marketplace Service Desk by phone at 855-267-1515 or by email at CMS_FEPS@cms.hhs.gov.
Partial County	Choose from the following: ◆ No—if the service area includes the entire county. No additional information is required for the identified county. ◆ Yes—if the service area covers only part of the county. If Yes is selected, an informational box appears showing the HHS partial county policy. Select OK. A Service Area ZIP Codes column and a Partial County Justification Filename column will appear on the template.
Service Area ZIP Code	Enter the five-digit ZIP Code (e.g., 12345) the issuer proposes to cover in the partial county. If entering more than one ZIP Code, separate each ZIP Code with a comma.
Partial County Justification Filename	Save the Partial County Justification Form using the naming convention in Table C-1: 12345_AZ_service_area_partial_county.

² For more information regarding Public Use Files, visit <https://www.cms.gov/marketplace/resources/data/public-use-files>.

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

Figure 2GI-1. Sample Service Area Template

A	B	C	D	E	F	G
2025 Service Area v14.0	All fields with an asterisk (*) are required					
Validate	To validate, press the Validate button or Ctrl + Shift + I. To finalize, press the Finalize button or Ctrl + Shift + F					
Finalize	Click Create Service Area IDs button (or Ctrl + Shift + R) to Create Service Area IDs based on your state					
	Service Area IDs will populate in the drop-down box in Service Area ID column					
	For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)					
HIOS Issuer ID:	12345					
Issuer State:	AZ					
Create Service Area IDs						
Service Area ID*	Service Area Name*	State*	County Name	Partial County	Service Area Zip Code(s)	Partial County Justification Filename
Required: Enter the Service Area ID	Required: Enter the Service Area Name	Required: Does this Service Area cover the entire state?	Required if State is "No": Select the County - FIPS this Service Area covers	Required if State is "No": Does this Service Area include a partial county?	Required if Partial County is "Yes": Enter the zip codes in this county that are covered by this Service Area	Required if Partial County is "Yes": Enter the filename of the partial county justification file you are uploading to SERFF or HIOS
AZS001 Service Area One	Yes					
AZS002 Service Area Two	No		Mohave - 04015	No		
AZS003 Service Area Three	No		La Paz - 04012	Yes	85325, 85328	12345_AZ_service_area_partial_county
AZS004 Service Area Four	No		Yuma - 04027	No		
AZS005 Service Area Five	No		Maricopa - 04013	No		
AZS006 Service Area Six	No		Apache - 04001	Yes	85920, 85924, 85925	12345_AZ_service_area_partial_county

If the issuer requests to serve a partial county (i.e., if **Yes** is selected in Column E of the Service Area Template), the issuer must complete the following steps.

Partial County Justification Supplemental Response
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. The issuer must submit a detailed supplemental response substantiating why they will not serve the entire county for each exception the issuer requests. The issuer must justify how the partial county service area is necessary, non-discriminatory, and in the best interests of consumers and the Exchange program, consistent with 45 CFR 155.1055.
Answer the questions on the Partial County Supplemental Response Form . If responses are not provided to each of these questions, the partial county request will be denied.
The issuer may request partial county service areas only if the issuer has received state authorization. If the issuer requests a partial county service area in an FFE state and submits the QHP Application via HIOS, the issuer must provide written evidence demonstrating that the appropriate state regulator has authorized the issuer's partial county service area. For example, the issuer might provide email correspondence with the state that lists the specific ZIP Codes in the partial county requested.
If the issuer's state performs plan management functions, the issuer must submit a partial county supplemental response but evidence of state approval is not required. If the state transmits the request, that will serve as state approval.
After completing the supplemental response, do the following:
- Combine the written evidence that the appropriate FFE state regulator has authorized the partial county service area and the partial county justification supplemental response into one PDF file. - Name the PDF file using the naming convention in Table C-1: 12345_AZ_service_area_partial_county. Enter this file name in Column G, <i>Partial County Justification Filename</i>, of the Service Area Template.
Upload the completed Partial County Supplemental Response Form and evidence of state approval into the Service Area section of MPMS.

After entering all data, click **Save** to ensure no data are lost. Once the Service Area Template is completed, it must be validated, finalized, and uploaded into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the template to create the .XML version of the template that will be uploaded in the Plan Validation Workspace in MPMS.

Template Validation and Submission Step	Step Description
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 application. Refer to the MPMS User Guide for details on how to complete these steps.

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

A service area can be associated with multiple plans. For example, an issuer might have five plans and four service areas as follows: The first plan has a service area (SA001) that covers the entire state. The second and third plans have a service area (SA002) that covers counties A and B. The fourth plan has a service area (SA003) that covers counties C and D. The fifth plan has a service area (SA004) that covers counties A, B, C, and D.

A QHP or SADP must always be associated with a single service area ID and with a single network ID, but networks and service areas may be used for multiple QHPs or SADPs. Create one template for all service areas and identify each service area with a unique service area ID. Complete the Network ID Template and create a unique network ID for each network. The Plans & Benefits Template maps each plan to a specific service area ID and network ID as entered in the Service Area and Network ID Templates. Service area IDs and network IDs may both be used for multiple plans and do not have to correspond one-to-one. For example, an issuer may have a single state-wide network that is identified with a network ID and assigned to all of the issuer's plans, but have two service area IDs that are each made up of half the state and each assigned to a different plan.

The Exchange does not require an issuer's service area to cover a complete rating area, but the issuer is bound by state service area requirements. Issuers should carefully review state guidance on this topic to ensure the proposed service areas comply with state requirements. Multiple rating areas are allowed within a service area as specified by the state. Separate service area IDs are not required, even if a service area is made up of multiple rating areas.

If an issuer's state performs plan management functions and the issuer files via SERFF, CMS strongly encourages the issuer to submit a Microsoft Excel (XLSM) version of their Service Area Template.

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

Section 2H: Network ID

1. Introduction

In the Network ID Template each of the issuer's provider networks—groups of providers providing services in an area—must be assigned to network IDs. This template is submitted in the Network ID section of the Marketplace Plan Management System (MPMS).

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

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. List of provider networks.

3. Quick Reference

Key Changes for 2025

- ◆ The Network ID Template is now submitted in the Network ID section of MPMS.

Tips for the Network ID Section

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

Additional Resources

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

4. Detailed Section Instructions

Follow these steps to complete the Network ID Template.

When completing the template, note the following special characters that are allowed in free text fields. Entry of other special characters will result in validation errors when uploading the template to MPMS.

Valid Special Characters for Free Text Fields in the Network ID Template						
() (parentheses)	- (hyphen)	, (comma)	. (period)	/ (slash)	\ (backslash)	& (ampersand)
\$ (dollar sign)	+ (addition sign)	' ' (apostrophe/ single quote)	_ (underscore)			

Network ID Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Using the drop-down menu, select the state in which the proposed plan will be offered.
Generate Network IDs	Click Create Network IDs . Enter the number of networks when prompted and select OK . This button automatically generates the network IDs based on the number of networks specified. Note: Issuers who submit via SERFF should click Create Network IDs and enter the total number of network IDs needed to ensure that no two templates use the same network ID. For example, if the Individual Market needs three network IDs and the SHOP Market needs two network IDs, enter "5" for the total number of networks.
Network Name	Enter a network name. Dual-product issuers must use the word "dental" in the dental network name to distinguish the dental network from the QHP network.
Network ID	Select a network ID from the drop-down menu. The network IDs consist of the state abbreviation, the letter "N," and a sequenced number (such as MDN001 or MDN002). <u>Dual-product issuers must create separate network IDs for their QHP and dental networks.</u>

Repeat these steps for each additional network ID.

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

Figure 2H-1. Sample Network ID Template

2025 Network Template v14.0		<i>All fields with an asterisk (*) are required.</i>
Validate		<i>To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.</i>
Finalize		<i>Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.</i>
		<i>Network IDs will populate in the drop-down box in Network ID column.</i>
		<i>Use each Network ID only once.</i>
HIOS Issuer ID*	12345	
Issuer State*	VA	
Create Network IDs		
Network Name* Required: Enter the Network Name	Network ID* Required: Select the Network ID	
Smith Network	VAN001	

After entering all data, click **Save** to ensure no data are lost. Once the Network ID Template is completed, it must be validated, finalized, and uploaded into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.

Template Validation and Submission Step	Step Description
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Continue this process until all errors are resolved.
Finalize Template	Click Finalize in the template 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 in the Network ID section. Refer to the MPMS User Guide for details on how to complete these steps.

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

Section 2I: Essential Community Providers

1. Introduction

In the Essential Community Providers (ECP) section of the Marketplace Plan Management System (MPMS), qualified health plan (QHP) issuers must demonstrate that they have a sufficient number and geographic distribution of ECPs to ensure that all services will be accessible to enrollees without unreasonable delay. QHP issuers must submit provider data in each network associated with a QHP.

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

- Medical QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Completed Network ID Template
4. A list of ECPs in each of the proposed networks, including the provider name, National Provider Identifier (NPI), ECP category, street address of the location providing services, city, state, county, ZIP Code, and associated issuer network IDs. Include only those providers located within the service area and state in which the issuer intends to operate.

3. Quick Reference

Key Changes for PY2025

- ♦ All medical QHP and stand-alone dental plan (SADP) issuers operating on the Federally-facilitated Exchange, including issuers in states performing plan management functions and State-based Exchanges on the Federal Platform (SBE-FP), must use the new User Interface (UI) in the ECP section of MPMS to submit their provider networks. The *Facility ECPs* tab within the Network Adequacy (NA) Template will only be available to collect ECP data for issuers in State-Based Exchanges (SBE) submitting through the System for Electronic Rates & Forms Filing (SERFF).
- ♦ The ECP Write-in Worksheet used in previous years has been retired. Its functions have been integrated into the MPMS UI.
- ♦ Issuers applying under the Alternate ECP Standard will submit ECP Write-ins using the MPMS UI. Issuers can only qualify to apply under the Alternate ECP Standard if they provide the majority of their covered professional services through providers that the issuer directly employs or through a single contracted medical group, as such providers do not qualify for inclusion on the Final ECP List. See Figure 2I-4a and 2I-4b.
- ♦ Issuers applying under the General ECP Standard have the option of contracting with Available ECP Write-ins to help them meet the ECP requirements. Available ECP Write-ins are providers that have been approved by CMS for inclusion on the subsequent plan year's Final ECP List. Both Alternate and General ECP Standard Issuers will receive credit toward satisfaction of the ECP standard for any providers they include as ECP Write-ins using the MPMS UI.
- ♦ The ECP Justification Form used in previous years has been retired. Issuers will report information previously contained in the ECP Justification Form in the ECP section of the MPMS UI.

Tips for the ECP Section

General

- ♦ Complete the Network ID Template before beginning the ECP section of the MPMS UI.
- ♦ Issuers must only include providers in the ECP section of the MPMS UI that are not at known risk for potential contract termination for the upcoming plan year.
- ♦ Issuers operating in SBEs will submit their completed NA Template (which will include ECP data for SBE issuers only) via SERFF.
- ♦ The ECP Justification Form will no longer be provided to the issuer through the Plan Management (PM) Community for retrieval and submission; the information previously collected via the ECP Justification Form will now be collected from the issuer through the ECP section of the MPMS UI.

Tips for the ECP Section

Essential Community Providers

- ♦ Issuers will no longer be able to select a “dummy” provider record (ECP reference number ZZ-000001).
- ♦ There is a limited exception to the provider network requirement for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers as determined by CMS; this exception is not available to medical QHP issuers.
 - Under this limited exception, an area is considered “prohibitively difficult” for the SADP issuer to establish a network of dental providers based on attestations from state departments of insurance (DOIs) with at least 80 percent of their counties classified as counties with extreme access considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Marketplace issuers, or significant geographic limitations impacting consumer access to dental providers.
 - CMS will not be accepting requests for this limited exception directly from SADP issuers. Once an eligible state DOI submits to CMS an attestation that they consider the area to be prohibitively difficult to establish a network of dental providers, CMS will review the attestation to determine if an exception will be granted. CMS will notify the SADP issuer directly if they qualify for this limited exception. SADP issuers that qualify for this limited exception will not be required to use a provider network or submit ECP data.

Additional Resources

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

4. Detailed Section Instructions

Begin the Essential Community Providers section by responding to the questions on the *Essential Community Providers (ECP) Introduction* screen (Figure 2I-1).

Figure 2I-1. Essential Community Providers Introduction and Setup

Essential Community Providers (ECP) Introduction

All issuers must submit ECP information as part of their QHP Application. Issuers must have a sufficient number and geographic distribution of ECPs, where available, in accordance with 45 CFR 156.235.

Are you an Alternate ECP Standard Issuer?

To qualify as an Alternate ECP Standard Issuer you must provide the majority of covered professional services through physicians employed by the issuer or through a single contracted medical group.

☐ Yes

☐ No

Do you want to import the ECPs you entered on last year's application into this year's application?

☐ Yes, I will select networks to import

☐ No

Issuers must respond to the two questions before proceeding with entering their ECP data. Issuers should only respond **Yes** to *Are you an Alternate ECP Standard Issuer?* if they qualify as an Alternate ECP Standard issuer as described under 45 CFR 156.235(b).

Issuers have the option of importing prior year network ID and associated provider data by selecting **Yes** to the second question. The prior year's network IDs will be available for selection for issuers that select **Yes**. Select those network IDs to import from the prior year. Although issuers may select **No** to the second question, it is recommended that issuers select **Yes** to save significant time by importing the prior year's provider data. Issuers that select **Yes** will choose from a list of only those ECPs submitted in the prior year for inclusion in their upcoming plan year's provider network(s). Issuers that select **No** will not have any data imported and will select providers from the complete list of available ECPs.

After responding to the two questions, click the **Save and Next** button. Note that issuers will be unable to change their response to either question after saving. Please ensure the responses are accurate before clicking on the button.

After responding to the questions, navigate to the *Select ECPs* screen. For issuers that selected **Yes** to the second question, the table on the Select ECPs screen will be pre-populated with the prior year's data. For issuers that selected **No** and for issuers that selected **Yes** but need to add additional providers, click on the **Add ECPs** button. The *Add ECPs* pop up screen (Figure 2I-2) displays identifying information about each provider, including row number, NPI, organization name, and site street address.

Figure 2I-2. Add ECPs

Add ECPs Remove ECPs Write-In ECP Download ECPs (CSV)					
ECP Reference Number	NPI	Site Street Address	Negotiation Status	Network ID	Status & Action
FL-002293	1740364009	225 E 7th St Apopka, FL 32703-5327 Orange	Contract Execu...	FLN001 x	Complete Edit Remove
FL-002294	1427132794	618 S Forest Ave Apopka, FL 32703-5338 Orange	Contract Execu...	FLN002 x	Complete Edit Remove
FL-002295	1780093229	1110 E Gibson St Bldg A Arcadia, FL 34266-5011 DeSoto	Contract Execu...	FLN001 x FLN002 x	Complete Edit Remove

The following table details the actions for partially completing the ECP section.

Add ECPs Screen	Steps
Filter ECPs	Data in the <i>Add ECPs</i> table can be filtered to facilitate data entry. For example, filter the table to show only family planning providers or available Indian Health Care Providers. The <i>Add ECPs</i> table also has sorting functionality and allows the user to click the arrow to the right of each column header to sort by any column on the screen in ascending or descending order.
Add ECPs	Click in the box at the left of each row to add that provider. Once selected, the box will be highlighted in blue; to deselect this provider, select the box again, and the row will be deselected. Continue selecting the ECPs until finished. To select all providers, mark the box to the left of the ECP Reference Number column header and a check mark appears in the box and in the equivalent box in each subsequent row. This

Add ECPs Screen	Steps
	action will select all available ECPs in the service area, not just those displayed on the current page. Once the Add ECPs button at the bottom of the screen has been clicked, all selected ECPs will be inserted into the <i>Select ECPs</i> table. For each record, the following information will be added: ECP Reference Number, NPI, Organization Name, Site Street Address.

Once ECPs have been added, issuers need to provide additional information for each selected ECP, as shown in Figure 2I-3.

Figure 2I-3. Select ECPs

Select ECPs

You must add and complete ECP details.

Add ECPs
Remove ECPs
Write-In ECP
Download ECPs (CSV)

ECP Reference Number	NPI	Site Street Address	Negotiation Status	Network ID	Status & Action
FL-002293	1740364009	225 E 7th St Apopka, FL 32703-5327 Orange	Contract Execu...	FLN001	Complete <a>Edit <a>Remove
FL-002294	1427132794	618 S Forest Ave Apopka, FL 32703-5338 Orange	Contract Execu...	FLN002	Complete <a>Edit <a>Remove

Issuers must follow these steps for each provider appearing in the Select ECPs table, as shown in Figure 2I-3.

1. Select the providers from last year's network(s) to retain. Review the network IDs for accuracy and update them as needed. For issuers operating in states performing plan management functions and SBE-FP states, corrections to the associated network IDs can be made only after the state transmits the issuer's Network ID Template from SERFF to MPMS through Plan Transfer.
2. Add any recruited providers that were not part of the prior year's network(s). Enter the provider's contract negotiation status and all network IDs associated with the provider.
3. Remove any providers imported from prior years that are no longer under contract for the upcoming plan year.
4. Review default contract negotiation statuses and update as needed. There are 12 contract negotiation status options. Select:
 - a. *Contract Executed*, if the issuer has already contracted with this provider for the upcoming plan year.
 - b. *Contract Offer Made-Awaiting Response*, if the issuer has offered a contract to a provider for the upcoming plan year and is waiting for a response.
 - c. *Pre-Contract Negotiations in Progress (Contract Offer Not Made Yet)*, if the issuer and provider are still developing contract terms and conditions for the upcoming plan year.
 - d. *Offer Rejected*, if the provider rejects the issuer's contract offer for the upcoming plan year.
 - e. *Contract Not Offered Due to No Response Following Issuer Outreach*, if the provider has not responded to repeated contract offers or attempts to offer a contract for the upcoming plan year.
 - f. *Facility Closed*, if the provider is no longer in business.

- g. *Facility Does Not Contract and has No Interest in Contracting with Commercial Insurance*, if the provider sites this reason for rejecting the contract. Note that this is distinct from a provider not wishing to contract with a *particular* issuer because of the offered contract's terms and conditions.
- h. *Facility Does Not Provide Medical Services*, if the facility does not provide medical services.
- i. *Facility Does Not Provide Dental Services*, if the facility does not provide dental services.
- j. *Provider is in an Exclusivity Contract that Prohibits Issuer from Contracting with Provider*, if the provider is prevented contractually from contracting with other issuers.
- k. *Provider is Not Licensed, Accredited, or Certified by the State*, if the provider fails to satisfy any of these requirements.
- l. *Provider has Relocated Outside Service Area Preventing Issuer from Contracting with Issuer*, if the provider has moved out of the issuer's declared service area.

The Status & Action column (Figure 2I-3) of each provider row shows a status of complete or incomplete. Incomplete indicates the need to provide additional information about the provider. Complete indicates that MPMS requires no additional information. The two actions available are **Edit** and **Remove**. Select **Edit** to provide the additional provider information (Figure 2I-4) and select **Remove** to delete the provider record from the UI.

