

Qualified Health Plan Issuer Application Instructions

2020

**Extracted subsection:
Section 2D: Plans & Benefits**

05/2019

Version 1.1

Section 2D: Plans & Benefits

1. Introduction

In the Plans & Benefits section, issuers enter data about their plans and list covered benefits with any quantitative limits or exclusions. They also provide cost-sharing values and basic plan variation information for each plan that they are submitting, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. This information is provided through two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, the issuer will need the following:

1. Completed Network ID (QHP and SADP), Service Area (QHP and SADP), and Formulary Excel Templates (QHP only);
2. Applicable plan URLs; and
3. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2020

- ◆ The EHB benchmark, which is populated through the **Refresh EHB** button in the Plans & Benefits Add-In, has been updated to reflect plan year changes.
- ◆ Catastrophic plans will be required to have a “Child-Only Offering” value of “Allows Adult and Child-Only” to validate.
- ◆ After running the Actuarial Value Calculator (AVC), if AVC screenshots are saved, they will each be on an Excel tab named with the plan variant ID, as opposed to a generic “Output” name.
- ◆ Issuers offering SADPs will be required to certify the “Issuer Actuarial Value” of each SADP’s coverage of pediatric dental EHB for PY2020. Issuers may offer the pediatric dental EHB at any actuarial value (AV).

Tips for the Plans & Benefits Section

- ◆ Download the most recent versions of the 2020 Plans & Benefits Template, Plans & Benefits Add-In file, and AVC.
- ◆ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template for the macros to run properly.
- ◆ All data elements that CMS *anticipates* displaying to individual market consumers on Plan Compare are **identified by a number sign (#)** next to the field name.
- ◆ All data fields required for SADP issuers are **identified by an asterisk (*)** next to the field name. 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, 4.26, and 4.27.
- ◆ All data fields used by the AVC are **identified by a caret (^)** next to the field name. See Appendix A for additional AVC instructions.
- ◆ Issuers should complete the Network, Service Area, and Prescription Drug Templates (QHPs only) and save the templates before filling out the Plans & Benefits Template. The Plans & Benefits Template requires issuers to assign a network, service area, and formulary ID to each plan based on the IDs already 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 the **Create New Benefits Package** button on the menu bar under the Plans & Benefits ribbon. The **HIOS Issuer ID**, **Issuer State**, **Market Coverage**, **Dental Only Plan**, and **Taxpayer Identification Number (TIN)** fields are auto-populated.
- ◆ Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost-sharing reduction (CSR) plan variation the issuer wishes to offer.

Tips for the Plans & Benefits Section

- ◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See **Appendix A** for how these values relate to AV.
- ◆ When a cell is grayed out, it is locked and cannot be edited. HIOS will not process data entered into the cell before it was grayed out.

4. Detailed Section Instructions

When opening the Plans & Benefits Template, if the issuer is asked to enable macros, use the **Options** button on the Security Warning toolbar, and select **Enable this content**. If the macros are not enabled before the data are entered, the template will not recognize those data fields and they will have to be reentered. Once the issuer enables macros, the **Plans & Benefits** ribbon should appear (Figure 2D-1) as a tab on the file's toolbar.

Figure 2D-1. Plans & Benefits Ribbon

Note: Before proceeding, the issuer should confirm that it has downloaded the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the QHP certification website (<https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits>).

4.1 General Information

The fields in the upper-left portion of the Benefits Package worksheet contain basic information about the issuer and the types of plans that will be entered into the template (Figure 2D-2). This information must be entered in the first Benefits Package worksheet; it will then auto-populate any additional Benefits Package worksheets generated by the issuer.

Figure 2D-2. Plans & Benefits Template

General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following options: ♦ Individual —if the plans are offered on the individual market. ♦ SHOP (Small Group) —if the plans are offered on the small-group market.
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 SADPs and prevents the fields from accepting data entry. ♦ No —if this is <i>not</i> a dental-only package.
TIN*	Enter the issuer's nine-digit (xx-xxxxxxx) TIN.

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 2D-3**). Complete this section for each standard plan the issuer plans to offer as part of this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage or an SADP; a benefits package is a group of plans that covers the same set of benefits. Each plan in a benefits package may have different cost-sharing values, which are entered in the corresponding Cost Share Variances worksheet. Enter each standard plan in the Benefits Package worksheet, and the template automatically creates the necessary plan variations in the Cost Share Variances worksheet.

If the issuer runs out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans & Benefits** ribbon. Each benefits package may have up to 50 plans. If there are more than 50 plans associated with the same benefits package, a new benefits package with the identical benefits package structure must be created to accommodate the additional plans.

Figure 2D-3. Plan Identifiers Section

2020 Plans & Benefits Template v9.0		To use this template, please review the user guide and instructions				
HIOS Issuer ID*		You will need to save the latest version of the add-in file (PlansBen				
Issuer State*		To create the cost share variance worksheet and enter the cost sha				
Market Coverage*		To create additional Benefits Package worksheets, use the Create				
Dental Only Plan*		To populate the benefits on the Benefits Package worksheet with yo				
TIN*						
Plan Identifiers						
HIOS Plan ID* (Standard Component)	Plan Marketing Name*	HIOS Product ID*	HPID	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.
HIOS Product ID*	Enter the 10-character, HIOS-generated product ID number.
HPID	Enter the 10-digit national Health Plan Identifier (HPID).

Plan Identifiers	Steps
Network ID*	Click the Import Network IDs button on the menu bar under the Plans & Benefits ribbon and select the completed Network ID Template Excel file to import a list of network ID values from the Network ID Template; then select the appropriate network ID from the drop-down menu. (The Excel version of the Network ID Template must be completed and saved before importing the network IDs.)
Service Area ID*	Click the Import Service Area IDs button on the menu bar under the Plans & Benefits ribbon and select the completed Service Area Template Excel file to import a list of service area ID values from the Service Area Template, then select the appropriate service area ID from the drop-down menu. (The Excel version of the Service Area Template must be completed and saved before importing the service area IDs.)
Formulary ID	Click the Import Formulary IDs button on the menu bar under the Plans & Benefits ribbon and select the completed Prescription Drug Template Excel file to import a list of values from the Prescription Drug Template; then select the appropriate formulary ID from the drop-down menu. (The Excel version of the Prescription Drug Template must be completed and saved before importing the formulary IDs.)

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 2D-4**).

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

Plan Attributes					
Notice Required for Pregnancy*	Is a Referral Required for Specialist?*	Specialist(s) Requiring a Referral	Plan Level Exclusions	Limited Cost Sharing Plan Variation - Est Advanced Payment	Does this plan offer Composite Rating?*

Plan Attributes	Steps
New/Existing Plan?*	Indicate whether this is a new or existing plan. Choose from the following options: <ul style="list-style-type: none"> ◆ New—if this is a new plan that was not offered last year. This includes a plan that was offered last year but is not considered to be the “same plan” as described in 45 CFR 144.103. This plan should use a new plan ID that was <i>not</i> used for the 2019 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. This plan should use <i>the same</i> plan ID that was used for the 2019 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 product network types: <ul style="list-style-type: none"> ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point-of-service) ◆ EPO (exclusive provider organization).
Level of Coverage^*#	Select the metal level of the plan based on its AV. A de minimis variation of -4/+2 percentage points is allowed for standard metal-level plans. Please note that, 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 through the Exchange, as described in Section 1302(d)(1) of the PPACA. Choose from the following: <ul style="list-style-type: none"> ◆ Bronze—AV of 60 percent.

Plan Attributes	Steps
	<ul style="list-style-type: none"> ◆ Expanded Bronze—AV of 56–65 percent. A plan may use this option if it either covers and pays for at least one major service, other than preventive services, 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. <p>Level of coverage for SADPs is required, however the AV for dental plans is optional. If an AV is provided, it must fall within the previous AV ranges of high or low, as described in 45 CFR 156.140:</p> <ul style="list-style-type: none"> ◆ Low—AV of 70 percent. ◆ High—AV of 85 percent.
Design Type*	This field is not applicable for PY2020. All plans should select Not Applicable for this field.
Unique Plan Design	<p>Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available for HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix A. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if the unique plan design features cause the use of the AVC to yield an AV result that materially differs from that of the other approved methods described in 45 CFR 156.135(b). This indicates that the plan is not compatible with the AVC. If Yes is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification (see Supporting Documentation). 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 <i>not</i> unique.
QHP/Non-QHP*	<p>Indicate whether the plan will be offered only through the Exchange, only outside the Exchange, or both through and outside the Exchange. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ On the Exchange—if the plan will be offered only through the Exchange. <i>Note:</i> Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered through the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan outside the Exchange. Issuers that offer a plan through the Exchange should select Both unless an exception to guaranteed availability applies. ◆ Off the Exchange—if the plan will be offered only outside the Exchange. This includes non-QHPs as well as plans that are substantially the same as a QHP offered through the Exchange for purposes of the risk corridor program (see 45 CFR 153.500 for more details). ◆ Both—if the plan will be offered both through and outside the Exchange. A plan that is offered both through and outside the Exchange must have the same premium, provider network, cost-sharing structure, service area, and benefits, regardless of whether it is offered through or outside of the Exchange. Selecting this option creates two separate plan variations in the Cost Share Variances worksheet when the worksheet is created: one on-Exchange plan and one off-Exchange plan.

