Qualified Health Plan
Issuer Application Instructions

2021

Extracted section:
Section 2E: Transparency in Coverage

[05/2020]

Version 1.1

PY2021 QHP Instructions: Version 1.1 Revisions

- Updated to guide issuers on the process for submitting Transparency in Coverage Template and URL data, including instructions on the following:
  - Steps for issuers who are submitting using dummy data
  - Expanded submission instructions for issuers with plan offerings that are not required to report Transparency in Coverage data (e.g., off-Exchange SADPs)
  - Guidance for issuers submitting the QHP Application using SERFF
  - Assistance for issuers who submit Transparency in Coverage or URL data prior to the Transparency in Coverage submission deadline.
- Updates to United States Pharmacopeia (USP) drug categories in relation to pharmacy claims.

Section 2E. Transparency in Coverage Template

1. Introduction

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

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

2. Data Requirements

To complete this section, issuers will need the following:

- Information on whether the issuer was on the Exchange in 2019
- HIOS Issuer IDs and all PY2021 plan IDs
- Number of PY2019 claims and denials
- Number of PY2019 appeals
- Claims Payment Policy and Other Information URL ("Transparency in Coverage URL").

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

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

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

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

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

[10] 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.

3. Quick Reference

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

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

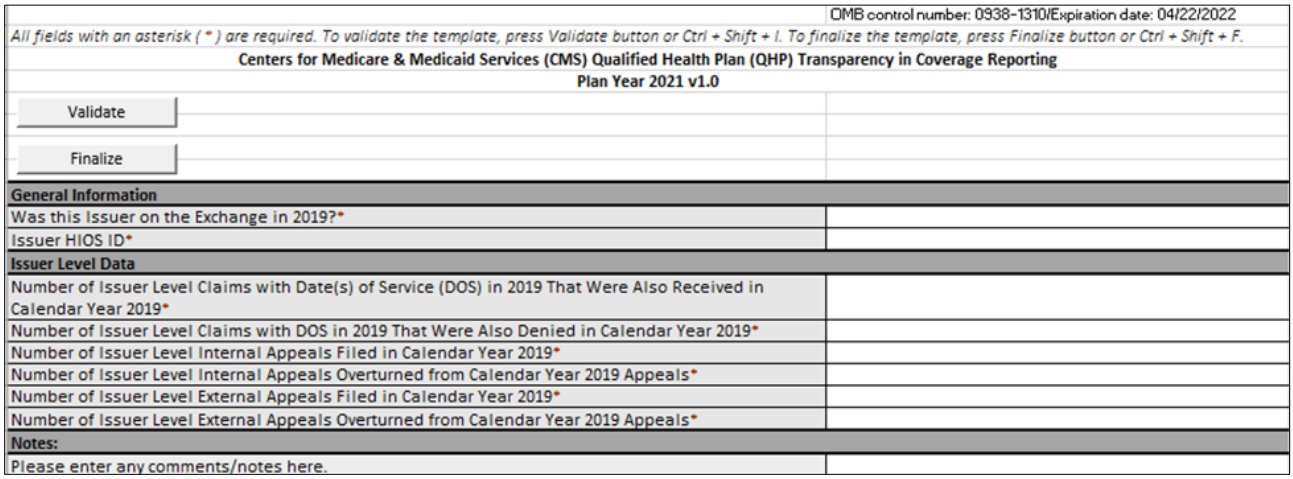
4. Transparency in Coverage Template

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

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

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

Figure 2E-1. Transparency in Coverage Template



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

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

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

Plan Year 2021 v1.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2019?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	
Notes:	
Please enter any comments/notes here.	