Figure 2I-4. Edit ECP Details

Edit Details: FL-002293 [Close](#)

Complete

ECP Details

ECP Reference Number FL-002293	National Provider Identifier (NPI) 1740364009
Provider Site Name COMMUNITY HEALTH CENTERS- APOPKA FAMILY & OB CARE	Organization Name COMMUNITY HEALTH CENTERS, INC.
Site Street Address 225 E 7th St Apopka, FL 32703-5327 Orange	
ECP Categories Federally Qualified Health Centers - Medical Services	

Provider Contract Details
All fields are required.

Negotiation Status
Once you select a negotiation status, additional required fields will display.

Contract Executed

Network ID [Clear All](#)

FLN001

Save **Save and Duplicate** [Cancel](#)

Table 2I-1 details the data elements that the issuer may need to provide to complete the ECP UI. Depending on the Status of Negotiations selection, the issuer may need to provide some or all the following information regarding a provider.

Table 2I-1. Data Elements Needed to Complete ECP UI

Provider Details	Steps
Contract Offer Date	Enter the date on which the issuer made a contract offer to the provider. This date cannot be a future date and must be on or after October 1 of the previous calendar year.
Point of Contact Name	Enter the name of the individual at the provider facility who provided the Status of Negotiations information.
Point of Contact Email	Enter the email address of the individual at the provider facility who provided the Status of Negotiations information.
Information Source	Provide the information source through which the issuer learned of the provider's changed status.
Save	Press the Save button when finished making selections and then select close (upper right corner) to return to the application.

Available ECP Write-ins for PY2025 QHP certification are available in the ECP UI, along with the ECPs on the Final PY2025 ECP List. General ECP Standard issuers may write in only those providers on the PY2025 List of Available ECP Write-ins.

Alternate ECP Standard issuers should use the custom Write-in ECP screen (See Figures 2I-5a and 2I-5b) to submit providers in Health Professional Shortage Areas (HPSAs) or low-income ZIP Codes that the issuer directly employs or contracts with through a single contracted medical group. CMS does not expect these providers to submit an ECP petition to be included on the Available ECP Write-in List because such providers are either employees of the issuer or practicing in a single contracted medical group and typically are unavailable to contract with other issuers.

Figure 2I-5a. Write-in ECP, Part 1

Write-In ECP [Close](#)

You must complete the ECP Details section to save the Write-In ECP, but it will not be complete until you provide Negotiation Status and Network ID.

ECP Details

Provider Site Name

Organization Name

National Provider Identifier (NPI)

ECP Categories [Clear All](#)

Site Street Address 1

Figure 2I-5b. Write-in ECP, Part 2

Site Street Address 2 (Optional)

Site State: Georgia

Site County: -Select-

Site City

Site Zip Code

HPSA ID (Optional)

Provider Contract Details

Negotiation Status
Once you select a negotiation status, additional required fields will display.

-Select-

Network ID [Clear All](#)

Save Cancel

To complete the information on the *Write-in ECP*, enter the following:

Write-in ECP	Required Information
Provider Site Name	Enter the provider site name.
Organization Name	Enter the provider's organization name.
National Provider Identifier (NPI)	Enter the provider's NPI.
ECP Category	Select the appropriate ECP category for each provider. Multiple ECP categories for each ECP may be selected, as applicable.
Site Street Address 1	Enter the site street address of the contracted provider.
Site Street Address 2	Enter additional street address information.
Site State	The provider's state is prepopulated.
Site County	Select the provider's site county from the drop-down list
Site City	Enter the provider's site city.
Site ZIP Code	Enter the provider's site ZIP Code. For Alternate ECP Standard issuers, all ECPs must be located in an HPSA or low-income ZIP Code.
HPSA ID (Optional)	Enter the HPSA designation ID, if applicable. For Alternate ECP Standard issuers, all ECPs must be located in an HPSA or low-income ZIP code.
Negotiation Status	Use the drop-down list to select each provider's contract negotiation status.
Network IDs	Use the drop-down list to select the network IDs for the networks to which the provider belongs.
Save	When the data entry is complete, press the Save button.

Issuers in states performing plan management functions and SBE-FP states will need to download their ECP data by clicking on the **Download ECPs (CSV)** button on the Select ECPs screen and then upload this file as a supporting document into SERFF. This will allow state DOIs to review the ECP data.

This concludes the ECP section of the QHP Application Instructions.

Section 2J: Network Adequacy

1. Introduction

In the Network Adequacy (NA) section of the Marketplace Plan Management System (MPMS), qualified health plan (QHP) issuers must demonstrate that they have a sufficient number and geographic distribution of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. QHP issuers must submit provider data in each network associated with a QHP (Figure 2J-1).

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

- Medical QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers will need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer state
3. Completed Network ID Template
4. A list of providers in each of the networks. When completing the NA Template, providers outside the service area may be included to satisfy time and distance requirements, even if they are across state lines. If a provider is in-network and enrollees can access services from the provider within the requisite time and distance standards for the respective county type designation, include the provider name, National Provider Identifier (NPI), individual provider or facility specialty type, telehealth service availability (only for individual providers), street address of the location providing services, city, state, county, and ZIP Code.
5. NA Justification Form (as applicable). Issuers will retrieve a partially populated NA Justification Form from MPMS with information regarding their deficient network, county, and specialty combinations. Once issuers have completed their portions of the NA Justification Form, they will submit the completed form to MPMS by the required deadline. CMS will accept only the official NA Justification Form in Excel format and does not accept individually customized supplemental response forms as a substitute for the official form.

3. Quick Reference

Key Changes for PY2025

Network Adequacy

- ♦ Existing issuers should download their previous year's NA provider data into their upcoming year's NA Template in MPMS. New issuers should download and populate a new NA Template.
- ♦ After making updates to the previous year's data or completing a new NA Template, issuers must upload the completed file to the Validation Workspace. All errors must be corrected before linking the NA Template to an application.
- ♦ Issuers will now retrieve and submit the NA Justification Forms in the Network Adequacy section in MPMS rather than in the Plan Management (PM) Community.
- ♦ All medical QHPs and stand-alone dental plans (SADPs) operating on the Federally-Facilitated Exchange (FFE), including issuers in states performing plan management functions and State-based Exchange on the Federal Platform (SBE-FP) states, will submit their completed NA Template via MPMS.
- ♦ Provider validations will identify provider data errors that an issuer has made upon upload of their NA Template into the Plan Validation Workspace of MPMS and require the issuer to correct such errors within the Plan Validation Workspace and verify that no additional errors exist before submitting their NA Template.

Tips for the NA Section

General

- ♦ Complete the Issuer Information section on the **User Control** tab before creating and entering data into the other tabs.
- ♦ Do not change the file names on NA files after finalizing the template. This file-naming convention helps CMS identify each issuer's NA Template. If the file name is changed, CMS may issue a required correction.

Tips for the NA Section

- ♦ Complete the Network ID Template before completing the NA Template.
- ♦ Issuers must only include providers on the NA Template that are not at known risk for potential contract termination for the upcoming plan year.
- ♦ All medical QHPs and SADPs operating on the FFE, including issuers in states performing plan management functions and SBE-FP states, will submit their completed NA Template via MPMS.
- ♦ NA Justifications are only required when at least one element of the NA standard is not met. Issuers that do not meet all elements of the NA standards are issued a correction notice and a partially populated NA Justification Form for the issuer to retrieve, complete, and submit via MPMS.

Network Adequacy

- ♦ All medical QHPs and SADPs must use a provider network and submit an NA Template, with the limited exception of SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers as determined by CMS; this exception is not available to medical QHP issuers.
 - Under this limited exception, an area is considered “prohibitively difficult” for the SADP issuer to establish a network of dental providers based on attestations from state departments of insurance (DOIs) with at least 80 percent of their counties classified as counties with extreme access considerations (CEAC), meaning that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Marketplace issuers, or significant geographic limitations impacting consumer access to dental providers.
 - CMS will not be accepting requests for this limited exception directly from SADP issuers. Once an eligible state DOI submits to CMS an attestation that they consider the area to be prohibitively difficult to establish a network of dental providers, CMS will review the attestation to determine if an exception will be granted. CMS will notify the SADP issuer directly if they qualify for this limited exception. SADP issuers that qualify for this limited exception will not be required to use a provider network or submit an NA Template.
- ♦ Issuers complete the NA Template by including all providers in their network in the *Network Adequacy Provider* tab, using the **Taxonomy Codes** tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for time and distance standards.
- ♦ Providers in another state that are part of the network may be included if they are located within the time and distance allowed for reasonable access¹ These parameters are foundationally based on approaches used by the Census Bureau and the Office of Management and Budget. Use this file only to reference the **Provider Time & Distance** tab columns A through E for QHP county type designations. Other information in this Health Service Delivery (HSD) Reference file is not applicable to QHP certification.
- ♦ Issuers must submit valid and active NPI values. If an NPI value is not found in the National Plan and Provider Enumeration System (NPPES), the issuer must remove the NPI from their NA Template data to clear the validation error in the Plan Validation Workspace within MPMS.
- ♦ Issuers must not select more than three individual provider specialty types for a single NPI within the NA Template. If greater than three individual provider specialty types are selected for a single NPI, the issuer must remove any excess selections to clear the validation error in the Plan Validation Workspace within MPMS.
- ♦ Issuers must not report an individual provider as practicing at more than 10 unique locations or a provider facility as operating at more than 10 unique locations within their NA Template. To clear the validation error, issuers must remove locations that exceed the limit of 10 unique locations for the respective provider.
- ♦ Issuers must enter no greater number of Acute Inpatient Hospitals (with emergency services available 24/7) within their NA Template than the total number of such hospitals operating in the respective states in which the providers are located (excluding specialty hospitals, such as those on the [Department of Health and Human Services [HHS] Essential Community Provider [ECP] List). If an issuer receives this validation error, the issuer must review their data and make the necessary corrections to accurately report their in-network Acute Inpatient Hospitals within their NA Template to clear the validation error in the Plan Validation Workspace within MPMS.
- ♦ Issuers must not enter a PO Box in the address field for a provider within their NA Template. To clear the validation error in the Plan Validation Workspace within MPMS, issuers must replace any PO Boxes with a valid street address at which the provider offers services to enrollees. Entering a valid street address enables CMS to calculate time and distance measurements for the respective provider.
- ♦ Issuers should reference the *Taxonomy Codes* tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for time and distance standards.

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

Tips for the NA Section

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

Additional Resources

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

4. Detailed Section Instructions

Existing issuers should navigate to the Application Tools section in MPMS, select Application Materials, and download the data from the prior year's template directly into the current year's NA Template. New issuers download a blank NA Template from the [QHP certification website](#) and populate it according to the following instructions and guidelines. All issuers must upload the NA Template into the Plan Validation Workspace and verify that no errors exist.

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

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User Control Tab	Steps
Issuer ID	Enter the five-digit HIOS Issuer ID.
SADP Only	Choose from the following: ♦ Yes—if the issuer only submits SADPs. ♦ No—if the issuer submits QHPs.
Source System	Select the name of the system used to submit the QHP Application: ♦ HIOS—if the issuer is in an FFE state. ♦ SERFF—if the issuer is in a state performing plan management functions.
State	Use the drop-down menu to select the state in which the issuer is applying to offer QHPs.

Follow these instructions and guidelines to determine the appropriate providers to include in the NA Template.

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- Reference the *Taxonomy Codes* tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for time and distance standards.
- Acute Inpatient Hospitals (facility specialty type code 040) are defined as facilities that provide inpatient medical care and other related services for surgery, acute medical conditions or injuries (usually for a short-term illness or condition), and 24/7/365 emergency services. Due to known data integrity issues (e.g., a high number of hospital outpatient facilities being incorrectly reported by providers as acute inpatient hospitals in NPPES), issuers should not use the National Uniform Claim Committee (NUCC) hospital taxonomy code to identify such hospitals for NA submissions. Additionally, inpatient specialty hospitals that fall within the ECP inpatient hospital category (e.g., Children’s Hospitals, Free-standing Cancer Centers, Critical Access Hospitals) that are participating in an issuer’s network should be listed only within the ECP section of MPMS, rather than within both the NA and ECP sections.
- For Cardiac Surgery Programs (facility specialty type code 041), Cardiac Catheterization Services (facility specialty type code 042), and Critical Care Services – Intensive Care Units (ICUs) (facility specialty type code 043), issuers must report within their network adequacy submissions the respective provider types that filter into these facility specialty types. Since these are services rather than facility types, there are no specific taxonomy codes that align completely with these specialty codes.
- For rural counties and CEACs for which issuers report within the issuer’s NA Justification a provider supply shortage of primary care pediatricians, issuers are permitted to enter the family medicine physician provider type to count toward satisfaction of the “Primary Care–Pediatric” specialty type. This is in addition to the family medicine physician provider type currently counting toward issuer satisfaction of the “Primary Care–Adult” specialty type.
- Under the following circumstances, APRNs and PAs can be included as primary care providers. APRNs who specialize in behavioral health services could be included in the outpatient clinical behavioral health provider category. Including APRNs and PAs informs CMS of the rare instances in which an issuer contracts with non-MD/DO primary care and behavioral health services providers in underserved counties to serve as the major source of these types of care for enrollees. In these instances, organizations can include submissions under the non-MD/DO primary care and outpatient clinical behavioral health specialty codes if the contracted APRN or PA satisfies the following conditions:
 - (1) Licensed in the state,
 - (2) Meets the state’s requirements governing the qualifications of that provider type,
 - (3) Fully credentialed by the organization as a provider of primary care or behavioral health services,
 - (4) Functions in accordance with state law as the primary source for the enrollee’s primary care or behavioral health services (i.e., not to supplement a physician’s care), and
 - (5) Practices in or renders services to enrollees residing in a HPESA.

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

Network Adequacy Provider Tab	Steps
NPI (required)	Enter the provider’s 10-digit NPI. Issuers should contact providers directly to acquire their NPIs. For NA purposes, issuers must report each individual provider under their unique practitioner NPI and each provider facility under their site-specific facility NPI. The parent organization-level NPI should not be reported. Issuers should only include providers in the NA Template after obtaining their NPI. CMS no longer accepts dummy entries for the NPI field. Ensure that the NPI is valid and active in the NPPES database.
Provider Name (First Name, Last Name or Facility Name)	Enter the individual provider’s first and last name or the name of the provider facility. An individual practitioner’s name should not be entered for a provider facility type, unless it is part of the name of the facility. Similarly, a provider facility’s name should not be entered for an individual provider specialty type.

Network Adequacy Provider Tab	Steps
Specialty Type (area of medicine) of Individual Provider or Facility	From the drop-down menu, select all specialties offered at the identified provider location. If a provider has multiple specialties at the same address, select all specialties in the same record that do not exceed three specialty types for individual providers. ♦ The template does not allow direct entry into this field. However, data may be copied and pasted into the template if the specialty type names match how they appear in the <i>Specialty Types</i> tab data, such as 001 General Practice. Errors will appear if pasted data do not exactly match the specialty type format used in the <i>Network Adequacy Provider</i> tab. ♦ To enter more than one specialty type for a provider, each specialty type must be separated by a comma and a space. Issuers must not select more than three individual provider specialty types for a single NPI within the NA Template. A validation error will result if an issuer exceeds this limit. ♦ Do not include provider specialties except those the provider is actively practicing and providing services. ♦ If the specialty type is not listed in the <i>Specialty Types</i> tab, do not list the provider. CMS does not accept specialties that do not fall within the defined Specialty Types lists.
Does this provider offer Telehealth?	For the purpose of this data collection and reporting, the term “telehealth” is defined as “professional consultations, office visits, and office psychiatry services through brief communication technology–based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation.” From the drop-down menu, select Yes or No to indicate whether the provider offers telehealth services. If the issuer has reached out to the provider and is awaiting a response, select Requested information from provider and awaiting their response.
Street Address	Enter the provider’s street address. If the provider has multiple locations, enter each street address in a separate row. <u>Do not</u> use a PO Box in the address field, because it cannot be geocoded for analysis. All providers with a PO Box in the address will be excluded from time and distance analysis. Issuers must not report an individual provider as practicing at more than 10 unique locations or a provider facility as operating at more than 10 unique locations within their NA Template. A validation error will result if an issuer exceeds this limit.
Street Address 2	Enter additional street address information, if applicable.
City	Enter the city where the provider is located.
State	Enter the state where the provider is located or select the state using the drop-down menu.
County	Enter the county where the provider is located or select the county using the drop-down menu. A list of accepted county names is available on the <i>County Names</i> tab of the NA Template. Do not include the Federal Information Processing Standards (FIPS) code when entering the county name.
ZIP Code	Enter the ZIP Code where the provider is located. ZIP Codes must include either five (12345) or nine (12345-6789) digits.
Network ID	When entering network IDs, use the same network IDs as those assigned in the Network ID Template and the Plans & Benefits Template. <u>Issuers that offer both medical QHPs and SADPs must create separate network IDs for their medical and dental plans.</u> Using the drop-down menu, select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, select all networks in the same record.

Figure 2J-2. Sample Network Adequacy Provider Tab

Reference information is provided in the four tabs listed below:

- The *Specialty Types* tab contains the specialty/facility types that can be added into the NA Template.
- The *Taxonomy Codes* tab contains the taxonomy codes that correspond to provider specialty types listed within the *Specialty Types* tab. The *Taxonomy Codes* tab may be used as a guide for the provider taxonomy types required for inclusion in submissions. The *Taxonomy Codes* tab also has columns to show which taxonomy codes crosswalk into each time and distance specialty type.
- The *County Names* tab contains the county names that are used and accepted in the NA Template.
- The *Errors* tab displays any validation errors identified when a completed NA Template is validated.
 1. Column A—Tab: indicates the tab that produced the error.
 2. Column B—Cell: indicates the cell location for the specific error and creates a hyperlink that allows the issuer to navigate to the exact cell in the correct tab.
 3. Column C—Validation Error Message: describes the error.

After entering all data, click **Save** to ensure no data are lost. Once the NA 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 <i>User Control</i> tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, the message “No validation errors were identified. Validation is complete.” will display, indicating that the template may be finalized.
Errors	Errors will appear on the <i>Errors</i> tab, which shows the data element, cell location, and validation error message for each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Create Documents	Once all validations are complete, click Create Documents on the <i>User Control</i> tab to create a separate .XML file for each tab in the workbook and compress all files into one .ZIP file.
Save Template	Save the .ZIP file and template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .ZIP file for easier reference.

Template Validation and Submission Step	Step Description
Upload and Validate Template In MPMS	Upload the saved .ZIP file in the Plan Validation Workspace in MPMS. Refer to the MPMS User Guide for additional guidance on how to complete these steps.
Link Template In MPMS	Link the validated template to the issuer's application. Refer to the MPMS User Guide for additional guidance on how to complete these steps.

After uploading the necessary NA files and linking them to the application, NA Justifications Forms may also need to be uploaded. Completed NA Justification Forms must be submitted in the Network Adequacy section in MPMS.