Plan Attributes	Steps
Notice Required for Pregnancy	Indicate whether the issuer has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if a notice is required. ◆ No—if a notice is <i>not</i> required.
Is a Referral Required for a Specialist?#	Indicate whether a referral is required to see a specialist. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if a referral is required to see a specialist. ◆ No—if a referral is <i>not</i> required to see a specialist.
Specialist(s) Requiring a Referral#	(Required if Yes is entered for “Is a Referral Required for a Specialist?”) Enter the types of specialists that require a referral.
Plan Level Exclusions*	Enter any plan exclusions.
Limited Cost-Sharing Plan Variation—Est Advance Payment	This data element is not necessary for PY2020 because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost-sharing plan variations. Leave this field blank.
Does this plan offer Composite Rating?	This field is not applicable for PY2020. All plans should select No for this field.
Child-Only Offering*	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (offered only to individuals who, as of the beginning of the plan year, have not attained the age of 21 for QHPs and 19 for SADPs); 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” in order to validate. Choose from the following options: <ul style="list-style-type: none"> ◆ Allows Adult and Child-Only—if the plan allows adult- and child-only enrollment and is offered at a child-only rate. ◆ Allows Adult-Only—if the plan does <i>not</i> allow child-only enrollment. This does not mean that only adults can enroll but that this plan requires an adult as 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 as they must have the option of being offered 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 for Child-Only Offering . Enter the corresponding 14-character plan ID if this plan does <i>not</i> allow child-only enrollment. The entered plan ID must correspond to a plan in which the Child-Only Offering is “Allows Adult and Child-Only” or “Allows Child-Only.” The corresponding plan must have the same Level of Coverage as the plan for which the issuer is entering data.

Plan Attributes	Steps
Tobacco Wellness Program Offered	<p>Indicate whether, as required to rate for tobacco use in the small-group market, 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. (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 options:</p> <ul style="list-style-type: none"> ◆ Yes—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. ◆ No—if the plan does <i>not</i> offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter No if either of the following applies: <ul style="list-style-type: none"> ▪ The plan is offered in the individual market. ▪ The plan is offered in the small-group market and does not rate for tobacco use.
Disease Management Programs Offered [#]	<p>Indicate whether the plan offers disease management programs. Choose one or more of the following options:</p> <ul style="list-style-type: none"> ◆ 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	<p>Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). This is required for all plans on the individual and SHOP markets except for catastrophic plans. Please note that if abortion services are included in the benefits package of the EHB benchmark plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below:</p> <ul style="list-style-type: none"> ◆ If the plan is a QHP offered in the FFE or a State-based Exchange (SBE), the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Because subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion. ◆ If the plan is not a QHP offered in the FFE or in an SBE, but is only offered outside of the Exchange, the percentage of the premium associated with abortion services should be included in the EHB percentage. <p>If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state-mandated benefits portion or the other benefits portion regardless of whether the plan is sold through or outside of the Exchange.</p>

4.4 Stand-Alone Dental Only

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

Figure 2D-5. SADP-Only Fields

Stand Alone Dental Only

EHB Apportionment for Pediatric Dental Guaranteed vs. Estimated Rate

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 to the 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). Issuers must also submit the Stand-Alone Dental Plans—Description of EHB Allocation Form as a supporting document.
Guaranteed vs. Estimated Rate*	<p>This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the Rates Table Template and the Business Rules Template. By indicating the rate is a “Guaranteed Rate,” the issuer commits to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers’ geographic location, age, and other permissible rating factors provided for in the Rates Table Template and Business Rules Template. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported.</p> <p>Select whether this plan offers guaranteed or estimated rates. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Guaranteed Rate—if the plan offers a guaranteed rate. ◆ Estimated Rate—if the plan offers an estimated rate.

4.5 Plan Dates

This section contains fields for the plan effective date and plan expiration date for each plan. The FFE rating engine uses the rate effective dates in the Rates Table Template, not the Plans & Benefits Template (**Figure 2D-6**).

Figure 2D-6. Plan Dates

Plan Dates

Plan Effective Date* Plan Expiration Date

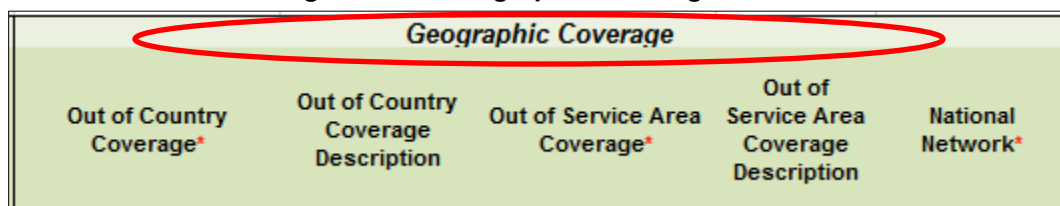
Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2020 plan year—even for existing plans offered on-Exchange in 2019. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2020, for all plans that will be offered through the FFE and Federally-facilitated Small Business Health Options Program (FF-SHOP).

Plan Dates	Steps
Plan Expiration Date*	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (it must be December 31, 2020, for the individual market). In the context of FF-SHOP, the plan is effective for a 12-month plan year. The plan expiration date is 12 months after the original employer coverage effective date.

4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Issuers should only select **Yes** for these data elements if the plan offers the entire package of benefits for the geographic unit. Issuers should not select **Yes** if the plan covers only emergency services for the geographic unit (**Figure 2D-7**).

Figure 2D-7. Geographic Coverage Fields

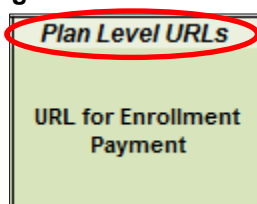


Geographic Coverage	Steps
Out of Country Coverage*	Indicate whether care obtained outside the country is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained out of the country. ◆ No—if the plan does <i>not</i> cover care obtained out of the country.
Out of Country Coverage Description*	(Required if “Yes” is selected for Out of Country Coverage.) Enter a short description of the care obtained outside the country that the plan covers.
Out of Service Area Coverage*	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options: <ul style="list-style-type: none"> ◆ Yes—if the plan covers care obtained outside the plan service area. ◆ No—if the plan does <i>not</i> cover care obtained outside the plan service area.
Out of Service Area Coverage Description*	(Required if “Yes” is entered for Out of Service Area Coverage.) Enter a short description of the care obtained outside the service area that is covered under the plan.
National Network**	Indicate whether a national network is available. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if a national network is available. ◆ No—if a national network is <i>not</i> available.

4.7 URLs

This section contains a field pertaining to URL information on plans (**Figure 2D-8**).

Figure 2D-8. URL Fields



URLs	Steps
URL for Enrollment Payment*	Enter the web address for enrollment payment information. Only submit a URL if it is a working payment site capable of collecting a consumer's first-month premium and it complies with the latest payment redirect business service description. The URL must start with "http://" or "https://" and must not contain blank spaces within the URL so that it will work properly for consumers. This URL is optional for SADPs.

4.8 Benefit Information

After completing the sections of the template detailed above, issuers will complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans (**Figure 2D-9**).

Figure 2D-9. Benefit Information Section

<i>Benefit Information</i>		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 the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. If this benefits package has multi-state plans (MSPs) using an alternate benchmark, click **Yes** in the pop-up. Otherwise, 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 not listed on the template, click the **Add Benefit** button on the menu bar under the **Plans & Benefits** ribbon.

- Look through the drop-down menu to determine whether the benefit already exists as an option; if the benefit is an option, select it. If the benefit is not an option, click the **Custom** button and type in the benefit name. New benefit names must be different from the existing benefit names.
- A row for this benefit appears below the last row in the Benefit Information section.
- If a benefit is mistakenly added, it cannot be deleted, but an issuer may do one of the following:
 - Select **Not Covered** under the "Is this Benefit Covered?" column (see Section 4.9).

- Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but also removes any other data entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.
- If the benefit added is not found in the state's benchmark, and the issuer is not substituting for an EHB found in the state's benchmark, select **Not EHB** as the EHB Variance Reason.
- If the benefit added is not found in the state's benchmark, but the issuer is substituting for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the EHB Variance Reason.
- If the benefit added is a state-required benefit enacted after December 2011, select **Not EHB** as the EHB Variance Reason.
- For more information on how to select the correct EHB Variance Reason, see **5.6 EHB Variance Reason and EHB Designation**.
- A benefits package should not have multiple benefits with identical names. In the event of multiple cost-sharing schemas for a given benefit based on multiple limits, choose the cost-sharing type that applies to the limits in the **Limit Quantity** and **Limit Unit** fields for each of the network types.

4.9 General Information

This section contains fields that give more information on each benefit in the benefits package, such as benefit coverage, benefit limits, applicable exclusions, and benefit explanations (**Figure 2D-10**).

Figure 2D-10. General Information Fields

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

General Information	Steps
EHB*	<p>This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. Issuers cannot edit this field.</p> <p><i>Note:</i> Issuers should carefully review the benefits covered by their applicable EHB benchmark plan as identified on CMS's "Information on Essential Health Benefits (EHB) Benchmark Plans" web page at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html. After reviewing the applicable EHB benchmark plan documents, issuers may need to update the Benefits Package worksheet with any changes required to accurately reflect their coverage of EHB benchmark benefits. See the EHB Variance Reason field instructions below for more information on updating the Benefits Package worksheet.</p>
Is this Benefit Covered?*	<p>This field is auto-populated with Covered for benefits identified in the template as EHB. If the "Is this Benefit Covered?" data element is changed to Not Covered, the issuer must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see the EHB Variance Reason field and Supporting Document section). 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 options:</p> <ul style="list-style-type: none"> ♦ Covered—if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar coverage or in combination with a cost-sharing mechanism (e.g., copays, coinsurance, or deductibles).