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

4.1 Issuer Level Data Tab

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

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

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

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

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

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

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

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

4.2 Plan Level Data Tab

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

PY2021 Plan Data	Steps
Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019[12] ***(Plan Level Claims Denied)****	Enter the number of **plan level** claims received by an issuer that ask for a payment or reimbursement by or on behalf of an **in-network** health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. **If a plan did not exist in PY2019, please enter N/A. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** ◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits. ◆ Include claims for all QHPs that fall under the reporting plan ID. ◆ If a claim is denied for more than one reason, only count it as one denied claim. ◆ Include all denials in the total number of claims denied in calendar year 2019. This includes, but is not limited to: ▪ pediatric vision and dental denials, including for SADPs; ▪ denials due to ineligibility; ▪ denials due to incorrect submission; ▪ denials for incorrect billing; and ▪ duplicate claims. ◆ Do not include the following claims: ▪ Claims that were pending or initially denied for additional information and subsequently paid, as shown in **Footnote 12**. ▪ Out-of-network claims. *The total number of Plan Level Claims Denied in the specified calendar year should also be accounted for in the six "Plan Level Claims Denial" categories. Note, however, that the totals from the "Plan Level Claims Denial" categories will not add up to the total number of Plan Level Claims Denied.*
Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019 ***(Plan Level Claims Denied)****	Enter the number of in-network **plan level** denials for non-emergency-related claims for service that required prior or preauthorization, referral, prior approval, or precertification; in this instance, the claim was denied for plans that require a prior or preauthorization, referral, prior approval, or precertification. **Issuers may also enter N/A in this field for PPOs or if a plan did not exist in PY2019. Otherwise, all on-Exchange plans (including SADP) must enter a value in this field; 0 is acceptable.** Issuers should include the following claims (individual claim line of service item): ◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification has been denied.

[12] For example:
# of Plan Level Claims Received: Plan has a total of 20,000 claims.
# of Plan Level Claims Denied: Plan denies 3,000 of those claims for various reasons.
The issuer would further report the reasons for the 3,000 claims denied in one or more of six denial categories:

1. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019.
2. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2019.
3. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019.
4. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2019.
5. Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, excluding Behavioral Health in Calendar Year 2019.
6. Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019.

In this example, an issuer could report denial *reasons* greater than 3,000 in the six reporting categories if claims were denied for more than one reason, but the number of plan level claims denied is 3,000.

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

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

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

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

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

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

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

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

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

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

4.3.1 Dummy Data—Issuer Level Data Tab

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

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

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

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

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

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

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

Plan Year 2021 v1.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2019?*	No
Issuer HIOS ID*	11111
Issuer Level Data	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2019 That Were Also Received in Calendar Year 2019*	N/A
Number of Issuer Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2019 Appeals*	N/A
Number of Issuer Level External Appeals Filed in Calendar Year 2019*	N/A
Number of Issuer Level External Appeals Overturned from Calendar Year 2019 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	This is dummy data.

4.3.2 Dummy Data—Plan Level Data Tab

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

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

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

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

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

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

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2021
Plan Level Data

Plan ID*	Number of Plan Level Claims with DOS in 2019 That Were Also Received in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2019*	Number of Plan Level Claims with DOS in 2019 That Were Also Denied for "Other" Reasons in Calendar Year 2019*	Notes: (Please enter any comments/notes here.)
11111VA1111111	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	This is dummy data.
11111VA2222222	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	This is dummy data.

5. Claims Payment Policy and Other Information URL

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

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

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

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

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

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

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

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

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

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

PY2021 URL	Minimum Requirements
Drug exception timeframes and enrollee responsibilities (not required for SADPs)	**Description**: ◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c). **Provide**: ◆ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs. ◆ The timeframe for a decision based on a standard review or expedited review due to exigent circumstances. ◆ Instructions on how to complete the application. **Example of Acceptable Language:** *Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form [link provided here]. If the drug is denied, you have the right to an external review.* *If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an Independent Review Organization (IRO). We must follow the IRO's decision.* *An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request:* *[Request Form Link]* *[Address]* *[Phone]* *[Fax].* *For standard exception review of medical requests where the request was denied, the timeframe for review is 72 hours from when we receive the request.* *For expedited exception review requests where the request was denied, the timeframe for review is 24 hours from when we receive the request.* *To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.*
Explanation of benefits (EOB)	**Description**: ◆ An EOB is a statement an issuer sends the enrollee to explain what medical treatments or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy. **Provide**: ◆ An explanation of what an EOB is. ◆ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. **Example of Acceptable Language:** *Each time we process a claim submitted by you or your health care provider, we explain how we processed it in the form of an Explanation of Benefits (EOB).* *The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.*

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

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

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

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

Figure 2E-5. Transparency in Coverage Checklist

Transparency in Coverage Checklist

Introduction

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

Note: This document is not for submission.

Checklist

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

Claims Payment Policies and Practices URL Data Display Elements:

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

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

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

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

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

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

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

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

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