Supporting Documents	Steps
NA Justification Form	♦ If a required correction for not meeting one or more of the NA standards is received, all required fields in the prepopulated NA Justification Form generated by CMS must be completed. This form can be retrieved from MPMS. Refer to the MPMS User Guide. ♦ The completed NA Justification Form should be saved in the required macro-enabled Excel format (.xlsm) and uploaded into the Network Adequacy section of MPMS by the required deadline for each submission round. Do not rename the Justification Form. If the file is renamed, the following naming convention should be used: (Issuer ID)-NA-(Round Abbreviation). For example, Issuer ID 12345 in the Initial Round would be 12345-NA-IR. Replace IR with SR for the Second Round of submission and with FR for the Final Round of submission. ♦ If CMS learns of local challenges impacting all issuers in a given service area, such as topographical features or insufficient provider supply, which have resulted in assignment of required corrections, CMS will assess any such challenges to verify the extent to which they impede issuers' ability to satisfy the respective NA standard for the purpose of potentially clearing the assigned correction, as CMS deems appropriate. ♦ On the <i>Monitoring & T&D Justification</i> tab of the NA Justification Form, an answer must be provided to the four service area monitoring questions at the top of the worksheet for CMS to consider any barriers reported within the "Primary Reasons on Record for Unmet Standard" column. ♦ On the <i>Monitoring & T&D Justification</i> tab of the NA Justification Form, a Primary Reason(s) must be provided for not meeting the standard related to each correction. ♦ On the <i>Recruitment Activity</i> tab of the NA Justification Form, CMS strongly encourages issuers to include provider recruitment activities for the network, county, and specialty combinations for which required corrections were received, including any ongoing, concluded, and unsuccessful activities. This additional provider recruitment data will inform next steps that may be required of the issuer as part of a compliance plan. ♦ All required fields in the NA Justification Form must be completed before submission. Incomplete justifications will not be accepted. ♦ After issuers submit the completed NA Justification Form, CMS will send additional corrections via MPMS if further corrections are required.

This concludes the NA section of the QHP Application Instructions.

Section 2K: Plan ID Crosswalk

1. Introduction

The Plan ID Crosswalk Template crosswalks PY2024 qualified health plan (QHP) plan ID and service area combinations to PY2025 QHP plan IDs. These data facilitate enrollment transactions from the Centers for Medicare & Medicaid Services (CMS) for enrollees in the Individual Market who did not actively select a different QHP during Open Enrollment. These instructions apply to QHP and stand-alone dental plan (SADP) issuers that offered Individual Market plans on the Exchange during PY2024.

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

- HIOS
- SERFF
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer's state
3. Market coverage
4. Completed Plans & Benefits Template
5. Completed Service Area Template
6. Completed State Authorization Form.

3. Quick Reference

Key Changes for 2025

- ◆ Issuers must submit their Plan ID Crosswalk Templates, necessary justifications, and state authorization in the Marketplace Plan Management System (MPMS) instead of the Plan Management (PM) Community.
- ◆ In MPMS, returning issuers can generate prepopulated Plan ID Crosswalk Templates to submit as part of their QHP Application. The prepopulated templates import an issuer's plan IDs and associated service areas and network IDs from the prior plan year.

Tips for the Plan ID Crosswalk Section

- ◆ Submit the Plan ID Crosswalk Template, justifications, and state authorization in MPMS. Submit separate Plan ID Crosswalk templates in MPMS for SADPs.
- ◆ New issuers are not required to submit Plan ID Crosswalk Templates to complete their application unless they will receive plans from a discontinuing issuer, which is a rare situation.
- ◆ Issuers are required to provide age off plans for catastrophic and child only plans.
- ◆ CMS has deferred the Federally-facilitated Small Business Health Options Program's (FF-SHOP's) ability to auto-renew employees for PY2025. Do not submit a Plan ID Crosswalk Template for FF-SHOP plans.
- ◆ The 2024 HHS Notice of Benefit and Payment Parameters requires Exchanges to ensure that a consumer whose current year QHP is no longer available be auto re-enrolled into a QHP that has the most similar network compared to the enrollee's current QHP, and that meets the other requirements that also apply to plan crosswalk at 45 CFR 155.335(j). Therefore, issuers should take into account network ID when selecting crosswalk plans, if possible, along with product ID and plan type as has been required in prior years.¹

Additional Resources

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

¹ For a complete list of plan crosswalk rules, see [45 CFR 155.335\(j\)](#).

Additional Resources

- ◆ There are [templates](#) for this section.

4. Detailed Section Instructions

The issuer must submit evidence that its state has authorized the issuer to submit their Plan ID Crosswalk Template no later than the deadline for the initial application submission. Evidence of state authorization, such as a signed State Authorization form or an email confirmation, must be submitted in MPMS along with the completed template.

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

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

Issuers in states that do not enforce the ACA market-wide requirements should submit the authorization form to their state's department of insurance and to CMS's Compliance and Enforcement Division (formfiling@cms.hhs.gov) to obtain the necessary authorization for submission.

In MPMS, returning issuers can generate prepopulated Plan ID Crosswalk Templates to submit as part of their QHP Application. The prepopulated templates import an issuer's plan IDs and associated service areas and network IDs from the prior plan year. Refer to the [MPMS User Guide](#) for details on how to generate prepopulated Plan ID Crosswalk Templates. New issuers are not required to submit Plan ID Crosswalk Templates to complete their application unless they will receive plans from a discontinuing issuer, which is a rare situation.

The following steps outline how to complete the Plan ID Crosswalk Template, beginning with the *2024 Plan Crosswalk* tab.

2024 Plan Crosswalk Tab	Steps
Import 2024 Plans & Benefits and Service Area Template	Note: A prepopulated Plan ID Crosswalk Template generated in MPMS will import the issuer's plan IDs and associated service areas and network IDs from PY2024. Refer to the MPMS User Guide for details on how to generate a prepopulated Plan ID Crosswalk Template in MPMS. Issuers that would like to manually import PY2024 data should follow these instructions: Click Import 2024 Plans & Benefits and Service Area Template to import the completed templates. The template will prompt the user to select the completed 2024 Plans & Benefits and Service Area Templates. Before these templates are imported, save them in the same folder; both must be uploaded at the same time. To select both files, click one template, then press and hold Ctrl on Windows or Cmd on macOS while clicking on the other template, and then click Open. Select exactly one of each type of template. The Plan ID Crosswalk Template will populate a list of PY2024 plan IDs and their associated service areas and network IDs on the <i>2024 Plan and Service Area Data</i> tab. Review this tab to ensure the data were accurately imported. After the PY2024 plan and service area data have been imported, the <i>2024 Plan Crosswalk</i> tab will be populated with all applicable issuer information and with a row for each PY2024 plan ID.
HIOS Issuer ID	Ensure the template has accurately populated the five-digit HIOS Issuer ID.
Issuer State	Ensure the template has accurately populated the state where the issuer is offering coverage.

2024 Plan Crosswalk Tab	Steps
Market Coverage	Ensure the template has accurately populated the market coverage from the drop-down menu. The FF-SHOP Exchange will not allow auto-renewals for PY2024, so this field will be hard coded to Individual.
Dental Only	Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental-only plans. Choose from the following: ◆ Yes—this template is for SADPs only. ◆ No—this template is for QHPs.
Crosswalk Level	Select the level at which the user would like to crosswalk each PY2024 plan from the drop-down menu. Choose from the following: ◆ Crosswalking to the same plan ID: Select this option if the issuer is crosswalking the PY2024 plan to the same plan ID for PY2025 and there are no service area changes. ◆ Crosswalking at the plan ID level: Select this option if the issuer has no service area changes but is using a different PY2025 plan ID to reflect the same plan. ◆ Crosswalking at the plan ID and county coverage level: Select this option if the issuer's service area changed for the upcoming year and the PY2024 plan needs to be crosswalked to two or more PY2025 plan IDs. Note: If the PY2024 plan covered the entire state, the plan must be crosswalked to PY2025 plan IDs for every county in the state. ◆ Crosswalking at the ZIP Code level for one or more counties: Select this option if the service area changed for the upcoming year and the PY2024 plan needs to be crosswalked to two or more PY2025 plan IDs for the same county. Selecting this option will require the issuer to select the counties from the PY2024 plan's service area that will be crosswalked at the ZIP Code level. The remaining PY2024 service area will be crosswalked at the county level. Note: Do not crosswalk at the ZIP Code level unless absolutely necessary. ◆ Discontinue with no crosswalk: Select this option if a PY2024 plan is being discontinued with no re-enrollment option for its enrollees. ◆ Plan withdrawn prior to certification: Select this option if the PY2024 plan was withdrawn from the Exchange before certification and has no enrollment. The issuer should also select this option if the PY2024 plan ID listed on the template was not approved by the state or the Federally-facilitated Exchange (FFE) to be offered on the Exchange in PY2025.
Counties Crosswalked at ZIP Code Level	Select the counties in the PY2024 plan's service area that will be crosswalked at the ZIP Code level from the pop-up menu.

To complete the information on the *2025 Plan Crosswalk* tab, follow the steps in the table below.

2025 Plan Crosswalk Tab	Steps
Create "2025 Crosswalk Tab"	Click Create "2025 Crosswalk Tab." This action creates the <i>2025 Plan Crosswalk</i> tab. The first four columns, 2024 HIOS Plan ID, County Name, Service Area ZIP Codes, and Crosswalk Level, and the last column, 2024 Network ID, will be auto-populated based on the issuer's entries in the <i>2024 Plan Crosswalk</i> tab. If the issuer crosswalks at the plan ID, county level for one or more plans, a row will appear for each county that plan covered in PY2024. If the issuer decides to crosswalk at the ZIP Code level for specific counties covered by a PY2024 plan, a row will appear for each combination of plan ID, county, and ZIP Code. Issuers should click Create "2025 Crosswalk Tab" only when certain that the <i>2024 Plan Crosswalk</i> tab is complete. A <i>2025 Plan Crosswalk</i> tab cannot be changed after it is created. To make changes, issuers must click Create "2025 Crosswalk Tab" again, which will clear all data and begin a new copy of the <i>2025 Plan Crosswalk</i> tab. Issuers

2025 Plan Crosswalk Tab	Steps
	can copy and paste previously entered information into a separate workbook and then into a new copy to save previous work when changes require replacing the <i>2025 Plan Crosswalk</i> tab.
Crosswalk Reason	Choose the reason for the crosswalk from the drop-down menu. Certain options will only be available for specific crosswalk levels. Table 2K-1 details crosswalk reason entries for each crosswalk level: ◆ Renewing exact same product/plan combination (same PY2024 plan ID): Select this option if the issuer is crosswalking this plan ID/service area to the exact same HIOS Plan ID. The template will auto-populate the <i>PY2025 Plan ID</i> field with the PY2024 plan ID. Use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2025 plan year. The issuer must comply with the “same plan” standards as defined in 45 CFR 144.103. ◆ Renewing exact same product/plan combination (different PY2025 plan ID): Select this option if the issuer is crosswalking this plan ID/service area to the same product/plan combination but with a different PY2025 plan ID. If possible, the issuer should use the same HIOS Plan ID if the previous year’s same plan ID/service area combination remains available. If the issuer is continuing a plan but wishes to crosswalk to a different HIOS Plan ID, the issuer must obtain approval from their state regulatory authority before submitting the Plan ID Crosswalk Template. The issuer must comply with the “same plan” standards as defined in 45 CFR 144.103. ◆ Renewing product: renewal in a different plan within product: Select this option if the issuer is renewing this product, but crosswalking this plan ID/service area to a different plan within the product offered on the FFE. If the issuer selects this option, the same product ID that is embedded in the plan’s 2024 plan ID must be used. ◆ Continuing product: no plan available in the particular service area under that product; enrollment in a different product: Select this option if the issuer is continuing this product in PY2025 but will no longer offer any plans in part of the service area covered by the product in PY2024 and is crosswalking to a plan within a different product offered on the FFE. Select this reason for the portion of the service area where the issuer no longer offers any plans under that product. If the issuer selects this option, the PY2024 plan ID must be crosswalked to a PY2025 plan ID with a different product ID. ◆ Continuing product: no plan available in the particular service area under that product; no enrollment option: Select this option if the issuer is continuing a PY2024 product, but there is no plan under this product available to crosswalk to for this plan/service area combination. Do not enroll such plans into a plan offered off the Exchange. Selecting this option will disable the <i>2025 HIOS Plan ID</i> field. ◆ Continuing product: no silver plan available in the particular service area under that product; enrollment in a silver plan under a different product: Select this option if there is no available silver plan within the enrollee’s product in a particular service area and the enrollee is being enrolled in a silver plan within another product. ◆ Discontinuing product: enrollment into a different product: Select this option if this PY2024 product is discontinued for PY2025 and enrollees in this plan and the associated service area will be re-enrolled in a plan under a different product offered on the FFE. The entered PY2025 plan ID must have a different product ID, and the issuer may not enter the discontinued PY2024 product ID for any other row under the PY2025 plan ID. Crosswalk any discontinued PY2024 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if the issuer does not provide a crosswalk for a discontinued plan but still offers products in the same service areas, CMS will crosswalk the discontinued plan to another product the issuer offers under the same HIOS Issuer ID. ◆ Discontinuing product: no enrollment option: Select this option if a PY2024 product is discontinued for PY2025 and there is no enrollment option on the FFE for PY2024 enrollees in this plan ID/service area combination. Do not enroll pertinent

Table 2K-1. Crosswalk Level, Reason for Crosswalk, and PY2025 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2025 HIOS Plan ID
Crosswalking to same plan ID	Renewing exact same product/plan combination (auto-populated) (same PY2024 plan ID)	Template auto-populates field with PY2024 plan ID
Crosswalking at the plan ID level	Renewing exact same product/plan combination (different PY2025 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2024 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2024 plan ID
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product	Plan ID with different product ID from PY2025 plan ID
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2024 plan ID
Crosswalking at the plan ID and county coverage level	Renewing exact same product/plan combination (same PY2024 plan ID)	Template auto-populates field with PY2024 plan ID
	Renewing exact same product/plan combination. (different PY2025 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2024 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2024 plan ID
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product	Plan ID with different product ID from PY2025 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	<i>PY2025 HIOS Plan ID</i> field is disabled
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2024 plan ID
	Discontinuing product; no enrollment option	<i>PY2025 HIOS Plan ID</i> field is disabled
Crosswalking at the ZIP Code level for one or more counties	Renewing exact same product/plan combination (same PY2024 plan ID)	Template populates field with PY2024 plan ID
	Renewing exact same product/plan combination (different PY2025 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2024 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2024 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	<i>PY2025 HIOS Plan ID</i> field is disabled
	Continuing product; no silver plan available in the particular service area under that product; enrollment in a silver plan under a different product	Plan ID with different product ID from PY2025 plan ID
	Discontinuing product; no enrollment option	<i>PY2025 HIOS Plan ID</i> field is disabled

Crosswalk Level	Crosswalk Reason	2025 HIOS Plan ID
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2024 plan ID
Discontinue with no crosswalk	Discontinuing product; no enrollment option	PY2025 HIOS Plan ID field is disabled
	Continuing product; no plan available in the particular service area under that product; no enrollment option	PY2025 HIOS Plan ID field is disabled
Plan withdrawn prior to certification	Plan suppressed; no enrollment option	PY2025 HIOS Plan ID field is disabled

Once the Plan ID Crosswalk Template is completed, it must be validated, finalized, and uploaded to MPMS for further validation.

Template Validation	Steps
Validate Template	Click Validate on the <i>2025 Plan Crosswalk</i> tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize on the <i>2025 Plan Crosswalk</i> tab to create the .XML version of the template you will upload in MPMS.
Save Template	Save the .XML template. CMS recommends issuers save the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload Template	Upload the completed template to the Plan Validation Workspace in MPMS.

The issuer must submit their Plan ID Crosswalk Templates, justifications (if necessary), and state authorization via MPMS. Detailed instructions on how to use the Plan Validation Workspace, complete the sections of an application, and submit the application can be found in the [MPMS User Guide](#).

This concludes the Plan ID Crosswalk section of the QHP Application Instructions.

Section 2L: Accreditation

1. Introduction

In the Accreditation section of the Marketplace Plan Management System (MPMS), issuers enter information to satisfy the accreditation qualified health plan (QHP) certification requirement (Figure 2L-1). Issuers can provide information for an accredited product in the Commercial, Medicaid, or Exchange markets. These instructions apply only to those issuers that are filing via the Health Insurance Oversight System (HIOS) to issue a QHP on the Federally-facilitated Exchange (FFE).

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

- QHP

See Appendix D for additional information.

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

2. Data Requirements

To complete this section, the following are needed:

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

Figure 2L-1. Accreditation Application Section

Accreditation

Applicants must respond to all questions in order to complete this section.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333TX-2025-01	2025	10333 - TX - impl1a Testing Marketing Name	QHPs Only	Individual Only

[← Return to Application Overview](#)

Question 1

Authorization

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

☐ Yes

☐ No

Supporting and Justifications Documents

Add document

SaveSave and Next

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 QHP Application.

Tips for the Accreditation Section

- ◆ Only provide information on accredited products in the same state and for the same legal entity that submits the QHP Application.
- ◆ Provide accrediting entities with the legal issuer name and the HIOS Issuer ID used in the QHP Application to ensure the HIOS Issuer ID is included in the data file the accrediting entity provides to the Centers for Medicare & Medicaid Services (CMS).

Additional Resources

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

4. Detailed Section Instructions

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

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

Accreditation Responses	Steps
If the issuer responds Yes to the accreditation question, the issuer must select the accrediting entity.	Choose from the following. If the issuer is accredited by multiple entities, select all that apply: ◆ NCQA—if the issuer is accredited by NCQA. ◆ URAC—if the issuer is accredited by URAC. ◆ AAAHC—if the issuer is accredited by AAAHC.
Irrespective of whether the issuer responds Yes or No to the accreditation question, proceed to the Authorization.	All issuers must respond to the Terms and Conditions attestation regardless of whether they are accredited. Note: Issuers who are not accredited are strongly encouraged to schedule a review of their QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). Issuers do not need to be accredited in their initial year of QHP certification, but must be accredited 90 days before the first day of Open Enrollment when entering any subsequent year of QHP certification.

After responding to the above question, issuers must complete the Terms and Conditions attestation (Figure 2L-2), regardless of their response.

Figure 2L-2. Authorization for All Issuers

Accreditation

Applicants must respond to all questions in order to complete this section.

Application	Plan Year	Issuer	Product Offering	Market Coverage Type
10333TX-2025-01	2025	10333 - TX - Impl1a Testing Marketing Name	QHPs Only	Individual Only

[← Return to Application Overview](#)

Question 1

Authorization

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

☒ I agree to the terms and conditions.

Back

Save

Save and Complete

The issuer may upload copies of their accreditation certificates into MPMS along with their answer(s) to Question 1.

Accreditation Certificate	Steps
Scan Certificate	Scan each accreditation certificate (one per accredited market type). If the issuer is accredited by NCQA and does not have a copy of their accreditation certificate, use the NCQA Interactive Survey System (ISS) to get a copy of the survey results. Log into ISS, click on the <i>Results</i> tab, view the survey results, and print the results screen.
Name File	Save the accreditation certificate using the naming convention in Table C-1: [Issuer ID]_[Name of Accrediting entity] (e.g. 12345_NCQA.pdf)
Upload Certificate	Upload the saved files in the Accreditation section of MPMS. Refer to the MPMS User Guide for further instruction.