General Information	Steps
	<p>◆ Not Covered—if this benefit is <i>not</i> covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.</p>
Quantitative Limit on Service?*	<p>(Required if Covered is entered in the Is this Benefit Covered? field.) This field is auto-populated for benefits identified in the template as EHBs. If this data element is changed, an EHB variance reason must be provided, along with associated supporting documents. For any benefits not identified as EHBs, choose from the following options:</p> <ul style="list-style-type: none"> ◆ Yes—if this benefit has quantitative limits. ◆ No—if this benefit does <i>not</i> have quantitative limits. <p><i>Note:</i> Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2018, issuers may not impose combined limits on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Plans & Benefits Template Benefits Package worksheet, issuers must provide a separate limit for those benefits.</p>
Limit Quantity**	<p>(Required if Yes is entered for the Quantitative Limit on Service? field.) This field is auto-populated for benefits in the template identified as EHBs. If the issuer changes this data element, it must provide an EHB variance reason. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., to set a limit of two specialist visits per year, enter 2 here).</p>
Limit Unit**	<p>(Required if Yes is entered for the Quantitative Limit on Service? field.) This field is auto-populated for benefits in the template identified as EHBs. If data are changed for this element, select the EHB variance reason of Substantially Equal. For any benefits not identified as EHBs, using the drop-down menus, enter the units being restricted per interval to show the quantitative limits that are placed on this benefit (e.g., if the plans have a limit of two specialist visits per year, enter Visits per year here). Choose from the following options:</p> <ul style="list-style-type: none"> ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year ◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. <p>If a benefit has limit units that do not align with the list above, the limit does not auto-populate in the Limit Unit field but does auto-populate in the Benefit Explanation field (such as a limit of 1 hearing aid per ear every 48 months for subscribers up to age 18).</p>

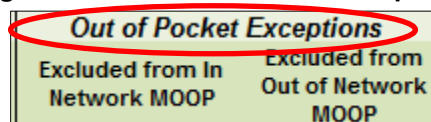
General Information	Steps
	<p>If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB benchmarks on the Center for Consumer Information and Insurance Oversight (CCIIO website (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html)). message “Quantitative limit units apply, see EHB benchmark” appears in the Benefit Explanation field (e.g., “Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services”).</p> <p>If a benefit has multiple limit units, they do not auto-populate. Put the limit quantity and limit unit that should be displayed on the Plan Compare function of the FFE website in these columns, and put all other quantitative limits in the Benefit Explanation field (such as “Outpatient Rehabilitative Services—90 days per year in the Limit Quantity and Limit Unit columns; two treatments per year in the benefit explanation”).</p> <p>The message “Quantitative limit units apply, see EHB benchmark” may appear in the Benefit Explanation field for a benefit that does not have quantitative limits in the Benefits and Limits section of the EHB benchmark on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). This message appears because certain benefits, identified in the Other Benefits section of the EHB benchmark Benefit Template, may have quantitative limits, which may not apply to all services in the higher-level benefit category.</p>
Exclusions**	<p>Enter any benefit-level exclusions.</p> <ul style="list-style-type: none"> ◆ If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions. ◆ If <i>no</i> services or diagnoses are excluded, leave this field blank.
Benefit Explanation**	<p>Enter any benefit explanations.</p> <ul style="list-style-type: none"> ◆ Examples of benefit explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed descriptions of services provided, and alternate cost-sharing structures if they depend on provider type or place of service.
EHB Variance Reason*	<p>(Required if the issuer changed the Is this Benefit Covered?, Limit Units, or Limit Quantity fields, or if the benchmark has an unallowable limit or exclusion under the PPACA.) Select from the following EHB variance reasons if this benefit differs from the state’s benchmark:</p> <ul style="list-style-type: none"> ◆ Not EHB—if this benefit is <i>not</i> an EHB. <ul style="list-style-type: none"> ▪ If the issuer has added a new benefit and it is not found in the state’s benchmark, the EHB field will be blank and the issuer should set the EHB variance reason to Not EHB. This benefit is <i>not</i> considered an EHB. ▪ If a benefit auto-populated as Yes in the EHB column, but the issuer has received guidance from CMS or the state indicating that it should not be considered an EHB, set the EHB Variance Reason to Not EHB. This benefit is <i>not</i> considered an EHB. ◆ Substituted—if a benefit is included in the state’s benchmark, the EHB field auto-populates as Yes. If substituting a different benefit for an EHB, set the EHB Variance Reason field to Substituted and the Is this Benefit Covered? field to Not Covered. The benefit that takes its place must be designated as an Additional EHB Benefit. ◆ Substantially Equal—if the limit quantity for a benefit differs from the limit quantity in the EHB benchmark, but is still substantially equal to the EHB benchmark, select Substantially Equal as the variance reason. Also, if the limit unit for a benefit differs from the limit unit in the EHB benchmark, but is still substantially equal to the EHB benchmark, select Substantially Equal as the variance reason. For example, if the benchmark lists a limit of 40 hours per month, and the plan defines a day as 8 hours and lists a limit of 5 days per month, the issuer should use that variance reason.

General Information	Steps
	<ul style="list-style-type: none"> ◆ Using Alternate Benchmark—multi-state plans use an alternate benchmark. Issuers should select this EHB variance reason for any benefit that has Yes for EHB but is not an EHB in the alternate benchmark. ◆ Other Law/Regulation—if a benefit is required by a state or federal law or regulation that was enacted on or before December 31, 2011, and the benefit is not represented in the state's EHB benchmark plan. (State-required benefits that were enacted after December 31, 2011, are <i>not</i> EHBs, and for those the issuer should use Not EHB as the variance reason instead.) For example, a benefit may not appear as an EHB because the benchmark plan is a small-group plan and coverage is only state-required in the individual market. When an issuer is filling out the template for an individual market plan, coverage of the benefit must be changed from blank to Covered using the EHB variance reason Other Law/Regulation. ◆ Additional EHB Benefit—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are covered. In this case, change the benefit to Covered, and choose Additional EHB Benefit as the EHB variance reason. 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 issuer is not covering a benefit because it is a dental EHB covered by a separate dental-only plan, set the EHB Variance Reason to Dental Only Plan Available. For example, an issuer may offer SADPs to cover pediatric dental benefits, so they will not need to cover pediatric dental as part of the medical plans. The issuer would select Not Covered and select Dental Only Plan Available as the EHB variance reason for benefits, such as Dental Check-Up for Children, Basic Dental Care—Child, Orthodontia—Child, and Major Dental Care—Child if the benefits are designated as a Covered EHB. (This option is not applicable to SADPs.) <p><i>Note:</i> Because EHB benchmark plan benefits are based on plans that were sold previously, some of the benchmark plan designs may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Issuers should carefully review the information available on the CMS “Information on Essential Health Benefits (EHB) Benchmark Plans” web page (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html).</p> <p>If more than one EHB variance reason applies, select the option related to EHB designation instead of the one related to limits. For example, if an issuer adds a new benefit that is an EHB and also changes its limits, the EHB variance reason that should be selected is Additional EHB Benefit instead of Substantially Equal. It is important that the issuer enters the correct EHB Variance Reason because it has implications for nondiscrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to CSR plan variations.</p>

4.10 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, issuers must create a new benefits package and then a new Cost Share Variances worksheet (**Figure 2D-11**).

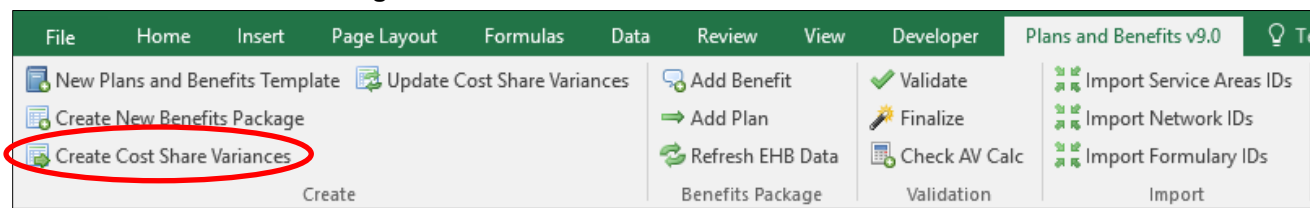
Figure 2D-11. Out of Pocket Exceptions



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

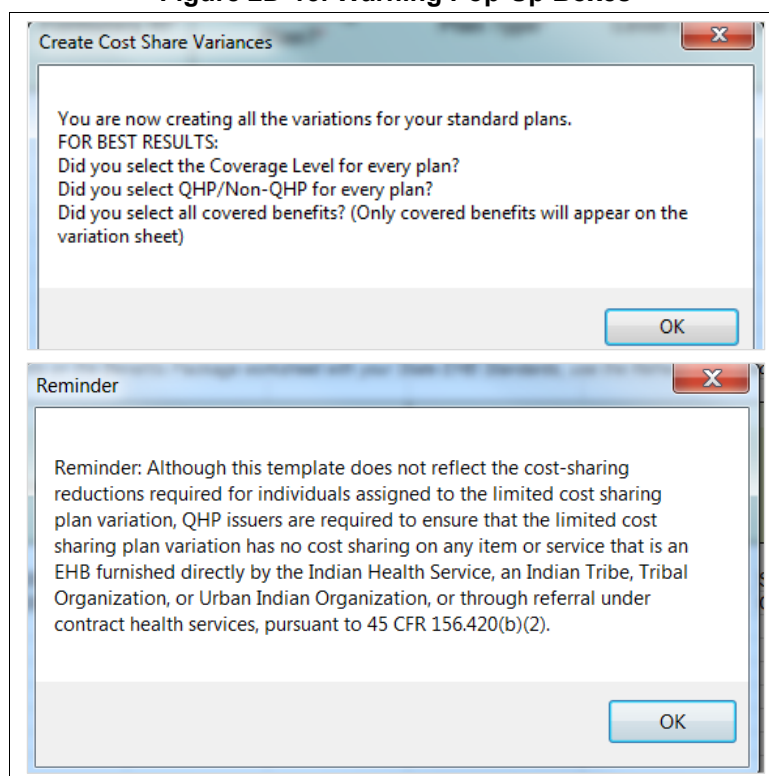
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon (**Figure 2D-12**). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2D-12. Create Cost Share Variances Button



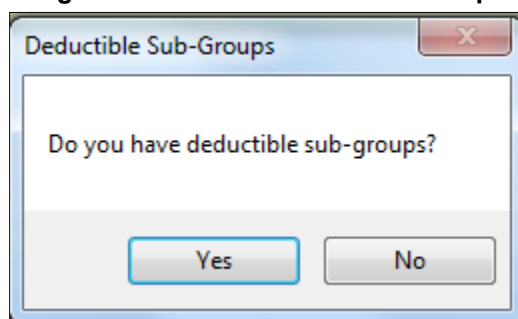
Click **OK** after reading the warnings (**Figure 2D-13**) and make any necessary changes.

Figure 2D-13. Warning Pop-Up Boxes



Once warnings are addressed, the following series of questions regarding deductible sub-groups (**Figure 2D-14**) appears. Deductible sub-groups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible sub-groups are not separate deductibles outside any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible sub-groups.

