Chapter 10: Instructions for the Plans and Benefits Application Section

Contents

1. Purpose 10-3
2 Overview 10-3
3 Key Template Updates 10-4
3.1 Key Changes to the Benefits Package Worksheet 10-4
3.2 Key Changes to the Cost Share Variances Worksheet 10-4
4. Application Instructions 10-6
4.1 Getting Started 10-6
4.2 General Information 10-7
4.3 Plan Identifiers 10-8
4.4 Plan Attributes 10-10
4.5 Stand-Alone Dental Only 10-15
4.6 AV Calculator Additional Benefit Design 10-15
4.7 Plan Dates 10-16
4.8 Geographic Coverage 10-16
4.9 URLs 10-17
4.10 Benefit Information 10-17
4.11 General Information 10-19
4.12 Out of Pocket Exceptions 10-24
4.13 Plan Cost Sharing Attributes 10-28
4.14 SBC Scenario 10-30
4.15 Maximum Out of Pocket and Deductible 10-30
4.16 Maximum Out of Pocket for Medical EHB Benefits 10-31
4.17 Maximum Out of Pocket for Drug EHB Benefits 10-32
4.18 Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) 10-33
4.19 Medical EHB Deductible 10-34
4.20 Drug EHB Deductible 10-35
4.21 Combined Medical and Drug EHB Deductible 10-36
4.22 Other Deductible 10-37
4.23 HSA/HRA Detail 10-37

4.24 URLs 10-38
4.25 Covered Benefits 10-39
4.26 Completed Plans & Benefits Template 10-45
5. Key Requirements and Application Guidance 10-46
5.1 MOOP and Deductible Guidance 10-46
5.2 Catastrophic Plan Instructions 10-48
5.3 Actuarial Value Details 10-49
5.4 Editing the Template 10-50
5.5 Requirements for Cost-Sharing Reduction Plan Variations 10-51
5.6 EHB Variance Reason and EHB Designation 10-53
5.7 Successive Cost-Sharing Guidance 10-54
5.8 Suggested Coordination of Drug Data Between Templates 10-64
5.9 Anticipated Template Data Elements To Be Shown on Plan Compare 10-65
5.10 Plan Compare Cost Sharing Display Rules 10-70
5.11 Troubleshooting the Plans & Benefits Add-In File 10-72

1. Purpose

This chapter guides issuers through completing the Plans & Benefits Template portion of their Qualified Health Plan (QHP) Application. Stand-alone dental plan (SADP) issuers should refer to Chapter 15, Instructions for Stand-Alone Dental Plan Application for guidance on how to complete the Plans & Benefits Template. Dual-product issuers completing an SADP application should refer to the instructions in this chapter and to Chapter 15. Issuers should also refer to Chapter 16 for instructions on uploading supporting documents associated with the Plans & Benefits Template including justifications.

2 Overview

In the Plans & Benefits Template, issuers provide data on their health plans, including plan identifiers, plan attributes, URLs, covered benefits and their limits, and cost-sharing information.

Issuers enter data about their plans in two types of worksheets: the Benefits Package worksheet and the Cost Share Variances worksheet. To reflect Essential Health Benefit (EHB) benchmark plan coverage requirements, the Plans & Benefits Add-In file populates state- and market-specific EHB benchmark data in the Benefits Package worksheet.

In the Benefits Package worksheet, issuers provide data on each set of plans and list covered benefits with any quantitative limits or exclusions. All plans defined within a Benefits Package share the same set of benefits and limits, but they may differ in cost sharing.

In the Cost Share Variances worksheet, issuers must provide cost-sharing and basic plan variation information for each submitted plan, including deductible, maximum-out-of-pocket (MOOP), copay, and coinsurance values. Each Cost Share Variances worksheet correlates to a Benefits Package worksheet. In addition, this worksheet allows issuers to create the cost-sharing reduction plan variations associated with each standard plan in the individual market.