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

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

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

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

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

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

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

This concludes the Accreditation section of the QHP Application Instructions.

Section 2M: Transparency in Coverage

1. Introduction

This document provides instructions for qualified health plan (QHP) issuers submitting Transparency in Coverage data for PY2025.¹

Issuers submitting a QHP Application for PY2025 must make accurate and timely disclosures of transparency reporting information to the appropriate Exchange, the Secretary of HHS, and the state insurance commissioner, and make the information available to the public.^{2,3} These instructions apply to issuers applying for QHP certification in Federally-facilitated Exchanges (FFE) in PY2025, including issuers in FFEs where states perform plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs). This includes:

- On-Exchange medical QHPs
- On-Exchange stand-alone dental plans (SADPs)
- Off-Exchange-only SADPs seeking QHP certification
- Small Business Health Options Program (SHOP) QHPs.

Note: If the issuer is in a State-based Exchange (SBE) state that is not on the federal platform, they are not required to submit Transparency in Coverage data at this time.

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

- QHP
- SADP

See Appendix D for additional information.

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

2. Data Requirements

To complete this section, the following are needed:

- Information on whether the issuer was on the Exchange in 2023
- Health Insurance Oversight System (HIOS) Issuer IDs and all PY2025 plan IDs
- Number of PY2023 claims received, denied, and resubmitted
- Number of PY2023 internal and external appeals
- Claims Payment Policy and Other Information URL ("Transparency in Coverage URL").

To apply for PY2025 QHP certification, except in an SBE state not on the federal platform, the issuer must submit a Transparency in Coverage Template that includes all on-Exchange PY2025 plan IDs. The QHP Application cannot be submitted without this template. However, only certain on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2023, through

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

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

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

December 31, 2023. Off-Exchange SADP issuers and on-Exchange issuers not on the Exchange in PY2023 should complete the template indicating reporting requirements are not applicable. See for more information.

- The Transparency in Coverage Template must include all on-Exchange PY2025 plan IDs and a separate Transparency in Coverage Template must be submitted for each unique HIOS Issuer ID. Only report claims data for plan IDs that were offered on the Exchange in PY2023 and will be offered on Exchange again in PY2025. Claims for plan IDs that were offered on the Exchange in PY2023 but will no longer be offered on the Exchange in PY2025 must be included within the total claims counts on the *Issuer Level* tab of the template. If a PY2025 plan ID was not offered on the Exchange in PY2023, but will be offered on the Exchange in PY2025, include it in the *Plan Level* tab of the template but indicate that PY2023 claims data is not applicable for that plan ID by entering “N/A” in the relevant fields. See for a summary of Transparency in Coverage reporting requirements.

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

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

Plan Type	Transparency in Coverage Template Required?	Transparency in Coverage Claims Data Required?	Transparency in Coverage URL Required?
On-Exchange QHP that was offered in PY2023	Yes	Yes. Do not include or count claims data for off-Exchange QHP enrollment.	Yes
On-Exchange SADP that was offered in PY2023	Yes	Yes. Do not include claims data for off-Exchange SADP enrollment.	Yes
Off-Exchange SADP that was offered in PY2023	Yes	No. Do not include claims data associated with any off-Exchange plans or plan IDs.	No
On-Exchange QHP that was <u>not</u> offered in PY2023	Yes	No. Note as N/A in the template.	Yes
On-Exchange SADP that was <u>not</u> offered in PY2023	Yes	No. Note as N/A in the template.	Yes

3. Quick Reference

Key Changes for 2025
◆ No changes for the 2025 QHP Application.

Tips for the Transparency Section

- ◆ Issuers applying to offer on-Exchange plans for PY2025 that did not offer on-Exchange plans in PY2023 must still submit a Transparency in Coverage Template.
- ◆ Issuer level data for returning issuers must be non-numeric for in- and out-of-network claims received and denied but can be zero for issuer level in- and out-of-network claims appealed and resubmitted.
- ◆ Do not include off-Exchange-only plans in the *Plan Level* tab of the Transparency in Coverage Template.
- ◆ Required data elements are identified by an asterisk (*) next to the field name.
- ◆ Complete a separate template for each unique HIOS Issuer ID.
- ◆ Use only the tabs provided in the Transparency in Coverage Template. Do not add additional tabs, rows, or columns.
- ◆ Enter all on-Exchange plan level data in the *Plan Level Data* tab. One plan ID should be captured in each row. Each plan ID listed should be a distinct 14-character ID.
- ◆ Check the templates for completeness and data validity before submitting by clicking Validate on the *Issuer Level Data* tab.
- ◆ For issuers that submit via the System for Electronic Rates & Forms Filing (SERFF), one identical Transparency in Coverage Template containing all plan IDs should be submitted in each submission binder. For example, if an issuer submits an Individual Market binder and a SHOP Market binder, both the Individual Market plan IDs and the SHOP Market plan IDs should be included in one Transparency in Coverage Template and submitted in each binder. Note that this is different from the process used for other templates submitted as part of the QHP Application and certification process, wherein each binder should include a unique template.

Additional Resources

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

4. Detailed Section Instructions

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

Note for issuers that submit via SERFF: Issuers should complete only one Transparency in Coverage Template containing all necessary information and submit that template in all SERFF binders. The Centers for Medicare & Medicaid Services (CMS) will only process the most recent Transparency in Coverage Template transferred by the state, and all other Transparency in Coverage Template data or versions will be overwritten. Include the same Transparency in Coverage Template across all SERFF binders. For example, if an issuer has an Individual Market SERFF binder with 3 on-Exchange plan IDs and a SHOP Market SERFF binder with 7 on-Exchange plan IDs, they should submit an identical Transparency in Coverage Template that contains all 10 on-Exchange plan IDs in both SERFF binders.

4.1 Defining and Reporting a Claim

For all claims data fields on the *Issuer Level* and *Plan Level* tabs, the following definitions apply:

- A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims).
- An In-Network provider is any provider, such as a hospital, physician, or pharmacy, that is contracted to be part of the issuer's network (such as a health maintenance organization [HMO] or preferred provider organization [PPO]).
- An Out-of-Network provider is any provider, such as a hospital, physician, or pharmacy, that is not contracted to be part of your network (such as an HMO or PPO).

Additionally, when calculating claim counts:

- Include those for all QHPs that fall under the reporting HIOS Issuer ID. Submit a separate template for each HIOS Issuer ID, if applicable.
- When reporting claims, calculate claim counts by dates of service (DOS) and report claims data with a single numerical value.
- Include pediatric vision claims and pediatric dental claims.

4.2 Issuer Level Data Tab

Figure 2M-1. Transparency in Coverage Template

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

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

Plan Year 2025 v5.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2023?*	
SADP Only?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2023 That Were Also Received in Calendar Year 2023*	
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2023*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2023 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2023*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2023 Appeals*	
Notes:	
Please enter any comments/notes here.	

The values submitted on the *Issuer Level* tab must include claims for all QHPs in 2023, including QHPs not returning to the Exchange in 2025. Therefore, the sum of plan level claims values reported elsewhere in the template may be less than the issuer level claims values reported.

If the issuer was not on the Exchange in 2023 or will offer only off-Exchange SADPs for 2025, please mark **N/A** for all claims data fields.

General Information	Steps
Was this issuer on the Exchange in 2023?*	Enter Yes or No to indicate whether or not this issuer was on the Exchange in 2023. ♦ If Yes , the issuer must fill out claims and appeals data. ♦ If No , the issuer must enter N/A in the claims and appeals data fields. ♦ If the issuer offers only off-Exchange SADPs, enter No .
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID. Submit a separate template for each HIOS Issuer ID, if applicable.
SADP Only?*	Select Yes or No from the drop-down menu to indicate whether the issuer offers only SADPs.

Issuer Level Data	Steps
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider. ◆ <u>Claims that were pending or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial, and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. <u>Do not include out-of-network claims.</u>
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider that you subsequently denied. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2023, including: ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. <u>Do not include out-of-network claims.</u>
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims resubmissions received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider. ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim</u>. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ <u>Regardless of who initiates the resubmission</u>—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim.

Issuer Level Data	Steps
	◆ <u>Duplicate claims do not count as resubmitted claims, assuming the duplicates are denied for being repetitious of a previously received claim that has been, or is in the process of being, adjudicated.</u> <u>Do not include out-of-network claims.</u>
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider. ◆ <u>Claims that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial, and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. <u>Do not include in-network claims.</u>
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider that the issuer subsequently denied. ◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2023, including: ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. <u>Do not include in-network claims.</u>
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	Enter the number of <u>issuer level</u> claims resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider. ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied).

Issuer Level Data	Steps
	◆ <u>Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim.</u> ◆ <u>Duplicate claims do not count as resubmitted claims</u>, assuming the duplicates are denied for being repetitious of a previously received claim that has been, or is in the process of being, adjudicated. <u>Do not include in-network claims.</u>
Number of Issuer Level Internal Appeals Filed in Calendar Year 2023*	Enter the number of requests for internal appeals involving adverse determinations the issuer received from or on behalf of consumers pursuant to 45 <i>Code of Federal Regulations</i> (CFR) 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage. Include appeals regarding services with DOS in 2023 that the issuer received, fully adjudicated, and completed in 2023. Do not include appeals that were subsequently withdrawn. CMS expects the number of issuer level internal appeals reported here to be less than the sum of the <i>Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023</i> and the <i>Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023</i> .
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2023 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for internal review, <u>in whole or in part</u> , pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment, or a rescission of coverage.
Number of Issuer Level External Appeals Filed in Calendar Year 2023*	Enter the number of requests for external appeals of final adverse determinations sent by or on behalf of consumers to an external review organization pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals regarding services with DOS in 2023 that the issuer received, fully adjudicated, and completed in 2023. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2023 Appeals*	Enter the number of final determinations adverse to consumers that were overturned on request for external review, <u>in whole or in part</u> , pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

4.3 Plan Level Data Tab

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

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting														
Plan Year 2025														
Plan ID	Number of Plan Level In-Network Claims with Denial of Service (DOS) in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023

Issuers must include all on-Exchange plan IDs that are present in their PY2025 QHP Application in the Transparency in Coverage Template. If a plan is off-Exchange or did not exist in PY2023, enter **N/A** in all Plan Level data fields. All other on-Exchange plans (including SADPs, except for SADPs offered by SADP-only issuers when reporting the *Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2023*) must enter a numerical value in all fields; 0 is acceptable.

Note: Report all reasons a claim is denied. A claim can be denied for more than one reason. Therefore, the sum of the reasons why claims were denied may either be equal to or greater than the sum of the *Number of In-Network Plan Level Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023* and *Number of Out-of-Network Plan Level Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*.

PY2025 Plan Data	Steps
2025 On-Exchange Plan ID*	Enter the 14-character PY2025 on-Exchange plan ID on the <i>Plan Level Data</i> tab. The plan ID is composed of the five-digit HIOS Issuer ID, the two-character state abbreviation, and the seven unique digits for the plan (e.g., 12345AZ1234567). If there is more than one PY2025 plan ID to report for a single HIOS Issuer ID, add each plan line by line in the <i>Plan Level Data</i> tab. All plan variants should be rolled up to one plan ID or line in the template. For example: - Reported claims for 12345AZ1234567 would include claims that fall under this plan ID from members on all associated plan variants: 12345AZ1234567-01: 100 claims 12345AZ1234567-02: 500 claim 12345AZ1234567-03: 200 claims 12345AZ1234567-04: 50 claims. Reporting for plan ID 12345AZ1234567 should be entered as <u>one</u> plan ID in <u>one</u> row of the template with a total of 850 claims (100 + 500 + 200 + 50) for the applicable data field.
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	Enter the number of <u>plan level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider. - Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 4 should only be counted once. For example, the following each count as one claim: - An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. - An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2025. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023 ⁴	Enter the number of <u>plan level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider that the issuer subsequently denied.

⁴ For example, if one of an issuer's plans were to receive 20,000 claims and deny 3,000 of those claims, the issuer would further report the reasons for the 3,000 denials in one or more of 10 denial categories:

1. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2023
2. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2023
3. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2023
4. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2023
5. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2023
6. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2023
7. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2023
8. Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2023

PY2025 Plan Data	Steps
(Plan Level Claims Denied)*	◆ <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2023, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. <u>Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the sum of the Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023 and the Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023 because individual claims may be denied for more than one reason.</u>
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	Enter the number of <u>plan level</u> claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an <u>in-network</u> health care provider. ◆ Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ <u>Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim.</u> ◆ <u>Duplicate claims do not count as resubmitted claims, assuming the duplicates are denied for being repetitious of a previously received claim that has been, or is in the process of being, adjudicated.</u> The total issuer level claims received data may include plans not offered in 2025. Therefore, the plan level claims total may not total the issuer level claims.

9. Number of Plan Level Claims with DOS in 2023 That Were Also Denied for Administrative Reasons in Calendar Year 2023

10. Number of Plan Level Claims with DOS in 2023 That Were Also Denied for “Other” Reasons in Calendar Year 2023.

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

PY2025 Plan Data	Steps
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	Enter the number of <u>plan level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider. Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 4 should only be counted once. For example, the following each count as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2025. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023 (Plan Level Claims Denied)*	Enter the number of <u>plan level</u> claims the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider that the issuer subsequently denied. <u>Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim:</u> ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2023, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. <u>Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the <i>Number of Plan Level Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023</i> because individual claims may be denied for more than one reason.</u>
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	Enter the number of <u>plan level</u> claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an <u>out-of-network</u> health care provider. Any claim that is <u>resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim.</u> This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied).

PY2025 Plan Data	Steps
	◆ <u>Regardless of who initiates the resubmission</u>—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ <u>Duplicate claims do not count as resubmitted claims</u>, assuming the duplicates are denied for being repetitious of a previously received claim that has been, or is in the process of being, adjudicated. The total issuer level claims resubmitted data may include plans not offered in 2025. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2023 (Plan Level Claims Denied)*	<u>Note: The following claim denial reporting instructions for columns H, I, J, K, L, M, N, O, P, & Q of the <i>Plan Level</i> tab are different from the instructions for claim denial reporting on the <i>Issuer Level</i> tab and columns C & F of the <i>Plan Level</i> tab. Rather than reporting denied claims based on their final adjudication, report each incidence of the following denials that occur throughout the life of a claim.</u> For example: ◆ For the <i>Issuer Level</i> tab and columns C & F of the <i>Plan Level</i> tab: ▪ If a claim is denied for any reason, then resubmitted and denied again without further resubmission, it will count as one denied claim. ◆ For columns H, I, J, K, L, M, N, O, P, & Q: ▪ If a claim is denied for lacking a prior authorization and being an excluded service, then resubmitted and denied again for lacking a prior authorization and being an excluded service, it will count twice in column H (<i>Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2023</i>) and twice in column J (<i>Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2023</i>). Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for non-emergency-related claims for service that required prior authorization, preauthorization, referral, prior approval, or precertification, from when a claim was first received to its final adjudication. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied. ◆ Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied for requiring a prior authorization, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for requiring a prior authorization, resubmitted with the required documentation, and paid, it will count as one denial in this category. <u>Do not include out-of-network claims.</u>

PY2025 Plan Data	Steps
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>plan level</u> denials the issuer issued for claims for service from outside the plan's network of health care providers if the plan has a closed network, from when a claim was first received to its final adjudication. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for point of service benefits provided by someone (e.g., health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plan's (HMO or closed network plans) network. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied for services from an out-of-network provider, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for services from an out-of-network provider, resubmitted with updated documentation, and paid, it will count as one denial in this category. ◆ <u>Do not include in-network claims.</u>
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims for excluded or non-covered services. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because certain services, tests, treatments, admissions, supplies, etc., are excluded, not covered, or limited under the plan, including claims denied because a drug is not on the formulary. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied as an excluded service, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied as an excluded service, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health, in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these. Include the following denials for lack of medical necessity (individual claim line of service item): ◆ Payment for services related to medical surgical diagnosis, including medical and pharmacy point of sales. ◆ Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: ▪ Analgesics ▪ Anesthetics ▪ Antibacterials ▪ Anticonvulsants ▪ Antidementia Agents ▪ Antiemetics ▪ Antifungals ▪ Antigout ▪ Antimigraine Agents ▪ Antimyasthenic Agents ▪ Antimycobacterials ▪ Antineoplastics ▪ Antiparasitics

PY2025 Plan Data	Steps
	▪ Antiparkinson Agents ▪ Antipasticity Agents ▪ Antivirals ▪ Blood Glucose Regulators ▪ Blood Products and Modifiers ▪ Cardiovascular Agents ▪ Central Nervous System Agents ▪ Dental and Oral Agents ▪ Dermatological Agents ▪ Electrolytes/Minerals/Metals/Vitamins ▪ Gastrointestinal Agents ▪ Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment ▪ Genitourinary Agents ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) ▪ Hormonal Agents, Suppressant (Adrenal) ▪ Hormonal Agents, Suppressant (Pituitary) ▪ Hormonal Agents, Suppressant (Thyroid) ▪ Immunological Agents ▪ Inflammatory Bowel Disease Agents ▪ Metabolic Bone Disease Agents ▪ Ophthalmic Agents ▪ Otic Agents ▪ Respiratory Tract/Pulmonary Agents ▪ Skeletal Muscle Relaxants ▪ Sleep Disorder Agents. Do not include the following claims: ◆ Behavioral or mental health claims or payment for services. ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied because it lacks medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because it lacks medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category.

PY2025 Plan Data	Steps
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat illness, injury, condition disease, or the symptoms of these related to behavioral or mental health, from when a claim was first received to its final adjudication. <u>If a plan is off-Exchange, an SADP offered by an issuer offering only SADPs, and/or a plan that did not exist in PY2023, enter N/A. All other on-Exchange plans, including SADPs offered by an issuer offering both SADPs and QHPs, must enter a numerical value in this field; 0 is acceptable.</u> ◆ Issuers should include the following claims denials for lack of medical necessity (individual claim line of service items): Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health. ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the DSM and the ICD. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD as well as federal or state guidelines. ◆ Issuers should use the following USP drug categories to count pharmacy claims including behavioral health: ▪ Anti-addiction/Substance Abuse Treatment Agents ▪ Antidepressants ▪ Antipsychotics ▪ Anxiolytics ▪ Bipolar Agents. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied because it lacks medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because it lacks medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category. Do not include payment for services related to medical surgical diagnosis, including medical and pharmacy point of sales.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims denied due to the beneficiary reaching their benefit limit. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because a beneficiary has reached or exceeded the benefit limit for their plan. This item refers to any annual limit on benefits (including monetary limits, cost maximums, quantity limits, visit limits, etc.). ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied because the beneficiary reached their benefit limit, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because the beneficiary reached their benefit limit, resubmitted with updated documentation, and paid, it will count as one denial in this category.