Figure 2D-14. Deductible Sub-Groups



1. Do you have any deductible sub-groups?
 - a. **Yes**—if the plan contains deductible sub-groups.
 - b. **No**—if the plan does *not* contain deductible sub-groups.
2. If you selected Yes to 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 the name of each sub-group and click **OK** after each. You must use a different name for each sub-group.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (**Figure 2D-15**). Corresponding worksheets are labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 2D-15. Cost Share Variances Worksheet

Plan Cost Sharing Attributes										
HIOS Plan ID* (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*	Medical & Drug Maximum Out of Pocket Integrated?*	Multiple in Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization

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

4.11 Plan Cost-Sharing Attributes

This section has fields that collect 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 by the issuer. However, CSRs do not apply to SADPs.

Plan Cost-Sharing Attributes	Steps
HIOS Plan ID*	<p>The HIOS-generated number auto-populates for each cost-sharing plan variation.</p> <ul style="list-style-type: none"> ◆ Standard plans to be offered on the Exchange have a plan ID variant suffix of “-01,” and standard plans to be offered outside 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 and one with limited cost sharing. These are indicated with a plan ID variant suffix of “-02” and “-03,” respectively. <ul style="list-style-type: none"> ▪ 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 if they have a referral from an Indian health care provider. ◆ In the individual market, each silver plan has three additional CSR plan variations created: a 73 percent AV plan, an 87 percent AV plan, and a 94 percent AV plan. These are indicated with a plan ID variant suffix of “-04,” “-05,” and “-06,” respectively.

Plan Cost-Sharing Attributes	Steps
	<ul style="list-style-type: none"> These silver plan variations offer a discount that lowers the amount consumers pay out of pocket for deductibles, coinsurance, and copayments, and lowers the MOOP. Consumers qualify for these plans if their income is below a certain level.
Plan Variant Marketing Name**	The name of the plan auto-populates for all standard plans and plan variations with the standard plan's plan marketing name. The field can be edited on this worksheet for each of the plan variations. The marketing name entered for each plan variation on this worksheet will be the one that displays to consumers. The field has a limit of 255 characters.
Level of Coverage^*	The coverage level for the plan auto-populates for standard plans.
CSR Variation Type^	The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, a standard off-Exchange plan, or one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	(Required if Yes is entered for Unique Plan Design .) Enter the issuer-calculated AV. This is required of SADPs for PY2020. Issuers may offer the pediatric dental EHB at any AV for PY2020. This applies to health plans that indicate they are a unique plan for AV purposes. SADP issuers must submit the "Stand-Alone Dental Plan Actuarial Value" supporting documentation noting the value of the AV level of the pediatric dental EHB and certifying that their AV was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methods.
AV Calculator Output Number	Clicking the Check AV Calc button on the Plans & Benefits ribbon and selecting the correct file populates this field with the AV for all plans on this worksheet with a non-unique plan design. All cost-sharing information and benefits package information must be completed before clicking this button. (For more information, see Appendix A .) This field is required for QHPs, but optional for SADPs.
Medical & Drug Deductibles Integrated?^	<p>Indicate whether the medical and drug deductible is integrated. An integrated deductible allows both medical and drug charges to contribute to a total plan-level deductible. A separate deductible indicates medical and drug charges contribute to separate plan-level deductibles. Choose from the following options:</p> <ul style="list-style-type: none"> ♦ Yes—if the medical and drug deductible is integrated. If Yes is entered, issuers should not enter information in the Medical Deductible or Drug Benefits Deductible sections. ♦ No—if the medical and drug deductible is <i>not</i> integrated. If No is entered, issuers should not enter information in the Combined Medical & Drug Deductible section.
Medical & Drug Maximum Out of Pocket Integrated?^	<p>Indicate whether the medical and drug MOOP is integrated. An integrated MOOP allows both medical and drug charges to contribute to a total plan-level MOOP. A separate MOOP indicates medical and drug charges contribute to separate plan-level MOOP values. Choose from the following options:</p> <ul style="list-style-type: none"> ♦ Yes—if the medical and drug MOOP is integrated. If Yes is entered, issuers should not enter information in the Maximum Out of Pocket for EHB Benefits or Maximum Out of Pocket for Drug Benefits sections. ♦ No—if the medical and drug deductible MOOP is <i>not</i> integrated. If No is entered, issuers should not enter information in the Maximum Out of Pocket for EHB and Drug Benefits (Total) section.
Multiple In Network Tiers?^*	<p>Indicate whether there are multiple in-network provider tiers, which would allow the plan to apply different levels of in-network cost sharing depending on the tier of the provider or facility. The value must be the same for all variations of a plan. Choose from the following options:</p> <ul style="list-style-type: none"> ♦ Yes—if there are multiple in-network provider tiers. Enter Tier 1 information into the In Network and In Network (Tier 1) sections and Tier 2 information into the In Network (Tier 2) sections.

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

4.12 Summary of Benefits and Coverage Scenario

This section contains fields for basic information on three Summary of Benefits and Coverage (SBC) scenarios. This section is not applicable to SADPs. Additional information containing SBC scenarios and further resources for completing the scenarios can be found in the Summary of Benefits and Coverage and Uniform Glossary section of the CCIIO website at <http://www.cms.gov/ccio/Resources/Forms-Reports-and-Other-Resources/index.html>. Any other concerns or technical assistance inquiries about these fields can be directed 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).

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.

4.13 Maximum Out-of-Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Not all of the sections should be filled out, depending on whether the medical and drug MOOP and deductibles are integrated, as indicated through the entries in the **Medical & Drug Deductibles Out of Pocket Integrated?** and **Medical & Drug Maximum Out of Pocket Integrated?** fields. SADP issuers should skip to Sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (For guidance completing the MOOP and Deductible sections of the template, and ensuring that all requirements are met, see **5.1 MOOP and Deductible Guidance**.)

The **Family** fields for **In Network**, **In Network (Tier 2)**, and **Out of Network MOOP** and deductibles 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 be displayed 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 new field:

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan (\$8,150) and for the specific CSR plan variations.⁴ See **5.5 Requirements for Cost-**

⁴ See the final annual *Notice of Benefit and Payment Parameters for the 2020 benefit year (final 2020 Payment Notice)*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2020*.

Sharing Reduction Plan Variations for more details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.

- There must be a per-person amount and per-group amount entered for MOOP; the issuer may not enter **Not Applicable** for all these cells in all **Family** fields. The only exception is if a given plan is available to consumers only as self-only coverage.

4.14 Maximum Out-of-Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in **Figure 2D-16**.

Figure 2D-16. 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

This section is used for inputting MOOP values for medical EHBs and is required only if the medical and drug MOOPs are *not* integrated (**No** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**). If the MOOPs are integrated (**Yes** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the individual and family MOOP for EHBs in the following areas of the template.

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

4.15 Maximum Out-of-Pocket for Drug EHB Benefits

This section is used for inputting MOOP values for drug EHBs and is required only if the medical and drug MOOPs are *not* integrated (**No** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**). If the MOOPs are integrated (**Yes** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the individual and family MOOP for drug EHBs in the following areas of the template.

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

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

This section is used for inputting MOOP values for medical and drug EHBs, and it is required only if the medical and drug MOOPs are integrated (**Yes** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**). If the MOOPs are *not* integrated (**No** is entered for **Medical & Drug Maximum Out of Pocket Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the individual and family MOOP for medical and drug EHBs in the following areas on the template.

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

MOOP Medical & Drug EHB Benefits	Steps
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Out of Network Family Maximum Out of Pocket .
Combined In/Out Network—Individual ^{^#}	If the MOOPs are integrated, enter the dollar amount for the Total Combined In/Out of Network Individual Maximum Out of Pocket .
Combined In/Out Network—Family [#]	If the MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Combined In/Out of Network Family Maximum Out of Pocket .

4.17 Medical EHB Deductible

This section is used for inputting deductible values for medical EHBs and is required only if the medical and drug deductibles are *not* integrated (**No** is entered for **Medical & Drug Deductibles Integrated?**). If the deductibles are integrated (**Yes** is entered for **Medical & Drug Deductibles Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the Individual and Family deductible for EHBs in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual ^{^#}	If the deductibles are <i>not</i> integrated, enter the dollar amount for In Network Individual Medical EHB Deductible .
In Network—Family [#]	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for In Network Family Medical EHB Deductible .
In Network—Default Coinsurance [^]	If the deductibles are <i>not</i> integrated, enter the numerical value for the in-network coinsurance. <i>Note:</i> If the deductibles are <i>not</i> integrated, this is a required field for the AV calculation for those plans using the AVC.
In Network (Tier 2)—Individual [^]	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Medical EHB Deductible . If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the deductibles are <i>not</i> integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Medical EHB Deductible . If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Default Coinsurance [^]	If the deductibles are <i>not</i> integrated, enter the numerical value for the in-network coinsurance. If there are <i>not</i> multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If the deductibles are <i>not</i> integrated, enter the dollar amount for Out of Network Individual Medical Deductible .
Out of Network—Family	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Out of Network Family Medical EHB Deductible .
Combined In/Out Network—Individual ^{^#}	If the deductibles are <i>not</i> integrated, enter the dollar amount for Combined In/Out of Network Individual Medical EHB Deductible .
Combined In/Out Network—Family [#]	If the deductibles are <i>not</i> integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Medical EHB Deductible .

4.18 Drug EHB Deductible

This section is used for inputting deductible values for drug EHBs and is required only if the medical and drug deductibles are *not* integrated (**No** is entered for **Medical & Drug Deductibles Integrated?**). If the deductibles are integrated (**Yes** is entered for **Medical & Drug Deductibles Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the individual and family deductible for drug EHBs in the following areas on the template.

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

4.19 Combined Medical and Drug EHB Deductible

This section is used for inputting deductible values for medical and drug EHBs and is required only if the medical and drug deductibles are integrated (**Yes** is entered for **Medical & Drug Deductibles Integrated?**). If the deductibles are *not* integrated (**No** is entered for **Medical & Drug Deductibles Integrated?**), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the individual and family deductible for medical and drug EHBs in the following areas on the template.