3 Key Template Updates

This section identifies the key changes made to the content of the 2016 Plans & Benefits Template. These changes are also identified throughout the instructions whenever the phrase "**2016 Template Update**" is included.

3.1 Key Changes to the Benefits Package Worksheet

- All template banners have been updated with the 2016 plan year identifier and version number; 2016 templates must be used for the 2016 QHP Certification submission.
- The fields *EHB Percent of Total Premium* and *Does this plan offer Composite Rating?* have been added to the template.
- *Child Only Plan ID* will no longer be required for catastrophic plans.
- "Weight Loss Programs" has been added as a drop-down option under *Disease Management Programs Offered.*
- The *Plan Effective Date* must be 1/1/2016 for 2016 plans that will be offered on the Exchange.
- The EHB reference table will be updated. The *Benefit Explanation* field may be changed without requiring an EHB variance reason.
- The *Subject to Deductible* fields on the Benefits Package have been removed. Subject to deductible status will now be taken from the copay and coinsurance values. Please see Chapter 11, Actuarial Value Calculator instructions, for more detail on how the Plans & Benefits Template facilitates an automated actuarial value calculation using the Actuarial Value Calculator and the data entered into the template.

3.2 Key Changes to the Cost Share Variances Worksheet

- The fields *HSA Eligible, HSA/HRA Employer Contribution, HSA/HRA Employer Contribution Amount*, *URL for Summary of Benefits & Coverage,* and *Plan Brochure* have been moved from the Benefits Package worksheet to the Cost Share Variances worksheet, where they can now be completed for each plan variation.
- The *SBC Scenario* fields are now required for medical QHPs.
- The *Family* fields for MOOP and Deductible will now require you to enter a per-person amount or "Not Applicable" in addition to the per-group amount.
- There is now a drop-down option of "Not Applicable" for all copay and coinsurance fields. For specific instructions on when issuers should use "Not Applicable," see Section 4.25. Specifically, "No Charge" and "Not Applicable" should not be used interchangeably and have specific definitions and cases for when each should be used.
- The fields *Inpatient Hospital Services (e.g., Hospital Stay), Skilled Nursing Facilities, Mental/Behavioral Health Inpatient Services,* and *Substance Abuse Disorder Inpatient Services* will now have copay per-day and per-stay options that apply before the deductible or after the deductible.

Helpful Tips

This section provides helpful tips for successfully completing the Plans and Benefits section.

Use the Current Template and Associated Tools

- ❑ To ensure proper functionality, the 2016 versions of the Plans & Benefits Template, Add-In file, and the Actuarial Value Calculator (AVC) must be used. Delete any older versions of those files.
- ❑ Download the latest versions of the Plans & Benefits Template and Add-In file from the Center for Consumer Information and Insurance Oversight (CCIIO) website (http://cciio.cms.gov/programs/exchanges/qhp.html). Using the correct template version is critical. The current and correct version of template includes 2016 in the banner.
- ❑ Download the 2016 AVC published on January 16, 2015, on the CCIIO website (http://cciio.cms.gov/resources/regulations/index.html).
- ❑ Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template (for the macros to run properly).

Understand the Format and Terminology

- ❑ Data elements listed in these instructions follow the same order as those in the Plans & Benefits Template.
- ❑ Data elements and section headings are *in italics*, and data entry options, buttons, and ribbon are in **bold**.
- ❑ All data elements that CCIIO anticipates displaying to individual market consumers on Plan Compare are identified by a number symbol (#) next to the field name (see Section 5.9).
- ❑ All data fields used by the AVC are identified by a carrot (^) next to the field name (see Chapter 11 for instructions on the AVC).

Understand How to Complete the Templates

- ❑ For SADP issuers, the Plans & Benefits Template has a macro that can be activated by selecting "Yes" in the Dental Only Plan field. Selecting "Yes" will grey out fields that are not required for SADPs (see Chapter 15 for instructions on SADPs).
- ❑ Complete the Network, Service Area, and Formulary Templates and save them on your computer before filling out the Plans & Benefits Template. This 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 you wish to offer. To create additional benefits packages, click the **Create New Benefits Package** button on the menu bar under the **Plans and Benefits** ribbon. The *HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan,* and *TIN* fields are auto-populated.
- ❑ Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost-sharing reduction plan variation you wish to offer.