PY2025 Plan Data	Steps
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims denied due to beneficiary enrollment status. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because of the beneficiary's enrollment status. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied because of beneficiary enrollment status, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because of beneficiary enrollment status, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims denied because the procedure was investigational, cosmetic, or experimental. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because the procedure for which the claim is submitted is considered investigational, cosmetic, or experimental. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied because the relevant procedure was investigational, experimental, or cosmetic, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied because the relevant procedure was investigational, experimental, or cosmetic, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied for Administrative Reasons in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> claims the issuer denied for administrative reasons. Issuers should include the following claims (individual claim line of service items): ▪ Duplicate Claim ▪ Missing/Insufficient Information ▪ Untimely Claim Filing ▪ Billing Provider Not Approved ▪ Coordination of Benefit ▪ Inconsistent Procedure Code/Diagnosis ▪ Workers Comp/Liability Issue ▪ Paid by Auto or Other Insurance ▪ Unable to identify patient. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> For example: ▪ If a claim is denied for administrative reasons, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied for administrative reasons, resubmitted with updated documentation, and paid, it will count as one denial in this category.
Number of Plan Level Claims with DOS in 2023 That Were Also Denied for "Other" Reasons in Calendar Year 2023 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of <u>in-network plan level</u> denials the issuer issued for claims rejected for reasons other than those specified in the above categories, from when a claim was first received to its final adjudication. ◆ <u>Include all instances of this type of denial throughout the life of a claim in the total reported for this column.</u> <u>Do not include out-of-network claims.</u>

Verify the following before submitting the PY2025 Transparency in Coverage Template:

- The number of issuer level In-Network Claims Received reported on the *Issuer Level* tab is greater than or equal to the sum of in-network claims received across all plan IDs on the *Plan Level* tab.
- The number of issuer level In-Network Claims Denied reported on the *Issuer Level* tab is greater than or equal to the sum of in-network claims denied reported across all plan IDs on the *Plan Level* tab.
- The number of issuer level In-Network Claims Resubmitted reported on the *Issuer Level* tab is greater than or equal to the sum of in-network claims resubmitted across all plan IDs on the *Plan Level* tab.
- The number of issuer level Out-of-Network Claims Received reported on the *Issuer Level* tab is greater than or equal to the sum of out-of-network claims received across all plan IDs on the *Plan Level* tab.
- The number of issuer level Out-of-Network Claims Denied reported on the *Issuer Level* tab is greater than or equal to the sum of out-of-network claims denied reported across all plan IDs on the *Plan Level* tab.
- The number of issuer level Out-of-Network Claims Resubmitted reported on the *Issuer Level* tab is greater than or equal to the sum of out-of-network claims resubmitted across all plan IDs on the *Plan Level* tab.
- The sum of issuer level In-Network and Out-of-Network Claims Denied reported on the *Issuer Level* tab is greater than or equal to the number of “Issuer Level Internal Appeals Filed” in calendar year 2023.
- The sum of plan level reasons for denied claims (columns H, I, J, K, L, M, N, O, P, & Q) is greater than or equal to the sum of reported in-network and out-of-network claims denied (columns C & F) for each plan ID.

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

To apply for PY2025 QHP certification, the issuer must submit a Transparency in Coverage Template that includes all the issuer’s on-Exchange PY2025 plan IDs. The QHP Application cannot be submitted without this template. However, the following issuers are not required to submit Transparency in Coverage data as described in 4.2 Issuer Level Data Tab and 4.3 Plan Level Data Tab:

- Issuers with no PY2023 on-Exchange plans
- Off-exchange certified SADPs.

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

This section describes how to submit the Transparency in Coverage Template without reporting numerical transparency data. Issuers must submit their **HIOS Issuer ID** in the *Issuer Level Data* tab () and all PY2025 plan IDs in the *Plan Level Data* tab (). **N/A** must be entered in all other data fields as indicated below.

4.4.1 Issuers With No Data Reporting Requirement—Issuer Level Data Tab

General Information	Expected Value
Was this issuer on the Exchange in 2023?*	No
Issuer HIOS ID*	Enter the five-digit HIOS Issuer ID.

Issuer Level Data	Expected Value
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	N/A

Issuer Level Data	Expected Value
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2023*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2023 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2023*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2023 Appeals*	N/A

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

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

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2025 v5.0	
Validate	
Finalize	
General Information	
Was this Issuer on the Exchange in 2023?*	No
SADP Only?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	N/A
Number of Issuer Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2023*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2023 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2023*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2023 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	N/A

4.4.2 Issuers With No Reporting Requirement—Plan Level Data Tab

Plan Level Data	Expected Value
2025 On-Exchange Plan ID*	Enter the 14-character PY2025 plan ID on the <i>Plan Level Data</i> tab. The issuer must include all on-Exchange plan IDs present in its QHP Application (do not include plan IDs for off-Exchange-only plans) on the <i>Plan Level Data</i> tab.
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023* (Plan Level Claims Denied)	N/A

Plan Level Data	Expected Value
Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health in Calendar Year 2023</u> (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health only, in Calendar Year 2023</u> (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2023 (Plan Level Claims Denied)*	N/A
Number of Plan Level Claims with DOS in 2023 That Were Also Denied for Administrative Reasons in Calendar Year 2023 (Plan Level Claims Denied)*	N/A

Plan Level Data	Expected Value
Number of Plan Level Claims with DOS in 2023 That Were Also Denied for “Other” Reasons in Calendar Year 2023 (Plan Level Claims Denied)*	N/A

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

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

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting															
Plan Year 2025															
Plan Level Data															
Plan ID	Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023	Number of Plan Level In-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Received in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Denied in Calendar Year 2023	Number of Plan Level Out-of-Network Claims with DOS in 2023 That Were Also Resubmitted in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, <i>and/or</i> Behavioral Health <i>and/or</i> in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health <i>and/or</i> in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2023	Number of Plan Level Claims with DOS in 2023 That Were Also Denied for "Other" Reasons in Calendar Year 2023	Notes (Please enter any comments/notes here)
Plan ID															

After you have entered all data, click **Save** to ensure no data are lost. Once the Transparency in Coverage Template is completed, it must be validated, finalized, and uploaded into the Marketplace Plan Management System (MPMS).

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the <i>Issuer Level Data</i> tab of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved.
Finalize Template	Click Finalize in the top left of the <i>Issuer Level Data</i> tab of the template to create the .XML file of the template that will need to be uploaded in the Plan Validation Workspace in MPMS. Issuers that submit via SERFF will upload their Transparency in Coverage Template in their SERFF binders.
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, link the validated template to the application and complete submission of your Transparency in Coverage URL. Issuers that submit via SERFF will submit the Transparency in Coverage Template in their SERFF binders and the Transparency in Coverage URL in MPMS. Refer to the MPMS User Guide for details on how to complete these steps.

5. Claims Payment Policy and Other Information URL

Issuers applying for PY2025 QHP certification, including issuers offering off-Exchange SADPs, must submit a Transparency in Coverage URL in MPMS (). Although SERFF issuers will submit their Transparency in Coverage Template in SERFF, the Transparency in Coverage URL must be submitted in MPMS.

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

Transparency in Coverage

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

[Return to Application Overview](#)

✓ Transparency in Coverage

Please upload your completed Transparency in Coverage document.

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

Transparency in Coverage URL:

https://Transparency@test.com

Documents Attached

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

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

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

Although a URL submission is required to apply for PY2025 QHP certification, issuers are required to submit an active URL that directs to a compliant claims payment policy website only if they offer on-Exchange QHPs and SADPs.

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

The information below provides an overview of the information the issuer must include on the Transparency in Coverage URL's web page and examples of how it might be explained.

PY2025 URL Contents	Minimum Requirements
Claims Payment Policies & Other Information URL	Enter the active and easily accessible URL. Ensure it meets the following requirements: - It can be viewed and accessed <u>directly</u> from the plan's public website via a clearly identifiable link or tab on the issuer's home or marketplace plan landing page without requiring an individual to create or access an account or enter a policy number - An individual can easily discern which information applies to each plan the issuer offers. The URL is the web address on the issuer website that directs consumers to the page on the issuer's website they can use to view pertinent information about the issuer's practices. All URLs should be live and compliant when they are submitted, with one URL for a landing page or a single page with one or more links providing the information indicated below. If the issuer has unique HIOS Issuer IDs in the same state and the Transparency in Coverage information is the same across the HIOS Issuer IDs, the same URL may be submitted for all HIOS Issuer IDs. Note: If the URL or website content refers to the plan year, it should refer to the plan year of the current application submission, not the plan year of the claims data.

PY2025 URL Contents	Minimum Requirements
Out-of-network liability and balance billing	Description: ◆ Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or the amount remaining on a deductible. Provide: ◆ Information regarding whether a consumer may have financial liability for out-of-network services. ◆ Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act. ◆ Information regarding whether a consumer may be balance billed. Specific dollar amounts for out-of-network liability or balance billing do not need to be included. <u>Example of Acceptable Consumer-Facing Language:</u> Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.
Enrollee claim submission	Description: ◆ An enrollee submits a claim instead of the provider, requesting payment for services received. Provide: ◆ General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, indicate this here. ◆ A time limit to submit a claim, if applicable. If there is no time limit imposed for claim submission, specify that there is no time limit to submit a claim. If the issuer's time limits vary by state, list out the states and their corresponding time limits. ◆ Links to any applicable forms. All forms must be easily identifiable and publicly accessible. ◆ Describe how an enrollee can submit a claim if you do not require any forms. List any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission. ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. <u>Example of Acceptable Consumer-Facing Language:</u> A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. There are time limits on how long you have to submit claims, with details on the limit by state below. You can also check your specific plan's claims filing time limit information to determine the specific time limit for submitting your claim. Enrollee medical claim submission and claim filing time limit information: <u>State (Maximum Claim Filing Time Limit)</u> VT, NH, CT (90 Days) CA (90 Days) WA (180 Days) To file a claim, follow these steps: 1. Complete a <u>claim form</u> [Include link to Claim Form]. 2. Attach an itemized bill from the provider for the covered service. 3. Make a copy for your records. 4. Mail your claim to the address below. [Company Name] [P.O Box 1234]

PY2025 URL Contents	Minimum Requirements
	[City, State, ZIP Code] 5. Alternatively, you can send the information by email to claims-submissions@companyname.com or by fax to [123-456-7890].
Grace periods and claims pending	Description: ◆ QHP issuers must provide a grace period of 3 consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least 1 full month's premium during the benefit year. During the grace period, the issuer must provide an explanation of the 90-day grace period for enrollees with premium tax credits, pursuant to 45 CFR 156.270(d). Provide: ◆ An explanation of what a grace period is. ◆ An explanation of what claims pending is. ◆ An explanation that the issuer will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. <u>Example of Acceptable Consumer-Facing Language:</u> You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in [state], we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period. If you are enrolled in an individual health care plan offered on the <i>Health Insurance Marketplace</i> and you receive an advance premium tax credit, you will get a 3-month grace period and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.
Retroactive denials	Description: ◆ A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment. Provide: ◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable. ◆ Ways to prevent retroactive denials when possible, such as paying premiums on time. <u>Example of Acceptable Consumer-Facing Language:</u> A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible. You can avoid retroactive denials by paying your premiums on time and in full and making sure you talk to your provider about whether the service performed is a covered benefit.

PY2025 URL Contents	Minimum Requirements
	You can also avoid retroactive denials by obtaining your medical services from an in-network provider.
Recoupment of overpayments	Description: ◆ If the issuer overbills an enrollee for a premium, the enrollee may use recoupment of overpayments to obtain a refund. Provide: ◆ Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact. <u>Example of Acceptable Consumer-Facing Language:</u> If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.
Medical necessity and prior authorization timeframes and enrollee responsibilities	Description: ◆ Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. ◆ Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit. Provide: ◆ An explanation that some services may require prior authorization and may be subject to review for medical necessity. ◆ Any ramifications should the enrollee not follow proper prior authorization procedures. ◆ A timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable. <u>Example of Acceptable Consumer-Facing Language:</u> We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests.
Drug exception timeframes and enrollee responsibilities (not required for SADPs)	Description: ◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c). Provide: ◆ An explanation of the internal exceptions process for people to obtain non-formulary drugs. ◆ An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or independent review organization (IRO). ◆ Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. ◆ Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact. <u>Example of Acceptable Consumer-Facing Language:</u> Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form [link provided here]. If the drug is denied, you have the right to an external review.

PY2025 URL Contents	Minimum Requirements
	If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). We must follow the IRO's decision. An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request: [Request Form Link] [Address] [Phone] [Fax]. For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request. For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request. For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request. For external review of expedited exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.
Explanation of benefits (EOB)	Description: ◆ An EOB is a statement the issuer sends an enrollee that lists the medical treatments or services the issuer paid for on an enrollee's behalf, what the issuer paid, and the enrollee's financial responsibility pursuant to the terms of the policy. Provide: ◆ An explanation of what an EOB is. ◆ Information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. <u>Example of Acceptable Consumer-Facing Language:</u> Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.
Coordination of benefits (COB)	Description: ◆ COB allows an enrollee who is covered by more than one plan to determine which plan pays first. Provide: ◆ An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). <u>Example of Acceptable Consumer-Facing Language:</u> Coordination of benefits (COB) is required when you are covered under one or more additional group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about COB can be found in your benefit booklet.

Once the Transparency in Coverage URL is entered, click the "Save" button to ensure no data are lost.

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

Section 2N: Rates Table

1. Introduction

In the Rates Table section of the Marketplace Plan Management System (MPMS), issuers enter rate information for each plan they offer in a Rating Area. If the issuer offers both medical and dental plans and submits their Qualified Health Plan (QHP) Application in the Health Insurance Oversight System (HIOS), a single Rates Table Template must be submitted that contains rate data for all its plans (QHPs and stand-alone dental plans [SADPs]).

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

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2025

- ◆ There are no key changes to the 2025 Rates Table Template.

Tips for the Rates Table Section

- ◆ Use separate worksheets in the Rates Table Template for medical plans and dental plans.
- ◆ Use separate worksheets for Individual Market plans and Small Business Health Options Program (SHOP) plans.
- ◆ For Individual Market plans, the rate effective date must be January 1, 2025.
- ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet is bound to a separate effective date range. If the issuer submits SHOP trended quarterly rates, a separate worksheet must be submitted for each date range that a set of rates will be effective.
- ◆ If the issuer submits in HIOS, a single Rates Table Template that contains rate data for all the issuer's plans (QHPs and SADPs) must be submitted in MPMS. If the issuer submits via the System for Electronic Rates & Forms Filing (SERFF), this requirement does not apply.

Additional Resources

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

4. Detailed Section Instructions

Complete the Rates Table Template using the steps outlined below to provide rate information. All required fields must be completed to validate the template.

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID .
Rate Effective Date	Enter the rate effective date as mm/dd/yyyy . For Individual Market plans, the rate effective date must be 01/01/2025 .

Rates Table Template	Steps
	◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet in the Rates Table Template is bound to a separate effective date range. If the issuer submits SHOP trended quarterly rates, a separate worksheet must be submitted for each date range that a set of rates will be effective. ◆ If the issuer submits a SHOP quarterly rate change, they must submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable data change submission window. The issuer may submit rate changes that would apply for the next quarter or any subsequent quarter in the remaining plan year. The issuer must not change or delete rates from the template for any current or previous quarter during the data change window. For example, during the submission for updated second-quarter SHOP rates, the first-quarter rates must match the original submission that contained the rates offered during the first quarter. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding Unified Rate Review Template (URRT).
Rate Expiration Date	Enter the rate expiration date as mm/dd/yyyy. ◆ For Individual Market plans, the rate expiration date must be 12/31/2025. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (03/31/2025, 06/30/2025, 09/30/2025, and 12/31/2025).
Rating Method	Select whether the plans on the worksheet use Age-Based Rates or Family-Tier Rates. Note: Only issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers or issuers entering rates for SADPs are eligible to select Family-Tier Rates. A list of states that use family-tier rating is available on the State Specific Rating Variations page.
Add Sheets	Click Add Sheet to add additional worksheets for the following: ◆ To separate SHOP plans with different rate effective and expiration dates. All plans on a single worksheet <u>must</u> have the same rate effective and rate expiration dates. ◆ To separate Individual Market plans and SHOP plans. ◆ To separate medical plans and dental plans. ◆ To separate plans that use age-based rating and family-tier rating. ◆ To separate by rating area.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (e.g., 12345AZ1234567) that identifies the plan associated with the rates in that row.
Rating Area	Select the rating area from the list. The rating area is the geographic area where the rates in the row are valid. Rating areas are defined by each state. A list of rating areas for each state is available on the State Specific Geographic Rating Areas page. If a set of rates is allowed to be offered in more than one rating area, issuers can elect to assign the set of rates to multiple rating areas within a template worksheet.
Tobacco	If the issuer uses age-based rates, select from the following to indicate whether rates vary based on tobacco use: ◆ Tobacco User/Non-Tobacco User—if rates differ for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require QHP tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.¹ QHPs rating by tobacco use may not apply tobacco rating to individuals age 0–20, for whom the sale and use of tobacco products is prohibited under federal law. For each underage tobacco age band (0–14, 15, 16, 17, 18, 19, and 20), enter the same rate values under <i>Individual (non-tobacco) Rate</i> and <i>Individual Tobacco Rate</i>. This entry will prevent application of unique tobacco rating to an underage enrollee.

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

Rates Table Template	Steps
	To offer small-group market medical plans (including SHOP QHPs) with tobacco rating, the issuer must offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the Public Health Service (PHS) Act and indicate the wellness program on your Plans & Benefits Template. If the issuer does not offer such a wellness program, the small-group market medical plan cannot rate for tobacco use. ◆ No Preference—if the rate applies to tobacco and non-tobacco users. No separate rates are submitted for tobacco and non-tobacco users.
Age	If the issuer uses age-based rates, the template will automatically generate a row for each age band from 0–14 through 64 and over. ◆ If the issuer elects to rate by tobacco use and enters the non-tobacco rates first for the underage age bands of 0–14 through 20, the worksheet will auto-populate the tobacco rate for each band with the non-tobacco rate. ◆ If the issuer is in a state that does not permit rating for age or tobacco use and that establishes uniform family tiers (and corresponding multipliers) or is entering rates for an SADP using Family-Tier Rates as the rating method, skip to Family Tier.
Individual Rate	◆ Enter the individual rate that applies to the plan ID. Market rules limit individual rate variation based on age to not more than three times the 21-age rate. In addition, QHPs may not have a 0–20 age rate higher than the 21-age rate and must follow the federal age-rating curve or your state's age-rating curve if it is within the 1:3 market rule. A list of states using state-specific age curve variations is available on the State Specific Rating Variations page. Note: QHPs and SADPs must enter a value above \$0.00 for all age bands under the Individual Rate column unless you responded Allows Child-Only under <i>Child-only Offering</i> in the Plans & Benefits Template. QHP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19, and 20 age bands and are allowed to enter a value of \$0.00 for adult age bands 21 through 64 and over. SADP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, and 18 age bands and are allowed to enter a value of \$0.00 for adult age bands 19 through 64 and over. ◆ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under <i>Individual Tobacco Rate</i> for age bands 21 through 64 and over. For the 0 through 20 age bands, QHPs must enter the same value as the non-tobacco rate under <i>Individual Tobacco Rate</i> to avoid applying tobacco rating to underage enrollees. For QHPs, tobacco rating cannot be applied to individuals age 0–20, for whom the sale and use of tobacco products is prohibited under federal law.
Family Tier	If the issuer's state does not permit rating for age or tobacco use and has established uniform family tiers and corresponding multipliers, or if the issuer is issuing SADPs and selected Family-Tier Rates in <i>Rating Method</i>, enter the individual rate in <i>Individual Rate</i>. Selecting Family-Tier Rates will also generate the following family tier columns: ◆ <i>Individual Rate</i> (required): Enter the rate of an individual primary subscriber. ◆ <i>Couple</i> (required): Enter the rate for a couple. A couple is defined as a primary subscriber and his or her spouse. A couple may also be a domestic partnership if Life Partner is allowed by the issuer in the Business Rules Template. ◆ <i>Primary Subscriber and One Dependent</i> (required): Enter the rate for a primary subscriber with one dependent. ◆ <i>Primary Subscriber and Two Dependents</i> (required): Enter the rate for a primary subscriber with two dependents. ◆ <i>Primary Subscriber and Three or More Dependents</i> (required): Enter the rate for a primary subscriber with three or more dependents. ◆ <i>Couple and One Dependent</i> (required): Enter the rate for a couple with one dependent. ◆ <i>Couple and Two Dependents</i> (required): Enter the rate for a couple with two dependents. ◆ <i>Couple and Three or More Dependents</i> (required): Enter the rate for a couple with three or more dependents.