Medical & Drug EHB Deductible	Steps
In Network—Individual ^{^#}	If the deductibles are integrated, enter the dollar amount for In Network Individual Combined Medical and Drug EHB Deductible .
In Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amount for In Network Family Combined Medical and Drug EHB Deductible .
In Network—Default Coinsurance [^]	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. (If deductibles are integrated, this field is required for the AV calculation for plans using the AVC.)

Medical & Drug EHB Deductible	Steps
In Network (Tier 2)—Individual [^]	If the deductibles are integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible . If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
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 amount for In Network (Tier 2) Family Combined Medical and Drug EHB Deductible . If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
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 for editing.
Out of Network—Individual	If the deductibles are integrated, enter the dollar amount for Out of Network Individual Combined Medical and Drug EHB Deductible .
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amount for Out of Network Family Combined Medical and Drug EHB Deductible .
Combined In/Out Network—Individual ^{^#}	If the deductibles are integrated, enter the dollar amount for Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible .
Combined In/Out Network—Family [#]	If the deductibles are integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Combined Medical and Drug EHB Deductible .

4.20 Maximum Out-of-Pocket for Dental EHB Benefits

This section is used for inputting MOOP values for dental EHBs. When entering the MOOP values, ensure that the following limits are met: The MOOP values must be equal to or below the required limits of \$350 for one covered child (considered the “individual” limit) and \$700 for two or more covered children (considered the “family” limit). 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 MOOP for dental EHBs in the following areas of the template.

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

4.21 Dental EHB Deductible

This section is used for inputting 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 deductible for EHBs in the following areas on the template.

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

4.22 Other Deductible

Issuers should complete this section if they have deductible sub-groups; they 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, and they still contribute to the MOOP and deductible limits.)

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

4.23 Health Savings Account (HSA)/Health Reimbursement Account (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: <ul style="list-style-type: none"> ◆ Yes—if the plan meets all HSA requirements. ◆ No—if the plan does <i>not</i> meet all HSA requirements.
HSA/HRA Employer Contribution [^]	(Required for small group only; must be left blank for individual market.) Indicate whether the employer contributes to an HSA/HRA. Choose from the following: <ul style="list-style-type: none"> ◆ Yes—if the plan has an HSA/HRA employer contribution. ◆ No—if the plan does <i>not</i> have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount [^]	(Required if Yes is entered for HSA/HRA Employer Contribution; must be left blank for individual market.) Enter a numerical value representing the employer contribution amount to the HSA/HRA. 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.

4.24 URLs

This section contains fields that collect URLs for applicable websites. URLs must start with “http://” or “https://” and must not contain blank spaces within the URL so that they will work properly for consumers. To give consumers access to all relevant plan information needed to compare and select plans, CMS asks that issuers ensure that these URLs link directly to up-to-date and accurate information that is readily obtainable on their websites. Issuers should ensure that prospective enrollees can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

For each standard plan or plan variation, issuer URLs should link directly to the relevant SBC or plan brochure, respectively. This will provide consumers with the best and most accurate shopping experience when searching for available plans through the FFE. Linking directly to the SBCs and plan brochures will guarantee that consumers will see the document that directly applies to the health plan that they are considering for purchase. Issuers offering SHOP plans through FF-SHOP must provide a URL linking to their SHOP plan information in the SBC URL field. This information will be displayed in the see Plans and Prices utility on HealthCare.gov.

As part of ongoing compliance monitoring, CMS may compare the benefits coverage and cost-sharing information input in the Plans & Benefits Template with the information issuers provide to consumers on the plan's SBC and plan brochure. Please take care to review the information submitted on this template, as well as the coverage that is represented on the plan's SBC and the plan brochure, to ensure that all of this information is aligned with the actual terms of coverage before submission.

URLs	Steps
URL for Summary of Benefits & Coverage [#]	Enter the URL that takes the consumer directly to the SBC content for the specific standard plan or plan variation. As defined in 45 CFR 155.205(b)(1)(ii), plans will <i>not</i> be displayed to consumers if this field is not completed.
Plan Brochure [#]	◆ Enter the URL that goes directly to the plan brochure for the specific standard plan or plan variation. These documents should clearly communicate any cost sharing and other information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage. For example, if the plan has different cost sharing for benefits depending on service location, further details on these cost-sharing differences should be communicated through the plan brochure.

URLs	Steps
	<ul style="list-style-type: none"> ◆ CMS expects issuers to submit SBC and plan brochure URLs by the final deadline for submission of QHP data so that the FFE can provide consumers access to the appropriate SBCs through its website (see 45 CFR 155.205). CMS expects these links to be active and route the user directly to the appropriate document by the time the issuer has signed its QHP agreement. Issuers are strongly encouraged to submit these links and make them active earlier so that they can fully test their data through Plan Preview.

4.25 AV Calculator Additional Benefit Design

This section contains optional fields, which may be filled out for use as inputs in the AVC.

AV Calculator Additional Benefit Design	Steps
Maximum Coinsurance for Specialty Drugs [^]	Indicate whether the per-script coinsurance amount for specialty drugs is capped at a set amount. 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? [^]	Indicate whether there is a limit on the number of days that a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day. Enter the maximum number of days allowed (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost Sharing After a Set Number of Visits? [^]	Indicate whether primary care cost sharing begins after a certain number of fully covered visits. Enter the maximum number of fully covered visits (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? [^]	Indicate whether primary care visits are subject to the deductible and/or coinsurance after a certain number of primary care visits with copay have occurred. Enter the maximum number of copay visits (1–10) that can occur before visits become subject to the deductible and/or coinsurance. If this option does not apply, leave the field blank.

4.26 Covered Benefits

This section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

Fill in information for each of the benefits as follows:

1. If the issuer has plans that do not have out-of-network benefits for a given covered benefit, enter **Not Applicable** for the out-of-network copay fields and **100%** for the out-of-network coinsurance fields.
2. There is a drop-down option of **Not Applicable** for all cost-sharing fields. This value should be used in the following scenarios:
 - a. If the issuer charges only a copay or a coinsurance for a benefit, enter **Not Applicable** for the other. For example, if an issuer wishes to charge a \$20 copay for a benefit, enter **\$20** for the copay and **Not Applicable** for the coinsurance. Please note that **No Charge** was used for this scenario in past years, but **Not Applicable** is the correct option in the 2020 template.
 - b. If the issuer has multiple in-network tiers, enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance for any benefit category that does not have tiers. For example, if the issuer has only multiple in-network tiers for its inpatient hospital covered benefits, it would enter Tier 2 cost sharing as described below. For other covered benefits without multiple in-network tiers, issuers should enter **Not Applicable** for the In Network (Tier 2) copay and coinsurance.
3. For further instructions on how to coordinate 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**.
4. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, please see **Appendix A**.

5. There are many cost-sharing requirements for the CSR silver plan variations and the zero and limited cost-sharing plan variations (see **5.5 Requirements for Cost-Sharing Reduction Plan Variations**).
6. If cost sharing varies based on place of service or provider type, ensure that no benefit already specifically applies to the place of service or provider type. If there is not one available, fill out the copay and/or coinsurance most typical for most enrollees (such as the highest used); in the **Benefit Explanation** field, add appropriate and brief detail to communicate the cost sharing exceptions for the scenarios that do not follow the most common structure entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) should also clearly communicate any cost-sharing information that may vary based on place of service or provider type.

Figure 2D-17 shows an example of how the fields for each benefit are laid out.

Figure 2D-17. Benefit Information Fields

BV	BW	BX	BY	BZ	CA
Primary Care Visit to Treat an Injury or Illness					
Copoly			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)*^#	<p>If an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter Not Applicable. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and 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 <i>not</i> 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)*^#	<p>If the plan has multiple in-network tiers and an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter Not Applicable. For any benefit category that does not have tiers, enter Not Applicable for this field and the Coinsurance—In Network (Tier 2) field. This field may be grayed out depending on answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).

Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ \$X—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and 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 there are not multiple tiers for this benefit. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—Out of Network ^{**}	<p>If an out-of-network copayment is charged, enter the amount in this field. If no copayment is charged, enter Not Applicable. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). Note that Not Applicable, not No Charge, should be used if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ \$X—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible). ◆ \$X Copay after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay with deductible—the consumer first pays the copay, and 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 <i>not</i> 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	<p>The following options are the only available benefits for Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure that all variations follow the same “per day” or “per stay” cost-sharing structure. If no copayment is charged, enter Not Applicable.</p> <p>The benefits Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services include these options as well as those described in the Copay—In Network (Tier 1) section above. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). <i>Note:</i> Use Not Applicable, not No Charge, if only a coinsurance is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no copayment 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 <i>not</i> subject to the deductible). ◆ \$X Copay per Stay—the consumer pays a copayment per stay (this indicates that this benefit is <i>not</i> subject to the deductible). ◆ \$X Copay per Day after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible).