Understand the Operational Requirements

- ❑ Cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Chapter 11 for how these values relate to actuarial value (AV).
- ❑ In the Cost Share Variances worksheet, your answers to the fields *Medical & Drug Deductibles Integrated?*, *Medical & Drug Maximum Out of Pocket Integrated?*, and *Multiple In Network Tiers?* may result in some fields no longer being applicable and thus being grayed out on the template. When a cell is grayed out, it is locked and cannot be edited. The Benefits and Service Area module will not process data entered into the cell before it was grayed out.
- ❑ See Section 5 for key requirements, additional guidance, and illustrative examples for completing the Plans & Benefits Template.

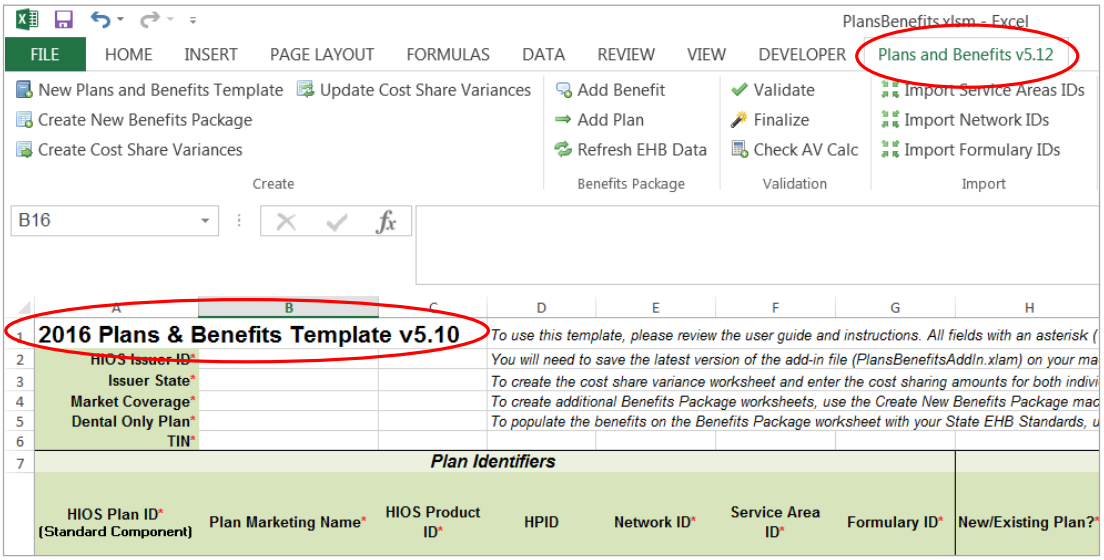
4. Application Instructions

The Plans & Benefits Template portion of the QHP Application uses an Excel template to collect plan- and benefit-level information. Issuers should complete the Plans & Benefits Template using the instructions that follow to provide information on each health plan they wish to submit. Issuers will need to submit a separate template for plans they intend to offer in a Federally-facilitated Marketplace (FFM) for the individual market and those in a Federally-facilitated Small Business Health Options Program (FF-SHOP) for the small group market.

4.1 Getting Started

Open the Plans & Benefits Template. You may be asked to enable macros in Microsoft Excel. You should use the **Options** button on the Security Warning toolbar, and select **Enable this content**. If you do not enable macros before entering data, the template does not recognize these data and you have to reenter them. Once you do this, you should see the **Plans and Benefits** ribbon (Figure 10-1), a tab on the toolbar at the top of the Excel file that contains various buttons used to complete the template.

Figure 10-1. Plans and Benefits Ribbon



Before proceeding, you should confirm that you have downloaded the latest versions of the Plans & Benefits Template and Add-In file from the CCIIO website (http://cciio.cms.gov/programs/exchanges/qhp.html).