Rates Table Template	Steps
	Note: A dependent is defined as any dependent relationship you allow as defined in the Business Rules Template. If any member of the enrollment group is determined to be ineligible, no rate will be returned for that plan.

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

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

2025 Rates Table Template v14.0		<i>All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.</i>		
Validate		<i>If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.</i>		
Finalize		<i>If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.</i>		
		<i>If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.</i>		
		<i>To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.</i>		
HIOS Issuer ID*		12345		
Rate Effective Date*		1/1/2025		
Rate Expiration Date*		12/31/2025		
Rating Method*		Age-Based Rates		
Add Sheet				
Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
12345VA0001001	Rating Area 1	No Preference	0-14	10.00
12345VA0001001	Rating Area 1	No Preference	15	11.00
12345VA0001001	Rating Area 1	No Preference	16	12.00
12345VA0001001	Rating Area 1	No Preference	17	13.00

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

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

2025 Rates Table Template v14.0		<i>All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.</i>			
Validate		<i>If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.</i>			
Finalize		<i>If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.</i>			
		<i>If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.</i>			
		<i>To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.</i>			
HIOS Issuer ID*		12345			
Rate Effective Date*		1/1/2025			
Rate Expiration Date*		12/31/2025			
Rating Method*		Family-Tier Rates			
Add Sheet					
Plan ID*	Rating Area ID*	Individual Rate*	Couple*	Primary Subscriber and One Dependent*	Primary Subscriber and Two Dependents*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Required: Enter the rate of a family based on a single parent with one dependent	Required: Enter the rate of a family based on a single parent with two dependents
12345VA0001001	Rating Area 1	10.00	20.00	30.00	40.00

After entering all data, click **Save** to ensure no data are lost. Once the Rates Table Template is completed, it must be validated, finalized, and uploaded into MPMS.

Template Validation and Submission Step	Step Description
Validate Template	Click Validate in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click Validate again. Repeat until all errors are resolved. The template will provide a notification when there are no errors with the callout box message "This Template is Valid!"

Template Validation and Submission Step	Step Description
Finalize Template	Click Finalize in the template 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.

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

Section 20: URL Collection

1. Introduction

In the URL Collection section of the Marketplace Plan Management System (MPMS), issuers are required to submit URLs as part of their Qualified Health Plan (QHP) Application. Issuers must submit the following URLs: Summary of Benefits and Coverage (SBC), Plan Brochure, Enrollment Payment, Network, and Formulary.

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

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. SBC URLs
3. Plan Brochure URLs
4. Enrollment Payment URLs
5. Network URLs
6. Formulary URLs.

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 QHP Application.

Tips for the URL Collection Section

- ◆ Verify that URLs are functional before submission.
- ◆ All URLs submitted via the MPMS (SBC, Plan Brochure, Payment, Network, Formulary) should be submitted by September 18, 2024. All URLs must be active and directly route consumers to the appropriate document by the deadline for returning signed QHP Certification Agreements.
- ◆ Please note that the URL requirements described here apply only to on-Exchange plans; URLs for off-Exchange plans should still be submitted to the Rate & Benefits Information System (RBIS).
- ◆ All QHP SBC URL submissions must end with “.PDF” to ensure that the SBC URL leads directly to an SBC form.
- ◆ Payment URLs are tested in a separate environment/outside of MPMS.

Additional Resources

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

4. Detailed Section Instructions

The Generate URL Template page (Figure 20-1) will display when the issuer logs into MPMS and navigates to the URL submission section. Issuers should select one or more URL types (SBC, Plan Brochure, Payment, Network, Formulary) to pre-populate in the generated URL Template and select the Generate and Download URL Template button to download the URL Template file (Figure 20-2). If the issuer's Product Offering is set to SADPs [stand-alone dental plans] Only, the Formulary URL will not appear as an option.

Figure 20-1. Generate URL Template

Figure 20-2. URL Template File

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

When completing the URL Template, the following special characters 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 URL Template						
~ (tilde)	` (grave)	! (exclamation point)	# (hashtag)	@ (at sign)	\$ (dollar sign)	% (percentage)
^ (carat)	& (ampersand)	* (asterisk)	() (parentheses)	? (question mark)	_ (underscore)	+ (addition sign)
- (hyphen)	= (equal sign)	[] (square brackets)	\ (backslash)	{ } (braces)	; (semicolon)	: (colon)
" " (quotation marks)	. (period)	/ (forward slash)				

After the issuer populates their URL Template, it is uploaded to MPMS by selecting the “Upload” link, as shown in Figure 20-3. The system will validate that any Issuer URL Template File uploaded is properly formatted and contains acceptable values. If an uploaded template contains no errors, a message of “No Errors Found” will display in the Validation Status field. If errors were identified, they must be corrected and the template reuploaded. If a template passes all validations, the URL updates will be stored in the system.

Figure 20-3. Upload URL Template File

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

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

Once URLs are uploaded, they can be edited individually by searching for the URL Type and a URL ID (Figure 20-4). To use the search function, enter search parameters by selecting a URL type in the drop-down menu, entering a URL ID, and selecting the Search button. Full or partial strings of a URL ID can be entered to find a specific URL. Leaving the search field blank will return all URLs for the selected type. MPMS will perform the same validations for URL updates submitted via the Search & Update URLs Section as for those submitted via the Issuer URL Template File.

URLs can also be deleted in this section. The delete option is disabled for SBC, Network, and Formulary URLs associated with On-Exchange plans, but is enabled for all Payment and Plan Brochure URLs because these URL types are optional, and for SBC, Network, and Formulary URLs associated with off-Exchange plans.

Figure 20-4. Search & Update URLs Section

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

URL Type **URL ID**

Plan Brochure [Search](#)

URL Type	URL ID	Current URL	New URL	Delete
Plan Brochure	10055TX0010002-00	www.google.com		
Plan Brochure	10055TX0010002-01	www.google.com		
Plan Brochure	10055TX0010002-02	www.google.com		

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

Issuers that offer QHPs must submit Network and SBC URLs. If an issuer offers SADPs, they must submit Network URLs.

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

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

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

Appendices

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

[Appendix A: Actuarial Value Calculator](#)

[Appendix B: Supporting Documentation](#)

[Appendix C: Review Tools](#)

[Appendix D: Understanding Issuer Types](#)

[Appendix E: Network Adequacy Standards](#)

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

[Appendix G: Machine Readable Submission](#)

Appendix A: Actuarial Value Calculator

1. Introduction

To satisfy the actuarial value (AV) requirements of 45 *Code of Federal Regulations* (CFR) 156.140 and 156.420, qualified health plan (QHP) issuers must use the Actuarial Value Calculator (AVC) developed and made available by the U.S. Department of Health and Human Services (HHS) for the given benefit year unless the plan design is not compatible with the AVC (a unique plan design, 45 CFR 156.135). To assist issuers with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AVC and the data entered into the template. When the issuer submits their QHP Application, HHS recalculates this value to validate that the issuer's plan designs meet AV requirements.¹ This section describes how cost-sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AVC.

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

- QHP
- See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. Completed Plans & Benefits Template
2. Standalone AVC.

3. Quick Reference

Key Changes for 2025

- ◆ There are no major differences between the 2024 AVC and 2025 AVC with respect to user interface and the calculation process.

Tips for Using the AVC

- ◆ To aid in resolving difficulty matching AVs from the Plans & Benefits Template to the stand-alone AVC, follow the instructions on troubleshooting in Section 4.2 Differences between Standalone AVC and Plans & Benefits Template.
- ◆ The AVC has an Additional Notes field that outputs error messages that can only be seen in the standalone AVC. These notes are intended to help users understand the AVC's assumptions and to provide some information on the AV calculation being run in the AVC. When an AV calculation is not returned because of an input error, check the *Additional Notes* field for an explanation of the error.²
- ◆ If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, rerun the procedure so that the AVs in the *AV Calculator Output Number* field are updated to reflect the changes.
- ◆ If unique plan design features cause the AVC to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AVC. In that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).

Additional Resources

- ◆ Download the [Final 2025 Standalone AVC](#).
- ◆ There are no supporting documents for this section.
- ◆ There are no instructional videos for this section.
- ◆ There are [templates](#) for this section.

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

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

4. Detailed Section Instructions

The Plans & Benefits Template uses the AVC to calculate AVs for all standard, non-catastrophic plans; all silver plan cost-sharing reduction (CSR) variations; and all limited cost-sharing plan variations. The AVC cannot be used with catastrophic plans or stand-alone dental plans (SADPs). The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and does not run for SADP-only Plans & Benefits Templates. If the Cost Share Variances worksheet contains unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique and the non-unique plan designs. If the standalone AVC returns an error for a unique plan design, resulting in a blank AV Calculator Output Number, the error does not need to be addressed to validate the template if the AV falls within the relevant de minimis range. The Centers for Medicare & Medicaid Services (CMS) recommends issuers run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that the issuer's submissions include the AV Calculator Output Number for plans that do not generate an error in the standalone AVC. Table A-1 describes the steps involved when using the **Check AV Calc** procedure in the Plans & Benefits Template.

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

Check AV Calc	Steps	
The Check AV Calc procedure on the Plans and Benefits ribbon allows the user to calculate AVs for all applicable plans.	Step 1	Select the relevant Cost Share Variances worksheet and fill out all the cost-sharing information necessary to run the AVC.
	Step 2	Click Check AV Calc . The Check AV Calc procedure will prompt the user to select the file location of the standalone AVC. Use a clean copy of the AVC file that does not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all of the messages to finish the Check AV Calc procedure.
	Step 3	◆ A prompt will appear asking if the user would like to save the screenshots. ◆ Select Yes to save screenshots. Using the prompt, select the file name and location to save the output and create a copy of the AVC with worksheets that contain AV screenshots for each plan and plan variation. ◆ Select No to skip saving screenshots. The Check AV Calc procedure will complete without creating any new files.
	Step 4	A validation message box will appear with the status/error messages from the AVC for each plan or plan variation. The <i>AV Calculator Output Number</i> field (column F in the Cost Share Variances worksheet) will be updated with the AV from the AVC. The <i>AV Calculator Output Number</i> field will remain blank if an error prevents an AV from being calculated.
	Step 5	If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, the procedure must be rerun so that the AVs in <i>AV Calculator Output Number</i> are updated to reflect the changes.
	Step 6	After the AVC is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template. The AVC file selected should not have any saved output worksheets in it; saved worksheets will cause the AVC to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all messages to finish the Check AV Calc procedure.

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

4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the application should include the [Unique Plan Design—Supporting Documentation and Justification Form](#) to certify that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice.⁴ For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under 45 CFR 156.135(b), use of the integrated version of the AVC should be attempted before reverting to using the unique plan design option.

For plans compatible with the AVC, issuers must always use an actuarially justifiable process when inputting plan designs into the AVC.⁵ If the AV obtained from the template is not identical to the AV obtained from the standalone AVC, take the following action:

1. Ensure the template has been filled out correctly per the instructions in this appendix.
2. Follow the steps in Section 4.2 Differences between Standalone AVC and Plans & Benefits Template on troubleshooting the AVC.
3. After following the troubleshooting steps, determine whether the results of the standalone AVC can be replicated using the Plans & Benefits Template and its **Check AV Calc** procedure.
 - a. If the standalone AVC results cannot be replicated because of the design of the Plans & Benefits Template, but the AVs obtained from the standalone AVC and via the Plans & Benefits Template both fall within the relevant de minimis range for the plan's metal level or CSR variation, the plan does not need to be designated as a unique plan design. Instead, set the *Unique Plan Design* field to **No**, leave the *Issuer Actuarial Value* field blank, and run the integrated AVC.
 - b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the standalone AVC does, designate that particular plan as a unique plan design by setting the *Unique Plan Design* field to **Yes**. For this plan, complete the *Issuer Actuarial Value* field with the value from the standalone AVC. The AV from the standalone AVC must fall within the relevant de minimis range. Upload a screenshot of the standalone AVC with the *Plan Name*, *Plan ID*, and *HIOS Issuer ID* fields filled in as a supporting document, and include the plan ID (standard component) and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification, and the plan is not considered unique for review purposes.

Note: There are certain cases in which it may not be possible to match AVs between the Plans & Benefits Template and the AVC, such as in the following examples:

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

³ Issuers can use the standalone AVC to test plan designs, but do not need to submit a completed standalone AVC or other supplemental documentation, such as a screenshot, except in scenarios described in Section 4.1 Unique Plan Design. Instead, issuers should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

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

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

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

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

4.2 Differences between Standalone AVC and Plans & Benefits Template

The screenshot feature allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the standalone AVC. When using the **Check AV Calc** procedure in the Plans & Benefits Template, select **Yes** after a prompt appears asking if the user wants to save the AVC screenshots, then select the location where the screenshots should be saved. Once the **Check AV Calc** procedure has finished, the folder can be opened and the automatically generated screenshots used to compare with those manually created in the standalone AVC. This side-by-side comparison will help determine if the cost-sharing structure has been entered and applied as intended.

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

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

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

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

Figure A-1. Standalone AVC Screenshot

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

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

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

Figure A-3. Screenshot Created by Check AV Calc

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

5. Field Mapping

This section describes how the **Check AV Calc** procedure automatically maps data from the Plans & Benefits Template into the AVC. If any of the required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error. The layout of the following instructions is intended to align with the order that the fields appear in the Plans & Benefits Template.

5.1 Metal Tier

The *Level of Coverage* field in the Plans & Benefits Template is mapped to the *Desired Metal Tier* field in the AVC.

Expanded Bronze Plans: The AVC includes an option for issuers to indicate that they are running an expanded bronze plan as finalized in the [HHS Notice of Benefit and Payment Parameters for 2018](#). The expanded bronze plan option in the AVC allows the user to calculate the AV for bronze plans that meet certain requirements, allowing the user to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major, non-preventive service before the deductible or meets the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2) as established in 45 CFR 156.140(c). The AVC does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. The issuer must ensure its bronze plan meets these requirements if it uses the expanded bronze plan de minimis range in the AVC. For those bronze plans, the allowable AV variation is -2 percentage points and +5 percentage points. See the AVC Methodology and the *HHS Notice of Benefit and Payment Parameters for 2024* for more information. For expanded bronze and silver plan CSR variations, the *Indicate if Plan Meets CSR or Expanded Bronze AV Standard?* checkbox in the AVC is checked. To ensure that the correct continuance table is used for these plans, *Desired Metal Tier* depends on the AV level of the variation. *Desired Metal Tier* for silver plan variances is set to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation. *Desired Metal Tier* must be set to **Bronze** for expanded bronze plans.

De Minimis Range: In April 2022, CMS released the HHS Notice of Benefit and Payment Parameters for 2023 Final Rule, which amended the de minimis variation range for the AV level of coverage in 45 CFR 156.140(c). For plan years beginning on or after January 1, 2023, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is -2 percentage points and +2 percentage points. An exception exists for bronze plans that either cover and pay for at least one major service, other than preventive services, before the deductible or meet the requirements to be a high-deductible health plan within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -2 percentage points and +5 percentage points. In addition in 45 CFR 156.200, HHS limited the de minimis range to +2 percentage points for individual market silver QHPs (individual market on-Exchange silver plans).

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

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

Figure A-4 shows the HSA/HRA input fields in the Plans & Benefits Template and Figure A-5 shows the corresponding input fields in the AVC.

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

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

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

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

5.3 Tiered Network Options

The AVC can accommodate plans using up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, maximum out-of-pocket (MOOP) costs, and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.⁷

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

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

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

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

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

Figure A-7. Multi-Tier Options in AVC

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

With the **Not Applicable** option, the user can explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a **Copay—In Network (Tier 2)** and a **Coinsurance—In Network (Tier 2)** equal to **Not Applicable**, the **Check AV Calc** procedure assumes the benefit does not have tiered cost sharing and uses the Copay—In Network (Tier 1) and Coinsurance—In Network (Tier 1) values when mapping

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

to Tier 2 in the AVC. This exception to the Tier 2 mapping applies to all fields other than MOOP, default coinsurance, and deductibles, but will not be noted in the individual sections that follow.

5.4 MOOP and Deductible Values

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

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

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

1. If *In Network* is a dollar value (\$X), *In Network* is used for the AVC.
2. If *In Network* is set to **Not Applicable** and *Combined In/Out of Network* is a dollar value (\$X), *Combined In/Out of Network* is used for the AVC.
3. If the *In Network* and *Combined In/Out of Network* fields are set to **Not Applicable**, the Plans & Benefits Template returns an error when attempting to calculate an AV.

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

1. If the *In Network* and *In Network (Tier 2)* fields are dollar values, the *In Network* and *In Network (Tier 2)* fields are used for the AVC.
2. If the *In Network* and *In Network (Tier 2)* fields are set to **Not Applicable** and the *Combined In/Out of Network* field is a dollar value, the *Combined In/Out of Network* field is used for the AVC. In that case, the combined in-/out-of-network MOOP or deductible is mapped to the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AVC.
3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:
 - a. *In Network* is a dollar value, and *In Network (Tier 2)* is set to **Not Applicable**.
 - b. *In Network* is set to **Not Applicable**, and *In Network (Tier 2)* is a dollar value.
 - c. The *In Network*, *In Network (Tier 2)*, and *Combined In/Out of Network* fields are set to **Not Applicable**.

5.4.1 Maximum Out of Pocket

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

1. The *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network—Individual OR Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 MOOP* in the AVC.
2. If the plan has multiple in-network tiers, the *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 2)—Individual OR Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 MOOP* field in the AVC.

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

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

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

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

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

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

1. The *Maximum Out of Pocket for Medical EHB Benefits—In Network—Individual OR Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical MOOP* field in the AVC.
2. The *Maximum Out of Pocket for Drug EHB Benefits—In Network—Individual OR Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug MOOP* field in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. The *Maximum Out of Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual OR Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical MOOP* in the AVC.
 - b. The *Maximum Out of Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual OR Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Drug MOOP* in the AVC.