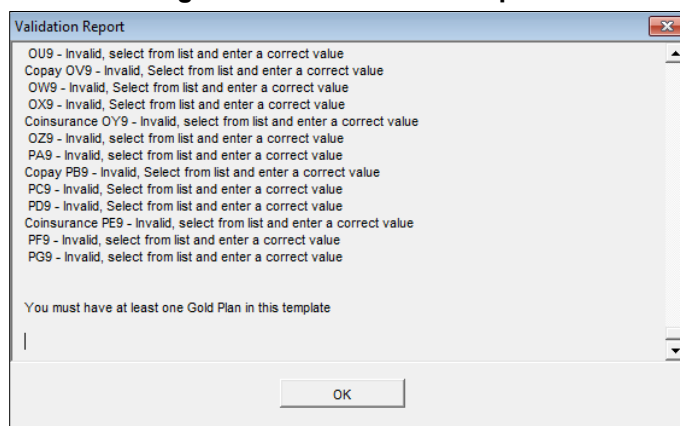
Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ \$X Copay per Stay after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ \$X Copay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

Covered Benefits	Steps
	<ul style="list-style-type: none"> ◆ X%—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> 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 <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network**	<p>If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If no coinsurance is 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 this benefit is not covered out of network, enter 100%. Choose from the following options:</p> <ul style="list-style-type: none"> ◆ No Charge—no cost sharing is charged (this indicates that this benefit is <i>not</i> subject to the deductible). <i>Note:</i> Use Not Applicable, not No Charge, if only a copay is charged. ◆ No Charge after deductible—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ X% Coinsurance after deductible—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ X%—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <i>not</i> subject to the deductible). ◆ Not Applicable—the consumer pays only a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is <i>not</i> subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.27 Completed Plans & Benefits Template

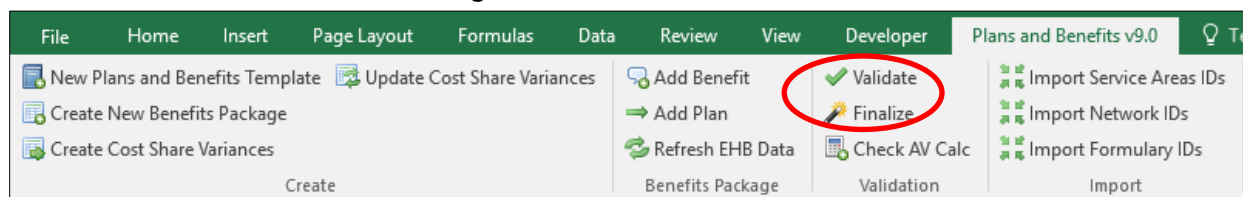
Once the entire template, including all Benefits Package and Cost Share Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans & Benefits** ribbon. If there are validation errors, a Validation Report (Figure 2D-18) will appear showing the data element and cell location of each error. The issuer must correct these errors for its Plans & Benefits Template to be accepted.

Figure 2D-18. Validation Report



Once errors are corrected and the validation is successful, click the **Finalize** button on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-19) to save the template as an XML file. Upload the saved file in the Benefits & Service Area Module. Before closing the template, save an XLSM version of the Excel file for future reference.

Figure 2D-19. Finalize Button



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. Issuers should read this section to ensure plan compliance.

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.⁵ When entering the MOOP values, ensure that the following limits are met for the in-network EHB MOOP. (See the final annual *Notice of Benefit and Payment Parameters for the 2020 benefit year [final 2020 Payment Notice]* for more details on the annual limit values.)
 - a. If the plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.
 - b. The standard plan's in-network EHB MOOP values must be less than or equal to \$8,150 for an individual (self-only) or \$16,300 for a family (other than self-only).
 - c. For the 73 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$6,500 for an individual (self-only) or \$13,000 for a family (other than self-only).
 - d. For the 87 percent and 94 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to \$2,700 for an individual (self-only) or \$5,400 for a family (other than self-only).
 - e. For the zero cost-sharing plan variations, the in- and out-of-network MOOP and deductible values for EHB must be \$0. These fields auto-populate and should not be changed for EHB.
 - f. 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 auto-populate whenever a value is entered for a standard plan and should not be changed.
2. Family MOOP Requirements. When entering the MOOP values, ensure that the following limits are taken into consideration. (See the *final 2020 Payment Notice*.)
 - 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 (\$16,300) 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 (\$8,150) and for the specific CSR plan variations as detailed in the annual limitation on cost sharing discussion immediately above.⁶

⁵ See the *final 2020 Payment Notice*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2020*.

⁶ See the *final 2020 Payment Notice*. Issuers must comply with policies that are incorporated into the final *HHS Notice of Benefit and Payment Parameters for 2020*.

- c. If a plan is available for self-only coverage only (an individual plan), 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 the Business Rules Template instructions for more details on offering self-only coverage and eligible dependent relationships.)
3. Definition of **Not Applicable** and **\$0** for Deductible and MOOP.
 - a. Do *not* enter **Not Applicable** if there is a zero-dollar deductible or MOOP; **\$0** is the appropriate data entry. For example, if a plan has a separate medical and drug deductible, and if there is no drug deductible, issuers must enter **\$0** as opposed to **Not Applicable**.
 - b. **Not Applicable** should be used in the In Network MOOP or deductible field only to imply that in-network service costs accumulate toward the entered Combined In/Out of Network MOOP or deductible.
 - c. If the **Individual In Network** and **Individual Combined In/Out of Network** deductible fields are equal to **Not Applicable**, the template returns an error when calculating the plan's AV using the AVC.
4. To include multiple children in child-only plans, use the "family" MOOP and deductible fields to capture the data.
5. The following explains how the values for various MOOP and deductible fields are related. Complete the fields as follows:
 - a. Some plans may have only combined in-network and out-of-network deductibles or MOOPs, rather than separate in-network and out-of-network deductibles or MOOPs. Other plans may have a mixture of in-network, out-of-network, and combined in-network and out-of-network deductibles or MOOPs. When defining deductibles and MOOPs, issuers must adhere to the guidelines.
 - b. If the plan does *not* have multiple in-network tiers, the following applies:
 - i. If the **In Network** field is equal to a dollar value (\$X), the **Combined In/Out of Network** field can be either a dollar value or **Not Applicable**.
 - ii. If the **In Network** field is **Not Applicable**, the **Combined In/Out of Network** field must be equal to a dollar value.
 - iii. The **Out of Network** field has no restrictions: it can be either a dollar value or **Not Applicable**.
 - c. If the plan has multiple in-network tiers, the following applies:
 - i. If the **In Network** and **In Network (Tier 2)** fields are equal to dollar values, the **Combined In/Out of Network** field can be either a dollar value or **Not Applicable**.
 - ii. If the **In Network** field is **Not Applicable**, the **In Network (Tier 2)** field must be **Not Applicable** and the **Combined In/Out of Network** field must be equal to a dollar value.
 - iii. If the **In Network (Tier 2)** field is **Not Applicable**, the **In Network** field must be **Not Applicable** and the **Combined In/Out of Network** field must be equal to a dollar value.
 - iv. The **Out of Network** field has no restrictions: it can be either a dollar value or **Not Applicable**.

5.2 Catastrophic Plan Instructions

Consistent with Section 1302(e) of the PPACA and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can be offered only in the individual market.
2. They are permitted, but not required, to cover multiple-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 PPACA and in the *final 2020 Payment Notice*. For PY2020, this limit is \$8,150 for individuals (self-only) and \$16,300 for families (other than self-only).
7. They have an out-of-network deductible and out-of-network MOOP greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP, and a combined in/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 equal to **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 the deductible for all EHBs, excluding primary care and preventive health services. (See **5.10 Plan Compare Cost-Sharing Display Rules** for direction on completing the copay and coinsurance fields to have this cost-sharing value displayed to the consumer.)
11. All benefits except primary care visits and coverage of preventive health services—in accordance with Section 2713 of the PHS Act—are subject to the in-network deductible. Issuers must provide benefits for at least three primary care visits and coverage of preventive health services (in accordance with Section 2713 of the PHS Act) prior to the consumer reaching the deductible.
12. Coverage of preventive health services (in accordance with Section 2713 of the PHS Act) is not subject to the in-network deductible and does not impose any other cost-sharing requirement.

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 $-4/+2$ percentage points is used for standard plans.
 - a. The AV for a bronze plan must be between 56 percent and 62 percent.
 - b. The AV for an expanded bronze plan must be between 56 percent and 65 percent.
 - c. The AV for a silver plan must be between 66 percent and 72 percent.
 - d. The AV for a gold plan must be between 76 percent and 82 percent.
 - e. The AV for a platinum plan must be between 86 percent and 92 percent.
2. A de minimis variation of ± 1 percentage point is used for silver plan variations.
 - a. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent.
 - b. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.
 - c. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
3. The AV of a standard silver plan and the AV of the associated 73 percent silver plan variation must differ by at least 2 percentage points.
4. The AV of the zero cost-sharing plan variations must be 100 percent.
5. The AV of the limited cost-sharing plan variations must be equal to the associated standard plan's AV.

(For more information on how the cost-sharing information from the Plans & Benefits Template translates to inputs for the stand-alone AVC, see **Appendix A**.)

5.4 Editing the Template

Keep the following in mind when making changes to the template:

1. If a benefit is mistakenly added as an additional benefit, it cannot be manually deleted, but issuers may do one of the following:
 - a. Select **Not Covered** under the “Is this Benefit Covered?” column. When the Cost Share Variances worksheet is generated, this benefit will not appear on that worksheet.
 - b. Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but also removes any other data entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.
 - c. Additional steps need to be taken if the issuer has already created the Cost Share Variances worksheet. See below.
2. If an issuer changes whether a benefit is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, the benefits will *not* update on the Cost Share Variances worksheet even if the issuer selects the **Update Cost Share Variances** button. Instead the issuer must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon and generate a new worksheet. The updated worksheet then reflects the changes made to the Benefits Package worksheet.
3. To add a new plan or delete a plan after the Cost Share Variances worksheet has already been created, do the following:
 - a. After adding a new plan to the Benefits Package worksheet, click the **Update Cost Share Variances** button on the menu bar under the **Plans & 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. If any plans are below that row, cut these rows and paste them into the empty row (see below). If the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below the blank row and their corresponding data are deleted from the Cost Share Variances worksheet.
 - c. Example: To delete Plan 2 (**Figure 2D-20**), delete all data from the plan’s row, cut and paste Plan 3 from Row 11 to Row 10, and then cut and paste Plan 4 from Row 12 to Row 11. Once those steps are completed, click the **Update Cost Share Variances** button; Plan 2 is removed from the Cost Share Variances worksheet, while Plans 3 and 4 remain.

Figure 2D-20. 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		

- d. If the issuer changes any benefits package data on a specific plan that already exists, only the following changes will be reflected on the Cost Share Variances worksheet when the issuer clicks the **Update Cost Share Variances**:
 - i. Plan Marketing Names will be updated;
 - ii. Plans added to the Benefits Package worksheet will be added to the Cost Share Variances worksheet; and
 - iii. Plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet.

- e. If there is a need to update the information for an existing plan, the issuer must first delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button. All previously entered information for this plan on the Cost Share Variances worksheet will be deleted. Reenter the plan and associated data on the Benefits Package worksheet, and click the **Update Cost Share Variances** button to add the plan back to the Cost Share Variances worksheet.

5.5 Requirements for Cost-Sharing Reduction 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 if they have a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the MOOP and lowers 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.⁷ 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.