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

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

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

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

Figure A-11. Separate Deductible and MOOP in AVC

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

The AVC will return an error to the Plans & Benefits Template when the sum of the medical and drug MOOPs exceeds \$9,200. Because the AVC can be available before the finalization of the annual limit on cost sharing for a given plan year, there is an estimated annual limit on cost sharing in the AVC to ensure that the final AVC does not contain an annual limit on cost sharing that is lower than the finalized one. For the 2025 AVC, the MOOP limit and related functions have been set at \$9,200 to account for the annual limitation on cost sharing for PY2025. The 2025 annual limitation on cost sharing was specified in [Premium Adjustment Percentage](#), [Maximum Annual Limitation on Cost Sharing](#), [Reduced Maximum Annual Limitation on Cost Sharing](#), and [Required Contribution Percentage for the 2025 Benefit Plan Year](#). Refer to this guidance for final self-only coverage and other than self-only coverage amounts. If the issuer is required to meet AV standards, the issuer must comply with the limit established in the guidance and may not use the projected estimates stated in the 2025 AVC when finalizing plan designs.

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

5.4.2 Deductibles

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

If *Medical & Drug Deductibles Integrated?* is set to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AVC is checked.⁸ The following applies to integrated deductibles:

1. The *Combined Medical & Drug EHB Deductible—In Network—Individual OR Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Combined Deductible* in the AVC.
2. If the plan has multiple in-network tiers, the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Individual OR Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Combined Deductible* in the AVC.

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

⁸ For information on the combined versus separate deductible in the AVC, please refer to the AVC User Guide located on the first tab of the AVC.

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

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

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

1. The *Medical EHB Deductible—In Network—Individual* OR *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical Deductible* in the AVC.
2. The *Drug EHB Deductible—In Network—Individual* OR *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug Deductible* in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. The *Medical EHB Deductible—In Network (Tier 2)—Individual* OR *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical Deductible* in the AVC.
 - b. The *Drug EHB Deductible—In Network (Tier 2)—Individual* OR *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Drug Deductible* in the AVC.

Figure A-13 and Figure A-14 show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and Figure A-15 shows a corresponding example of separate medical and drug deductibles in the AVC.

Figure A-13. Medical EHB Deductible Fields in Plans & Benefits Template

Medical EHB Deductible								
In Network			In Network (Tier 2)			Out of Network		
Individual	Family	Default Coinsurance	Individual	Family	Default Coinsurance	Individual	Family	
\$1,500 \$1500 per person \$3000 per group		20%	\$2,000 \$2000 per person \$4000 per group		30%	\$3,000 \$3000 per person \$6000 per group		
\$0 \$0 per person \$0 per group		0%	\$0 \$0 per person \$0 per group		0%	\$0 \$0 per person \$0 per group		
\$1,500 \$1500 per person \$3000 per group		20%	\$2,000 \$2000 per person \$4000 per group		30%	\$3,000 \$3000 per person \$6000 per group		

Figure A-14. Drug EHB Deductible Fields in Plans & Benefits Template

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

Figure A-15. Separate Medical and Drug Deductibles and Integrated MOOP in AVC

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible (\$)	\$1,500.00	\$1,500.00	
Coinsurance (%; Insurer's Cost Share)	80.00%	70.00%	
MOOP (\$)	\$4,000.00		
MOOP if Separate (\$)			

5.5 Default Coinsurance

While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AVC represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AVC must be set to 1–X percent, where X percent is the coinsurance value entered in the Plans & Benefits Template. For example, if enrollees pay 10 percent of specialist visit costs, the coinsurance in the Plans & Benefits Template would be equal to 10 percent. The coinsurance in the AVC would be equal to 90 percent to represent the 90 percent of costs the issuer will incur. Table A-3 shows the mapping between the Plans & Benefits Template and the AVC and provides examples of coinsurance values in both.

Table A-3. Coinsurance Mapping between the Plans & Benefits Template and the AVC

Plans & Benefits (Enrollee's Cost Share)	AVC (Issuer's Cost Share)
X%	(1–X)%
10%	90%
40%	60%

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AVC. If *Medical & Drug Deductibles Integrated?* is set to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Combined Medical & Drug EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Combined Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).
2. If the plan has multiple in-network tiers, one minus the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Combined Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

Figure A-12 shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and Figure A-9 shows an example in the AVC.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AVC. If *Medical & Drug Deductibles Integrated?* is set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Medical EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Medical Coinsurance* in the AVC (found in the Tier 1 Plan Benefit Design table).
2. One minus the *Drug EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Drug Coinsurance* in the AVC.
3. If the plan has multiple in-network tiers, the following applies:
 - a. One minus the *Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Medical Coinsurance* in the AVC (found in the Tier 2 Plan Benefit Design table).

- b. One minus the *Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Drug Coinsurance* in the AVC.

5.6 Subject to Deductible?

The copay and coinsurance qualifiers in the Plans & Benefits Template determine whether the *Subject to Deductible?* checkbox in the AVC is checked (see Figure A-16 and Figure A-17). For each benefit, if either the *Copay—In Network (Tier 1)* **OR** the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template contains the text “with deductible” or “after deductible,” the *Tier 1 Subject to Deductible?* checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers (the plan has multiple tiers and both *Copay—In Network (Tier 2)* and *Coinsurance—In Network (Tier 2)* are not equal to **Not Applicable**), the same logic applies to Tier 2.

Figure A-16. Fields in Plans & Benefits Template Mapping to Subject to Deductible? Fields in AVC

Primary Care Visit to Treat an Injury or Illness						Specialist Visit					
Copay			Coinsurance			Copay			Coinsurance		
In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network	In Network (Tier 1)	In Network (Tier 2)	Out of Network
\$20.00	\$25.00	\$40.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	10.00% Coinsurance after deductible	20.00% Coinsurance after deductible	40.00% Coinsurance after deductible

Figure A-17. Benefit Categories in AVC

Click Here for Important Instructions				
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☒ All	☒ All		
Emergency Room Services	☒	☒		
All Inpatient Hospital Services (inc. MHSU)	☒	☒		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		\$20.00
Specialist Visit	☒	☒	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☒	☒		
Imaging (CT/PET Scans, MRIs)	☒	☒		
Speech Therapy	☒	☒		
Occupational and Physical Therapy	☒	☒		
Preventive Care/Screening/Immunization	☐	☐	100%	\$0.00
Laboratory Outpatient and Professional Services	☒	☒		
X-rays and Diagnostic Imaging	☒	☒		
Skilled Nursing Facility	☒	☒		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☒	☒		
Outpatient Surgery Physician/Surgical Services	☒	☒		
Drugs	☒ All	☒ All		
Generics	☒	☒		
Preferred Brand Drugs	☒	☒		
Non-Preferred Brand Drugs	☒	☒		
Specialty Drugs (i.e. high-cost)	☒	☒		

Table A-4 shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AVC—including the *Subject to Deductible?* logic—for all benefits other than Mental/Behavioral Health and Substance Use Disorder benefits. For Mental Health and Substance Abuse benefits, see Table A-6. Section 5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services describes the copay and coinsurance mappings in more detail.

Table A-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AVC

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

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

5.7 Subject to Coinsurance?

For each benefit, if *Coinsurance—In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked. For a plan with multiple in-network tiers, if *Coinsurance—In Network (Tier 2)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 2 Subject to Coinsurance?* checkbox for the corresponding benefit in the AVC is checked.

5.8 Different Coinsurance Values

A coinsurance value for a benefit category is mapped to the AVC only if the coinsurance for the given benefit differs from the relevant default coinsurance. For each benefit, if the *Tier 1 Subject to Coinsurance?* checkbox in the AVC is checked as described above, 1–X%, where X% is the coinsurance value from the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template, is mapped to the *Tier 1 Coinsurance, if different* field for the corresponding benefit in the AVC. For a benefit with multiple in-network tiers, if the *Tier 2 Subject to Coinsurance?* checkbox in the AVC is checked, 1–X%, where X% is the coinsurance value from the *Coinsurance—In Network (Tier 2)* field, is mapped to the *Tier 2 Coinsurance, if different* field for the corresponding benefit in the AVC.

The AVC functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AVC User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.⁹

The AVC treats **No Charge** (or **Not Applicable**) and **0%** coinsurance differently when a benefit's copay is greater than \$0. If the benefit has coinsurance equal to **No Charge** (or **Not Applicable**) and a copay greater than \$0, the relevant *Subject to Coinsurance?* checkbox in the AVC is unchecked, and the AVC assumes that the enrollee pays a copay until reaching the MOOP. If the benefit has a coinsurance equal to **0%** and a copay greater than \$0, the relevant *Subject to Coinsurance?* checkbox in the AVC is checked and **100%** is entered into the relevant *Coinsurance, if different* field in the AVC. In the latter case, the AVC assumes that the enrollee pays a copay until meeting the deductible, and then pays nothing.

5.9 Copay Values

For each benefit, if *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **\$X**, **\$X Copay with deductible**, **\$X Copay per Day**, **\$X Copay per Stay**, **\$X Copay per Stay with deductible**, or **\$X Copay per Day with deductible**, then the *Tier 1 Copay, if separate* field in the AVC is set equal to **X**. If *Copay—In Network (Tier 1)* is equal to **\$X Copay after deductible**, **\$X Copay per Stay after deductible**, or **\$X Copay per Day after deductible** and the corresponding *Coinsurance—In Network (Tier 1)* field is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable**, then the *Tier 1 Copay, if separate* field in the AVC is set equal to **X**. If *Copay—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable**, then the *Tier 1 Copay, if separate* field in the AVC is left blank.

When both coinsurance and copay values are present for a given benefit, the AVC can consider a copay in the deductible range and a coinsurance rate in the coinsurance range. However, the standalone AVC does not support applying both a copay and a coinsurance in the coinsurance range. If a benefit's copay is only after the deductible and before the MOOP and the benefit also has a coinsurance, the AVC considers only the coinsurance value in the coinsurance range. Therefore, if *Copay—In Network (Tier 1)* is equal to **\$X Copay after deductible**, **\$X Copay per Stay after deductible**, or **\$X Copay per Day after deductible** and *Coinsurance—In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Copay, if separate* field in the AVC is left blank. For benefits with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

As discussed in the AVC Methodology and AVC User Guide, five service types (Mental/Behavioral Health and Substance Use Disorder Outpatient Services, Imaging, Speech Therapy, Occupational Therapy and Physical Therapy, and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient-Facility or Outpatient-Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility component and an Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The AVC also allows the user to indicate the cost sharing for Primary Care and Specialist Office Visits and X-rays. The standalone AVC will indicate if the special cost sharing was engaged in the AV calculation in the *Additional Notes* field. For additional information on the operations of these features, review the [AVC Methodology](#) and [AVC User Guide](#).

5.10 Copay Applies Only After Deductible

For each benefit, if *Copay—In Network (Tier 1)* is equal to **\$X after deductible**, **\$X Copay per Stay after deductible**, or **\$X Copay per Day after deductible** and *Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the *Tier 1 Copay applies only after the deductible?* checkbox for the corresponding benefit in the AVC is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. Although the standalone AVC returns an error if the *Copay applies only after the deductible?* checkbox is checked and the benefit is also subject to a

⁹ The AVC User Guide can be found on the first tab of the AVC. The appendix at the end of the User Guide contains charts that provide detail and examples regarding the application of cost sharing within the deductible and coinsurance range.

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

5.11 Benefit Categories¹⁰

Table A-5 shows the alignment of benefit categories in the Plans & Benefits Template and the AVC, and Figure A-17 displays the benefit categories, along with their cost-sharing fields, in the AVC.

No inputs into the AVC are specific to the Pediatric Dental or Vision benefits. Pediatric Dental and Vision are generally low-cost benefits that do not have a material impact on AV. Additional information on how Pediatric Dental and Vision benefits are taken into account in the AVC is available in the AVC methodology.

Table A-5. Benefit Category Alignment between Plans & Benefits Template and AVC

Plans & Benefits Template Category Name	AVC Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., hospital stay)	All Inpatient Hospital Services (including MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (excluding Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Use Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy
Preventive Care/Screening/Immunization ¹¹	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (high-cost)

5.11.1 Inpatient Hospital Services

If *Inpatient Hospital Services Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **\$X Copay per Day**, **\$X Copay per Day with deductible**, or **\$X Copay per Day after deductible**, then the *Apply Inpatient*

¹⁰ The 2025 AVC updates the factor applied to trend claims from 2021 to 2025. Spending was trended forward from 2021 to 2022 at an annual rate of 3.2 percent for medical and 4.55 percent for drug spending. For 2022 to 2023, projection factors of 5.8 percent for medical costs and 8.7 percent for drug costs were selected, and for 2023 to 2024 we added projection factors of 5.4 percent for medical costs and 8.2 percent for drug costs. For trending from 2024 to 2025, we added 1 year projection factors of 6.4% for medical and 9.9% for drug spending. For information about the considerations of the new claims data, please refer to the [AVC Methodology](#).

¹¹ Section 2713 of the Public Health Service (PHS) Act, codified in 45 CFR 147.130, requires issuers to offer certain preventive care services without cost sharing, so the standalone AVC automatically takes into account no cost sharing for these services in the AV calculation and does not allow issuers to enter cost sharing for the Preventive Care/Screening/Immunization benefit category. Thus, regardless of the cost sharing in the Preventive Care/Screening/Immunization benefit category in the Plans & Benefits Template, no mapping occurs between the Plans & Benefits Template and the standalone AVC for this benefit category.

Copay per Day? checkbox in the AVC is checked. If the Inpatient Hospital Services copay is charged per day for Tier 1, the AVC automatically assumes that the Inpatient Hospital Services copay is also charged per day for Tier 2, if applicable.

If *Maximum Number of Days for Charging an Inpatient Copay?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, then the *Set a Maximum Number of Days for Charging an In Patient (IP) Copay?* checkbox in the AVC is checked and the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template is mapped to *# Days (1–10)* in the AVC. If the *Maximum Number of Days for Charging an Inpatient Copay?* field is blank in the Plans & Benefits Template, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AVC is unchecked and *# Days (1–10)* in the AVC is left blank.

The *Maximum Number of Days for Charging an Inpatient Copay?* field is set at the plan variation level, allowing the values to differ between variations. However, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox and the *# Days (1–10)* field cannot vary between Tier 1 and Tier 2. Figure A-18 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template, and Figure A-19 shows the corresponding checkbox and field in the AVC.

If the issuer intends to use the *Maximum Number of Days for Charging an Inpatient Copay?* feature when filling out the standalone AVC, ensure that the *Apply Inpatient Copay per Day?* checkbox in the AVC (Figure A-20) is checked. Otherwise, the AVC will return an error when trying to calculate the AV. On the Plans & Benefits Template side, follow the instruction in the first paragraph of this section and select a cost-sharing option that includes the text “per day” to ensure the *Apply Inpatient Copay per Day?* checkbox is checked in the AVC mapping.

Figure A-18. AVC Additional Benefit Design Fields in Plans & Benefits Template

AV Calculator Additional Benefit Design			
Maximum Coinsurance for Specialty Drugs	Maximum Number of Days for Charging an Inpatient Copay?	Begin Primary Care Cost-Sharing After a Set Number of Visits?	Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?
\$200	5	3	

Figure A-19. Maximum Number of Days for IP Copay Checkbox and Field in AVC

Set a Maximum Number of Days for Charging an IP Copay?	☒
# Days (1-10):	5

Figure A-20. Apply IP Copay Checkbox in AVC

User Inputs for Plan Parameters	
Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☒
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

5.11.2 Skilled Nursing Facility

If the *Skilled Nursing Facility Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **\$X Copay per Day**, **\$X Copay per Day with deductible**, or **\$X Copay per Day after deductible**, then the *Apply Skilled Nursing Facility Copay per Day?* checkbox in the AVC is checked. If the skilled nursing facility copay is charged per day for Tier 1, the AVC automatically assumes that the skilled nursing facility copay is also charged per day for Tier 2, if applicable.

If the issuer intends to charge a skilled nursing facility copay per day, the issuer should ensure the *Apply Skilled Nursing Facility Copay per Day?* checkbox is selected while filling out the standalone AVC to ensure accuracy of AV calculations.

5.11.3 Primary Care

If *Begin Primary Care Cost-Sharing After a Set Number of Visits?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, then the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is checked and the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field in the Plans & Benefits Template is mapped to *# Visits (1–10)* in the AVC. If the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field is blank in the Plans & Benefits Template, then the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AVC is unchecked and *# Visits (1–10)* in the AVC is left blank. As discussed in the AVC User Guide, the use of this option does not imply a benefit designed for primary care visits after the initial fully covered visits have occurred. The issuer must still indicate whether or not primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under *Primary Care Visit to Treat an Injury or Illness*.

If *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is checked and the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field in the Plans & Benefits Template is mapped to *# Copays (1–10)* in the AVC. If the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field is blank in the Plans & Benefits Template, then the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AVC is unchecked and *# Copays (1–10)* in the AVC is left blank. Per the AVC User Guide, the use of this option does not imply a benefit design for primary care visits after the initial copays have occurred. The issuer must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under *Primary Care Visit to Treat an Injury or Illness*.

The *Begin Primary Care Cost-Sharing After a Set Number of Visits?* and *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* fields (Figure A-21) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (Figure A-21) cannot vary between Tier 1 and Tier 2. In addition to inputting any copay amount, these options must be used in conjunction with the *Subject to Deductible?* option for primary care services. Unchecking *Subject to Deductible?* with these options selected will trigger an error message.

Figure A-21. Primary Care Options in AVC

49	Begin Primary Care Cost-Sharing After a Set Number of Visits?	☒
50	# Visits (1-10):	3
51	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
52	# Copays (1-10):	

5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AVC Mental/Behavioral Health and Substance Use Disorder Outpatient Services copay and coinsurance inputs are weighted averages of the *Mental/Behavioral Health Outpatient Services* and the *Substance Abuse Disorder Outpatient Services* cost-sharing fields in the Plans & Benefits Template. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the Mental/Behavioral Health Outpatient Services benefit in the Plans & Benefits Template when mapping to the *Mental/Behavioral Health and Substance Use Disorder Outpatient Services Subject to Deductible?*, *Subject to Coinsurance?*, and *Copay applies only after the deductible?* checkboxes in the AVC. The copay and coinsurance values for the Substance Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AVC checkboxes.

If either *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* or *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the *Mental/Behavioral Health and Substance Use Disorder Outpatient Services Tier 1 Subject to Deductible?* checkbox in the AVC is checked.

If *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC is checked. Then, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)})]$ is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC.

In the following two scenarios, $[0.8 \times (\text{Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)})] + [0.2 \times (\text{Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)})]$ is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC:

1. *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **\$X** or **\$X with deductible** in the Plans & Benefits Template
2. *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **\$X after deductible** and the *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template.

If *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **\$X after deductible** and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the *Tier 1 Copay applies only after the deductible?* checkbox for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC is checked.

The logic described above (and captured generically in Table A-5) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the Tier 2 copay and Tier 2 coinsurance are equal to **Not Applicable**. If *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AVC. If *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)* values for Substance Abuse Disorder Outpatient Services when mapping to the Mental/Behavioral Health and Substance Use Disorder Outpatient Services Tier 2 fields in the AVC.

Table A-6 shows the detailed mappings described in this section.

Table A-6. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Cost-Sharing Mapping between Plans & Benefits Template and AVC

Plans & Benefits Template— Mental/Behavioral Health Outpatient Services		AVC—Mental/Behavioral Health and Substance Use Disorder Outpatient Services				
Copay	Coinsurance	Subject to Deductible?	Subject to Coinsurance?	Coinsurance	Copay	Copay applies only after deductible?
\$X Copay after deductible No Charge after deductible	X% X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
No Charge Not Applicable	X% Coinsurance after deductible					
\$X	X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	X% X% Coinsurance after deductible					
No Charge Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge Not Applicable No Charge after deductible					
\$X Copay after deductible	No Charge Not Applicable No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked
\$X	No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked
\$X Copay with deductible	No Charge Not Applicable No Charge after deductible					
No Charge Not Applicable	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
\$X	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
No Charge Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
\$X	No Charge Not Applicable	Unchecked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked

5.11.5 Drugs

The Plans & Benefits Template and the AVC require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs.

The AVC does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AVC returns an error. If a drug benefit has only a copay, enter **No Charge, No Charge after the deductible, or Not Applicable** rather than **0%** or **0% Coinsurance after deductible** in the *Coinsurance—In Network (Tier 1)* or *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template to avoid an error from the AVC. Likewise, if a drug benefit has only a coinsurance, enter **No Charge, No Charge after the deductible, or Not Applicable** rather than **\$0** or **\$0 Copay after deductible** in the *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* fields in the Plans & Benefits Template.

5.11.5.1 Specialty Drugs

If the *Maximum Coinsurance for Specialty Drugs* field includes a positive number in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is checked, and the *Maximum Coinsurance for Specialty Drugs* field in the Plans & Benefits Template is mapped to the *Specialty Rx Coinsurance Maximum* field in the AVC. If the *Maximum Coinsurance for Specialty Drugs* field is blank in the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AVC is unchecked, and the *Specialty Rx Coinsurance Maximum* field in the AVC is left blank.

The *Maximum Coinsurance for Specialty Drugs* field (Figure A-22) is set at the plan variation level, allowing the values to differ between variations. However, the *Specialty Drugs Maximum Coinsurance* checkbox and *Amount* field (Figure A-22) cannot vary between Tier 1 and Tier 2.

Figure A-22. Specialty Drugs Maximum Payment Fields in AVC

Set a Maximum on Specialty Rx Coinsurance Payments?	☒
Specialty Rx Coinsurance Maximum:	\$200

6. Zero Cost-Sharing and Limited Cost-Sharing Plan Variations

Zero cost-sharing plan variations, which are required to have zero cost sharing for all Essential Health Benefit (EHB) categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee's costs. Limited cost-sharing plan variations, which are required to have the same cost sharing and MOOPs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost-sharing plan variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization or via referral under contract health services (45 CFR 156.420[b][2]), these CSRs are not represented in the Plans & Benefits Template and are not included in the AV calculation.

Appendix B: Supporting Documentation

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

Note: Not all QHP Application sections require submission of supporting documentation or justifications.

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

Table B-1. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Submission Location	Suggested File Name
State Partnership Exchange Issuer Program Attestation Response Form	Provides program attestations if the issuer's state performs plan management functions and the issuer is not able to respond to attestations via MPMS.	Required only if the issuer's state performs plan management functions (see Program Attestations section).	System for Electronic Rates & Forms Filing (SERFF)	[Issuer ID]_SPEIssuer Attestations
Accreditation Certificate	Demonstrates that the issuer is accredited.	The issuer may choose to submit this certificate if they are accredited.	Accreditation	[Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes a payment structure that provides increased reimbursement or other market-based incentives to improve plan enrollee health outcomes. Access the QIS Guidance and QIS forms on the QIS page of the CMS website.	Required if the issuer has issued QHPs on an Exchange for 2 or more consecutive years that offer family or adult-only medical coverage and meet the QIS minimum enrollment threshold in the Individual Market or Small Business Health Options Program (SHOP) Exchange. Review the QIS threshold in the QIS Technical Guidance and User Guide for the 2025 Plan Year. Issuer submission requirements are in the QIS Issuer List for the 2025 Plan Year.	Accreditation	If submitting an Implementation Plan: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[IP] If submitting a Progress Report: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[PR] If submitting a Modification Summary: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_[MS]

Title	Description	Submission Criteria	Submission Location	Suggested File Name
Network Adequacy Justification Form	Explains why the issuer is not meeting the network adequacy requirements and describes ongoing provider recruitment activities. Issuers that receive a correction notice for not meeting one or more of the network adequacy standards, complete the required fields within the partially pre-populated Network Adequacy Justification Form generated by CMS (posted in the Network Adequacy section of Marketplace Plan Management System [MPMS]) and submit the completed justification via MPMS.	CMS will notify the issuer of any failure to meet one or more of the network adequacy standards by issuing a correction notice and partially pre-populated Network Adequacy Justification Form for the issuer to complete and submit via MPMS.	Network Adequacy	(Issuer ID)-NA-(Round Abbreviation) Example for Issuer ID 12345 in the Initial Round: 12345-NA-IR. For Second Round use SR in place of IR and for Final Round, use FR.
Service Area Partial County Supplemental Response	Describes why the issuer cannot serve an entire county.	Required if the issuer requests to serve only part of a county in a service area.	Service Area	[Issuer ID]_[State Abbreviation]_service_area_partial_county
Combined Prescription Drug Supporting Documentation and Justification	Explains why a correction was required in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count and how each is not discriminatory.	Required if CMS issues a correction in Clinical Appropriateness, Formulary Outlier, or Category/Class Benchmark Count.	Prescription Drug	[Issuer ID]_[State Abbreviation]_combineddrug
Discrimination—Treatment Protocol Supporting Documentation and Justification	Explains why a drug list's outlying out-of-pocket cost is not discriminatory.	Required if CMS determines the out-of-pocket cost is an outlier.	Prescription Drug	[Issuer ID]_[State Abbreviation]_treatmentprotocol
Discrimination—Cost Sharing Outlier: Supporting Documentation and Justification	Explains why outlying cost sharing values should be allowed and are not discriminatory.	Required if CMS determines cost sharing values are outliers at the national or state levels and the issuer	Plans & Benefits	[Issuer ID]_[State Abbreviation]_discrimination_cost_sharing

Title	Description	Submission Criteria	Submission Location	Suggested File Name
		does not correct them. States determine the System for Electronic Rates & Forms Filing (SERFF) submission requirements.		
Discrimination—Adverse Tiering: Supporting Documentation and Justification	Explains why the prescription benefit covers all 1st line therapeutics and most or all drugs on the highest tier(s).	Required if CMS issues a correction in the review based on drug tier coverage.	Prescription Drug	[Issuer ID]_[State Abbreviation]_adversetiering
Unique Plan Design—Supporting Documentation and Justification	Describes why a plan qualifies as unique (why it is incompatible with the standard Actuarial Value Calculator [AVC]) and the methods used to calculate the actuarial value (AV).	Required if the issuer responds Yes to <i>Unique Plan Design</i> ?	Plans & Benefits	[Issuer ID]_[State Abbreviation]_unique_plan_design
EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification	Describes Essential Health Benefit (EHB) compliance for issuers that opt to substitute benefits for EHBs.	The issuer may submit this form or an alternative form to demonstrate EHB compliance. Issuers that submit via SERFF are not required to submit this form.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_EHB_actuarial_equivalent
Interoperability Justification	Describes when interoperability requirements will be met, how enrollees will be impacted by non-implemented requirements, and the issuer's plan for completing implementation.	Required if the issuer responds No to any of the four Interoperability Questions.	Interoperability	[Issuer ID]_Interoperability Justification.pdf

Saving Supporting Documents

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

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

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

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

Uploading Supporting Documents

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

Appendix C: Review Tools

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

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

Tool	Purpose
Data Integrity Tool ^a	Identifies critical data errors within and across templates. Provides immediate feedback about data to reduce issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports QHP and SADP data from most application templates. Conducts validations beyond the standard HIOS and SERFF checks. Looks across templates for consistency in key fields. Produces error reports that describe the error and its location in a template.
Plan ID Crosswalk Tool ^a	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring that all counties in all Federally-facilitated Exchange (FFE) plans that were offered in 2024 are included in the crosswalk, the plans are crosswalked to valid 2025 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 <i>Code of Federal Regulations</i> (CFR) 155.335(j).
Data Consolidation Tool ^a (formerly Master Review Tool)	Aggregates data from the Plans & Benefits, Service Area, Network Adequacy, and Prescription Drug templates and serves as a data input file to the other standalone tools.
Essential Community Providers Tool for medical QHPs	Calculates the total number of medical ECPs an issuer has in each plan's network and compares this to the number of available medical ECPs in that service area. This tool checks whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235. The tool also checks for satisfaction of the ECP category per county and Indian health provider contract offering requirements.
Essential Community Providers Tool ^a for SADPs	Calculates the total number of dental ECPs an issuer has in each plan's network and compares this to the number of available dental ECPs in that service area. This tool checks whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235. The tool also checks for satisfaction of the Indian health provider contract offering requirement.
Non-Discrimination Tool	Performs an outlier analysis for <i>QHP Discriminatory Benefit Design</i> as discussed in the final 2025 Letter to Issuers. This tool looks at all plans in the state, goes through a group of predetermined benefits, and determines whether any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
Cost Sharing Tool ^a	Runs four different checks (when they are applicable to the plan) for cost-sharing standards. This includes the Maximum Out-of-Pocket (MOOP) Cost Review, Cost-Sharing Reduction (CSR) Plan Variation Review, Expanded Bronze Plan Review, and Catastrophic Plan Review.
Category & Class Drug Count Tool	Compares the count of unique, chemically distinct drugs in each United States Pharmacopeia (USP) v8 category and class for each drug list against a state's benchmark.
Formulary Review Suite: Non-Discrimination Formulary Outlier Review	Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization or step therapy requirements in 27 USP classes.

Tool	Purpose
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with certain conditions as recommended in clinical guidelines to ensure that issuers are offering sufficient types and numbers of drugs.

^a Indicates tools that apply to SADP issuers.

Appendix D: Understanding Issuer Types

An issuer's Qualified Health Plan (QHP) Application submission will differ based on whether the issuer offers medical QHPs, stand-alone dental plans (SADPs), or both plan types. Each section of this document indicates the type of issuers to which the information applies in a callout box, as shown in **Figure D-1**.

Figure D-1. Example Identification Box

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

- QHP
- SADP

See Appendix D for additional information.

Table D-1 identifies how CMS categorizes issuer types for this document.

Table D-1. Terms and Descriptions

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

Appendix E: Network Adequacy Standards

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

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

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

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

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

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

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

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

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

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

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

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

Appendix F: Standardized Plan Option Requirements

Table F-1. 2025 Standardized Plan Options Set One
(For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	63.81%	70.01%	73.09%	87.33%	94.14%	78.06%	88.04%
Deductible	\$7,500	\$5,000	\$3,000	\$500	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,200	\$8,000	\$6,400	\$3,000	\$2,000	\$7,800	\$4,300
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$15*	\$30*	\$10*
Non-preferred Brand Drugs	\$100	\$80	\$80	\$60	\$50*	\$60*	\$50*
Specialty Drugs	\$500	\$350	\$350	\$250	\$150*	\$250*	\$150*

*Benefit category not subject to the deductible.

Table F-2. 2025 Standardized Plan Options Set Two (For Exchange Issuers in Delaware and Louisiana)

	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	63.81%	70.01%	73.10%	87.36%	94.37%	78.10%	88.07%
Deductible	\$7,500	\$5,000	\$3,000	\$500	\$0	\$1,500	\$0
Annual Limitation on Cost Sharing	\$9,200	\$8,000	\$6,400	\$3,000	\$2,000	\$7,800	\$4,300
Emergency Room Services	50%	40%	40%	30%	25%*	25%	\$100*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	\$350*
Primary Care Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Urgent Care	\$75*	\$60*	\$60*	\$30*	\$5*	\$45*	\$15*
Specialist Visit	\$100*	\$80*	\$80*	\$40*	\$10*	\$60*	\$20*
Mental Health & Substance Use Disorder Outpatient Office Visit	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	\$100*
Speech Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Occupational, Physical Therapy	\$50*	\$40*	\$40*	\$20*	\$0*	\$30*	\$10*
Laboratory Services	50%	40%	40%	30%	25%*	25%	\$30*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	\$30*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	\$150*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	\$150*
Generic Drugs	\$25*	\$20*	\$20*	\$10*	\$0*	\$15*	\$5*
Preferred Brand Drugs	\$50	\$40*	\$40*	\$20*	\$5*	\$30*	\$10*
Non-preferred Brand Drugs	\$100	\$80	\$80	\$60	\$10*	\$60*	\$50*
Specialty Drugs	\$150	\$125	\$125	\$100	\$20*	\$100*	\$75*

*Benefit category not subject to the deductible.

Appendix G: Machine Readable Submission

1. Introduction

In the Issuer Details section of the Marketplace Plan Management System (MPMS), issuers are required to submit and/or edit their index URL and technical point of contact email for their Machine Readable (MR) data.

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

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, the following are needed:

1. State
2. Health Insurance Oversight System (HIOS) Issuer ID
3. MR Index URL
4. Technical Point of Contact Email Address

3. Quick Reference

Key Changes for 2025

- ◆ No changes for the 2025 Qualified Health Plan (QHP) Application.

Tips for the Machine Readable Issuer Details Section

- ◆ Verify that URLs are functional before you submit them.
- ◆ All MR URLs submitted via MPMS should be submitted by the deadline of September 18, 2024. All URLs must be active and directly route to the issuer's MR JSON data.

Additional Resources

- ◆ The [Coverage Portal](#) contains more information, FAQs, and tools about the MR submission process.

4. Detailed Section Instructions

On the *Issuer Details* tab on MPMS, select the State and Issuer from the dropdown menus and select the **Search** button to populate the table. The State and Issuer dropdowns are only populated with the values that the current user has access to.

Figure G-1. Issuer Details Page in MPMS

Issuer Details

Machine-Readable

QHP issuers on the FFE are required to create a set of machine-readable data files using the JavaScript Object Notation (JSON) format specified in the [CMS Machine-Readable Tools](#).

State: Florida Issuer: -Select- Search Download (CSV)

Issuer	Machine-Readable URL	Technical POC Email	Action
62662 - FL - Time Insurance Company	https://www.timeinsurance.com/json/mrf/index.json	Cschepker@timeinsurance.com	Edit
71675 - FL - Principal Life Insurance Company	https://www.principallife.com/json/mrf/index.json	Jake.Smith@principallife.com	Edit

Show 5 results per page < Previous 1 Next > Showing 1-2 of 2 results

Select **Edit** in the Action column of the table to open the *Edit URL or Email* pop-up window to submit or edit the MR URL and email. After updating the URL or email, click the **Apply** button to save the changes. Select the **Cancel** or **Close** links to avoid making or to reject any changes.

Figure G-2. Edit URL or Email Pop-up

Edit URL or Email [Close](#)

To apply the same URL and email to multiple issuers, check the Apply to additional issuers box and select which issuers to apply the new URL and email to.

Issuer
62662 - FL - Time Insurance Company

Machine-Readable URL

Technical POC Email

☐ Apply to additional issuers

Apply [Cancel](#)

To apply the same URL and email to multiple Issuers click the *Apply to additional issuers* check box and select which issuers the URL and email should apply to.

Figure G-3. Edit URL or Email Pop-up – Additional Issuers

Edit URL or Email [Close](#)

To apply the same URL and email to multiple issuers, check the Apply to additional issuers box and select which issuers to apply the new URL and email to.

Issuer
62662 - FL - Time Insurance Company

Machine-Readable URL

Technical POC Email

☒ Apply to additional issuers

Issuer [Clear All](#)

Apply [Cancel](#)

Selecting **Apply** begins the validation process. A pop-up window will appear to indicate that the validation process has started.

Figure G-4. Validation in Progress Pop-up

Validation in Progress



Validation could take up to a minute.

Do not close this tab or browser window until saving is complete or your work won't be saved.

The user will receive an error if they do not use “https://” at the start of the URL and “.json” at the end of the URL. The **Apply** button will be disabled if there is an in-line error.

Any Validation Warnings or Errors will be displayed in a pop-up message. Selecting the **Continue Editing** button redirects the user back to the *Edit URL or Email* pop-up to edit any data with errors.

Figure G-5. Validation Results Pop-up

Machine-Readable Validation Results

[Close](#)

Warnings may not have to be addressed to save and continue. Double check to see if these can be addressed before moving forward.

Download (CSV)

Severity	Validation Code	Validation Message
Warning	22220001	The following URL associated to Issuer ID 62662 is not active. All URLs submitted must lead to a live, active webpage that loads in under 60 seconds. Please resubmit an active URL (https://www.fltimeinsurance.com/json/mrf/index.json).

Show 5 results per page

Previous
1
Next

Showing 1-1 of 1 results

Save and Continue
[Continue Editing](#)

If there are no Validation Results to review, the *Issuer Details* page will open and display a success banner, confirming that the URL and email have been updated (Figure G-6).

Figure G-6. Success Banner on Issuer Details Page

[Issuer Dashboard](#)
[Plan Validation Workspace](#)
[QHP Applications](#)
[Application Tools](#)

[Issuer Dashboard](#) > [Issuer Details](#)

Issuer Details

Machine-Readable

Machine-Readable

QHP issuers on the FFE are required to create a set of machine-readable data files using the JavaScript Object Notation (JSON) format specified in the [CMS Machine-Readable Tools](#).

Successfully updated the URL and email for 1 issuer.

State

Florida

Issuer

-Select-

Search

Download (CSV)

Issuer	Machine-Readable URL	Technical POC Email	Action
62662 - FL - Time Insurance Company	https://www.fltimeinsurance.com/json/mrf/index.json	Cschepker@timeinsurance.com	Edit
71675 - FL - Principal Life Insurance Company	https://www.principallife.com/json/mrf/index.json	Jake.Smith@principallife.com	Edit

Show 5 results per page

[Previous](#)
1
[Next](#)

Showing 1-2 of 2 results

MR Submission Process	Steps
Access the MPMS	Log into the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal and select the MPMS application on the My Portal page.
Go to Issuer Details	Once in MPMS, at the top, click to go to the <i>Issuer Details</i> tab.
Search for Issuers	Select the State and Issuer from the dropdown menus and click the Search button to populate the table.
Edit or Submit MR Index URL and Technical Point of Contact Email	Select Edit in the Action column.
	A pop-up window will appear to edit or submit the MR URL or email details.
	To apply the same URL and email to multiple issuers, click the <i>Apply to additional issuers</i> check box and select the issuers the URL and email should apply to.
	Select the Apply button to save changes.

This concludes the MR Submission section instructions.