⁷ Under 45 CFR 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but it excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

- b. The AV of the limited cost-sharing plan variation must be greater than or equal to the associated standard plan's AV.
 - c. All MOOP values for EHBs must be the same as the associated standard plan's MOOP values for EHBs.
 - d. All deductible values must be the same as the associated standard plan's values.
 - e. All EHBs must have the same cost-sharing values as the associated standard plan's values (see **5.6 EHB Variance Reason and EHB Designation**).
 - f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see **5.7 Successive Cost Sharing Guidance**).
 - g. Tier utilization must be the same as the associated standard plan's tier utilization.
3. The requirements for silver plan variations are as follows:
- a. Each silver plan offered on the individual market must have 73 percent AV, 87 percent AV, and 94 percent AV silver plan variations.
 - b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and it must also 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 86 percent and 88 percent.
 - d. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.
 - e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to \$6,500 for an individual (self-only) or \$13,000 for a family (other than self-only).
 - f. For the 87 percent and 94 percent AV silver plan variations, the MOOP must be less than or equal to \$2,700 for an individual (self-only) or \$5,400 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 Cost-Sharing Reduction 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 the **EHB** and **EHB Variance Reason** fields for the benefit on the Benefits Package worksheet as outlined in **4.10 Out of Pocket Exceptions**. **Table 2D-1** explains when a benefit is considered an EHB based on different inputs.

Table 2D-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 Cost-Sharing Reduction Plan Variations**, successive cost sharing is required to be reviewed for multiple plan variations and data fields. The purpose of successive cost sharing is to

ensure that a specific element in a given plan variation always has an equal or more generous cost-sharing value for the consumer compared with a standard plan or plan variation.

The following explains which plan variations should be compared depending on the requirement:

1. A standard silver plan and its associated silver plan variations must follow successive cost sharing for the MOOP, deductible, copay, and coinsurance fields. This includes EHBs and non-EHBs. All of the following must be true:
 - a. The cost sharing value of the 73 percent AV silver plan variation must be less than or equal to that of the associated standard plan.
 - b. The value of the 87 percent AV silver plan variation must be less than or equal to that of the 73 percent AV silver plan variation.
 - c. The value of the 94 percent AV silver plan variation must be less than or equal to that of the 87 percent AV silver plan variation.
2. A zero cost-sharing plan variation must follow successive cost-sharing with the associated limited cost-sharing plan variation for the copay and coinsurance fields for non-EHBs. This means that 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. This means 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. This means 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.

Again, the fields that may be used for successive cost sharing include MOOP, deductible, copay, and coinsurance. Because successive cost sharing requires that the plan *always* be equal or preferable to the consumer, changes to the cost-sharing structures are not allowed when the consumer in the higher AV plan variation may pay increased cost sharing in any circumstance. The following two 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 better value depends on the total cost of the service.
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. The better value depends on whether the deductible has already been reached.

Table 2D-2 through **Table 2D-8** show the compliant and noncompliant data entry options for the different cost-sharing fields discussed, as well as numerous examples.

Table 2D-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 2D-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 2D-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	<ul style="list-style-type: none"> ◆ No Charge ◆ 0% Coinsurance ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (all values)
No Charge After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ 0% Coinsurance ◆ 0% Coinsurance After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (when greater than 0)
X% Coinsurance	<ul style="list-style-type: none"> ◆ No Charge ◆ Y% Coinsurance (when $Y\% \leq X\%$) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ Y% Coinsurance (when $Y\% \leq X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% \leq X\%$) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ Y% Coinsurance (when $Y\% > X\%$) ◆ Y% Coinsurance After Deductible (when $Y\% > X\%$)
Not Applicable	<ul style="list-style-type: none"> ◆ Not Applicable ◆ No Charge 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ Y% Coinsurance (all values) ◆ Y% Coinsurance After Deductible (all values)

Table 2D-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%	

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

Plan	Coinsurance	Compliance
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 2D-6. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Option for Copay Values

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
No Charge	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Copay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
No Charge After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay ◆ \$0 Copay After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (when greater than 0) ◆ \$Y Copay With Deductible (all values)
\$X Copay	<ul style="list-style-type: none"> ◆ No Charge ◆ \$Y Copay (when $\\$Y \leq \\X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay After Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ No Charge After Deductible ◆ \$Y Copay (when $\\$Y \leq \\X) ◆ \$Y Copay After Deductible (when $\\$Y \leq \\X) ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when $\\$Y > \\X) ◆ \$Y Copay After Deductible (when $\\$Y > \\X) ◆ \$Y Copay With Deductible (all values)
\$X Copay With Deductible	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Copay ◆ \$Y Copay With Deductible (when $\\$Y \leq \\X) ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay (when greater than 0) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (when $\\$Y > \\X)

Table 2D-6. Compliant and Noncompliant Successive Cost-Sharing Data-Entry Option for Copay Values

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

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

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay Values
\$X Copay Per Day	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day (when $Y \leq X$) ◆ \$Y Copay Per Stay (when $Y \leq X$) ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day (when $Y > X$) ◆ \$Y Copay Per Stay (when $Y > X$) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay (when $Y \leq X$) ◆ \$0 Copay Per Day ◆ No Charge ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay (when $Y > X$) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Day With Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when $Y < X$) ◆ \$Y Copay Per Stay With Deductible (when $Y < X$) ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay Per Day ◆ \$0 Copay Per Stay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (when $Y > X$) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Stay With Deductible (when $Y > X$) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay With Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (when $Y < X$) ◆ \$Y Copay Per Day With Deductible (when $Y < X$) ◆ No Charge ◆ No Charge After Deductible ◆ \$0 Copay Per Stay ◆ \$0 Copay Per Day ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (when $Y > X$) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

**Table 2D-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 After Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day After Deductible (\$Y < \$X) ◆ \$Y Copay Per Stay After Deductible (\$Y < \$X) ◆ \$Y Copay Per Day (\$Y < \$X) ◆ \$Y Copay Per Stay (\$Y < \$X) ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Day (when \$Y > \$X) ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Stay (when \$Y > \$X) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
\$X Copay Per Stay After Deductible	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay After Deductible (\$Y < \$X) ◆ \$Y Copay Per Stay (\$Y < \$X) ◆ \$0 Copay Per Day After Deductible ◆ \$0 Copay Per Day ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when \$Y > \$X) ◆ \$Y Copay Per Stay (when \$Y > \$X) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when greater than 0) ◆ \$Y Copay Per Day (when greater than 0) ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
No Charge After Deductible	<ul style="list-style-type: none"> ◆ No Charge After Deductible ◆ No Charge ◆ \$0 Per Day ◆ \$0 Per Stay ◆ \$0 Copay Per Day After Deductible ◆ \$0 Copay Per Stay After Deductible ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (when greater than 0) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (when greater than 0) ◆ \$Y Copay Per Day (when greater than 0) ◆ Not Applicable ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)
No Charge	<ul style="list-style-type: none"> ◆ No Charge ◆ \$0 Per Day ◆ \$0 Per Stay ◆ Not Applicable 	<ul style="list-style-type: none"> ◆ \$Y Copay Per Stay With Deductible (all values) ◆ \$Y Copay Per Stay After Deductible (all values) ◆ \$Y Copay Per Stay (when greater than 0) ◆ \$Y Copay Per Day With Deductible (all values) ◆ \$Y Copay Per Day After Deductible (all values) ◆ \$Y Copay Per Day (when greater than 0) ◆ No Charge After Deductible ◆ \$Y Copay (all values) ◆ \$Y Copay After Deductible (all values) ◆ \$Y Copay With Deductible (all values)

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

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

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Example	Copay	Compliance
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 available in the market today: 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. The following are some options for how issuers could translate their cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template:

1. Enter the cost-sharing data for the tier in the Prescription Drug Template with the highest generic drug utilization into 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 with 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 the 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 with 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 generally 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. While the concept of “tiers” is 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 could enter the cost-sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to **In Network (Tier 1)**.
2. Non-preferred 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 on 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 equal to **Not Applicable**.

The **Maximum Coinsurance for Specialty Drugs** field is defined only once in the Plans & Benefits Template for each plan; it cannot change among plan variations, and it 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 their plan variations.

Regardless of the method used to translate the plan's cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template, the inputs into the Plans & Benefits Template for the drug tiers should be reflective of the cost sharing used in the AV calculation.

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Throughout this section, all data fields that CMS anticipates displaying to consumers on Plan Compare for individual market coverage are identified by a number symbol (#) next to the field name. **Table 2D-9** and **Table 2D-10** list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This should not be viewed as the final list of data elements for display to consumers, and CMS may change this list after these instructions are published. It is provided here as a reference for issuers before they submit QHP Applications.

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

Plan Compare Label Name	Template Value	Template Source
Deductibles and Maximum Out of Pocket Rules	<ul style="list-style-type: none"> ◆ If Medical and Drug amounts are integrated, the combined amount displays. ◆ If Medical and Drug amounts are not integrated, only the Medical amount displays on the Plan Summary page. (The Drug amount displays in the Prescription Drug Details section.) ◆ If there is only one person in the enrollment group, the Individual Per Person amount displays. ◆ If there is more than one person in the enrollment group, the Family Per Group amount displays. The dollar amount will display followed by "Per Group." ◆ If there is more than one person in the enrollment group and the plan design does not have a per group deductible, then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by "Per Person." 	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template

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

Plan Compare Label Name	Template Value	Template Source
	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 the deductible business rule above)	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	Network ID
Summary of Benefits and Coverage	URL for Summary of Benefits and Coverage	Plans & Benefits Template
Insurance Company + Plan Marketing Name + Plan Type <i>Issuer Legal Name (as recorded in HIOS) will display if Issuer Marketplace Marketing Name is null</i>	Issuer Marketplace Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care (Adult) Major Dental Care—Adult <i>Note: All three must be available to show Adult Dental Included</i>	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child <i>Note: All three must be available to show Pediatric Dental Included</i>	Plans & Benefits Template
National Provider Network Offered/National Network	National Network	Plans & Benefits Template
Health Care Costs	Derived from Level of Coverage	Plans & Benefits Template
Reduced Costs	Indicates whether the plan is a CSR variant	Based on Consumer Eligibility information

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

Plan Compare Label Name	Template Value	Template Source
Plan Brochure	Plan Brochure URL	Plans & Benefits Template
<i>Benefit Data Rules</i> These data display for each covered benefit below when the Is This Benefit Covered? value is Yes	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit "Limits and Exclusions Apply" hyperlink displays when Explanation or Exclusions is not null	Plans & Benefits Template
Medical Care Coverage		
Visit to a Primary Care Provider	Primary Care Visit to Treat an Injury or Illness	Plans & Benefits Template
Visit to a Specialist	Specialist Visit	Plans & Benefits Template
X-Rays and Diagnostic Imaging	X-Rays and Diagnostic Imaging	Plans & Benefits Template
Laboratory and Outpatient Professional Services	Laboratory Outpatient and Professional Services	Plans & Benefits Template
Hearing Aids	Hearing Aids	Plans & Benefits Template
Routine Eye Exam for Adults	Routine Eye Exam for Adults	Plans & Benefits Template
Routine Eye Exam for Children	Routine Eye Exam for Children	Plans & Benefits Template
Eyeglasses for Children	Eyeglasses for Children	Plans & Benefits Template
Health Savings Account Eligible Plan	HSA-Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template
3 Month In-Network Mail Order Pharmacy Benefit Offered?	3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug Template
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When the Medical & Drug Deductibles Integrated? value is Yes , "Included with Medical" displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out-of-Pocket: In-Network—Individual Drug EHB Maximum Out-of-Pocket: In-Network—Family (When the Medical & Drug MOOP Integrated? value is Yes , "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
Provider Directory	Network URL	Network ID Template
National Provider Network	National Network	Plans & Benefits Template

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

Plan Compare Label Name	Template Value	Template Source
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: <ul style="list-style-type: none"> ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit 	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: <ul style="list-style-type: none"> ◆ 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: <ul style="list-style-type: none"> ◆ Deductible ◆ Copayment ◆ Coinsurance ◆ Limit 	Plans & Benefits Template
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
Orthodontia	Orthodontia—Adult	Plans & Benefits Template
Find Dentists	Network URL	Network ID
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

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

Plan Compare Label Name	Template Value	Template Source
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

The anticipated display logic follows for the deductible, MOOP, copay, and coinsurance cost sharing for Plan Compare for individual market coverage effective starting January 1, 2020. It covers the majority of situations but is not exhaustive. This should not be viewed as the final display logic for Plan Compare, and CMS may make changes after these instructions are published. It is provided here as a reference for issuers before submitting QHP Applications.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug amounts are integrated, then the total amount for the medical and drug data element will display on the Plan Summary page. “Included with Medical” will display on the Plan Details page under the Drug amounts.
- If medical and drug amounts are not integrated, only the medical amount displays on the Plan Summary page. The drug amount displays 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 amount displays on the Plan Summary and Plan Details pages.
- On the Plan Summary page, if more than one person is in the enrollment group, the Family Per Group MOOP amount displays. The dollar amount will display followed by “Per Group.”
- On the Plan Summary page, if there is more than one person in the enrollment group, and if the issuer entered either \$0 or a positive dollar amount for the **Family Per Group** data field, the Family Per Group deductible amount displays. The dollar amount will display followed by “Per Group.” If there is more than one person in the enrollment group and the plan design does not have a per-group deductible (i.e., the Family Per Group Deductible is **Not Applicable**), then the Individual Per Person deductible will display on the Plan Summary page. The dollar amount will display followed by “Per Person.”

- On the Plan Details page, the Family Per Group and the Family Per Person deductible and MOOP amounts will appear.
- The out-of-network deductible and MOOP are not displayed 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 is displayed.
- When copay is greater than zero and coinsurance is **Not Applicable**, the entered copay value is displayed.
- If coinsurance is equal to **100%**, a benefit is displayed as “Not Covered.”
- “No Charge After Deductible” is displayed if one of the following occurs:
 - **No Charge After Deductible** is entered for copay and coinsurance.
 - The issuer entered **Not Applicable** for copay and **No Charge After Deductible** for coinsurance, or vice versa.
- “No Charge” is displayed 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** is displayed.
- When copay and coinsurance are each greater than zero, both are displayed.

5.11 Troubleshooting the Plans & Benefits Add-In File

When opening the Plans & Benefits Add-In file before the template, Excel sometimes loads an older version of the Add-In file not compatible with the template. This causes run-time errors when entering data into the template or clicking buttons on the **Plans & Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for best results.
2. *Never* rename the Add-In file to a different name.
3. Ensure that only one copy of the Add-In file is on the computer; delete all extra copies. When downloading a new one, always “Replace” the old version.

If the issuer still experiences run-time errors, Excel may have loaded a previous version of the Add-In file. Take the following steps to remove the previous version:

1. Open a blank sheet in Excel (no template or file). The Excel ribbon should not have a **Plans & Benefits** ribbon.
 - a. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (**Figure 2D-21** through **Figure 2D-23**). In Excel 2007, the label names may differ slightly.
2. Verify that the **Plans & Benefits** ribbon is gone.
3. Open a Plans & Benefits Template.
4. The template should open the Add-In automatically after **Enable Macros** is clicked. This means the template successfully loaded the Add-In.

Figure 2D-21. Excel Options Window

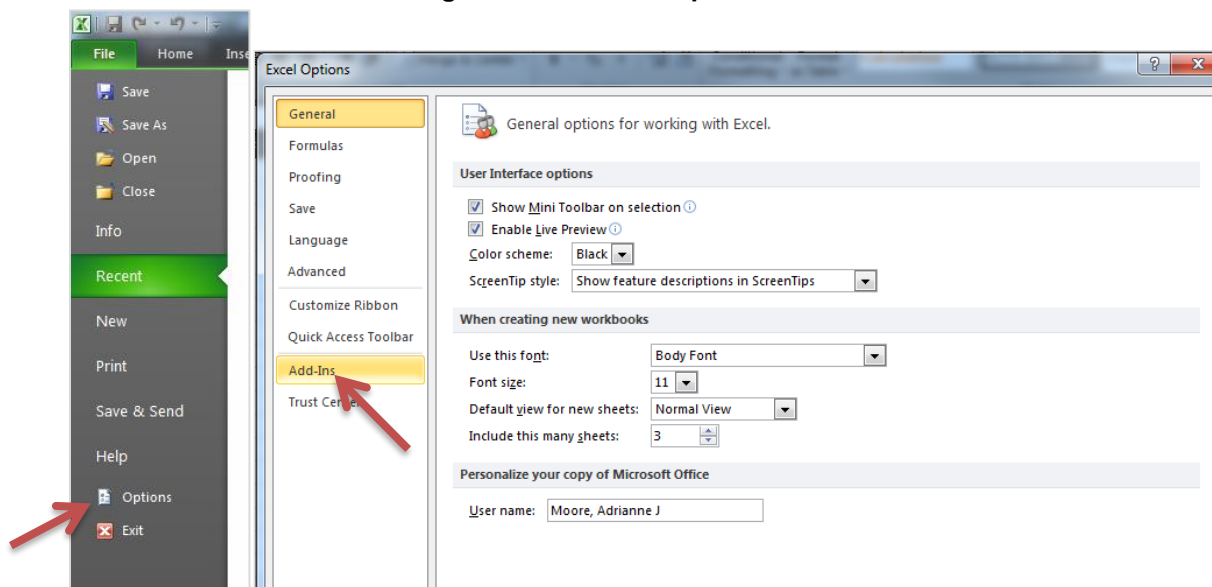


Figure 2D-22. Add-Ins Tab in Excel Options Window

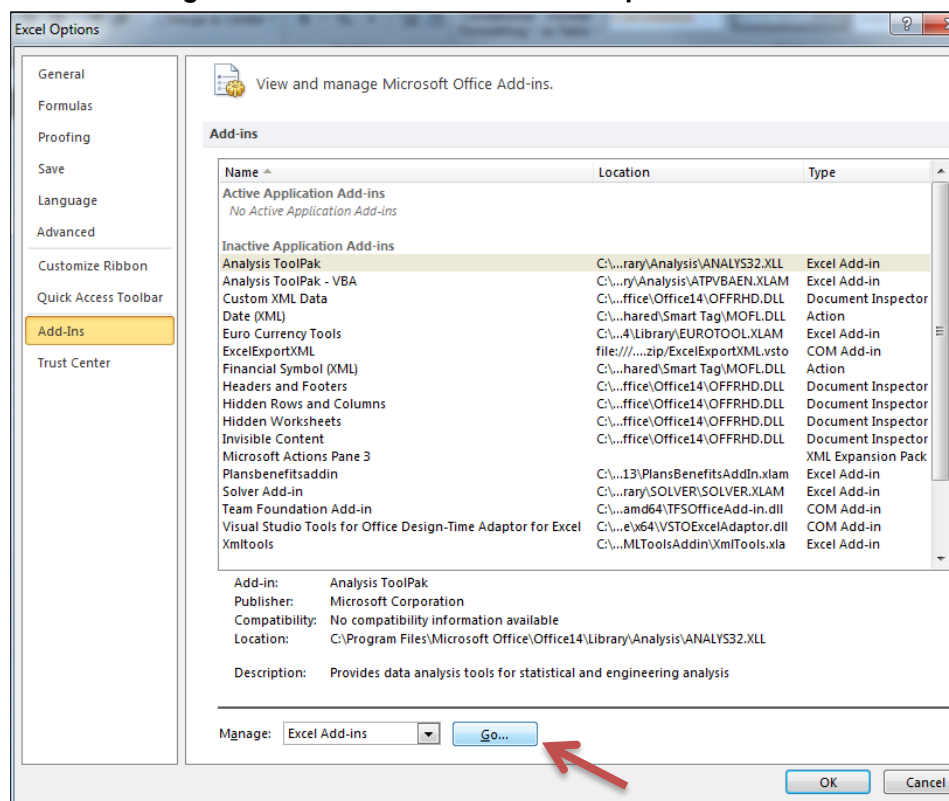


Figure 2D-23. Add-Ins Window