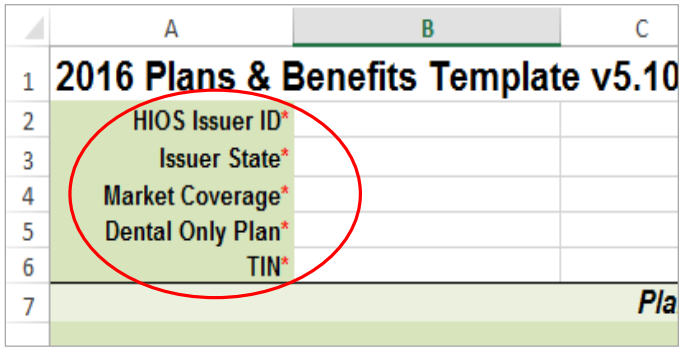
To verify that you have the latest versions, compare the version numbers for the files you downloaded with the equivalent version numbers displaying in the Plans & Benefit Template and the Add-In file. The version number for the Add-In file can be located in new the Plans and Benefits ribbon. The version number for the template—which is labelled "2016 Plans & Benefits Template," followed by a version number—should appear in the upper left-hand corner of the benefits package worksheet. Figure 10-1 shows the location of the version numbers for the Plans & Benefits Template and the Add-In file.

Once you have the current versions of the Plans & Benefits Template and the Add-In File, all macros should run without problems.

4.2 General Information

The fields in the upper-left portion of the Benefits Package worksheet contain basic information about the issuer and the type of plans to be entered into the template (Figure 10-2). This information must be entered in the first Benefits Package worksheet; it then auto-populates any additional Benefits Package worksheets generated by the issuer.

Figure 10-2. Plans & Benefits Template



1. *HIOS Issuer ID* (required). Enter the five-digit Health Insurance Oversight System (HIOS)–generated Issuer ID number.

2. *Issuer State* (required). Select the state in which you are licensed to offer these plans using the drop-down menu.

3. *Market Coverage* (required). Select the market coverage. Choose from the following:

   a. **Individual**—if the plans are offered on the individual market.

   b. **SHOP (Small Group)**—if the plans are offered on the small group market.

   Note**:** The following certification requirement—45 *Code of Federal Regulations* (CFR) 156.200(g)—only applies if the issuer or another issuer within its issuer group has more than a 20 percent share of the small group market in this state. An issuer group is defined under 156.200 as "all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark."

   - CMS interprets 45 CFR 156.200(g)(1) to require that issuers who have greater than 20 percent small group market share offer at least one silver-level QHP and one gold-level QHP through FF-SHOP as a condition of participation in the federally-facilitated individual market exchange.

- CMS also interprets 45 CFR 156.200(g)(1) to require that issuers that do not have greater than 20 percent market share in a state's small group market, but that are members of an issuer group that has at least one member with greater than 20 percent market share, would have to offer the required silver- and gold-level coverage through SHOP as a condition of participation in the individual market exchange.

- Pursuant to 45 CFR 156.200(g)(2), issuers that do not offer small group market products in a state, but that are members of an issuer group that has at least one member with greater than 20 percent market share, would not have to offer the required SHOP coverage themselves. Instead, another issuer in that issuer's group would do so, and in light of the fact that CMS intends the tying provision to fall primarily on issuers with greater than 20 percent market share, CMS interprets 45 FR 156.200(g)(2) to require that the issuer meeting the requirement in these circumstances be an issuer whose small group market share exceeds 20 percent.

4. *Dental Only Plan* (required). Indicates whether the plans contained in the template are dental-only plans. Choose from the following:

   a. **Yes**—if this is a dental-only package. SADP issuers should refer to the SADP instructions. When "Yes" is selected, the template grays out areas that do not apply to SADPs. See Chapter 15 for more details.

   b. **No**—if this is not a dental-only package.

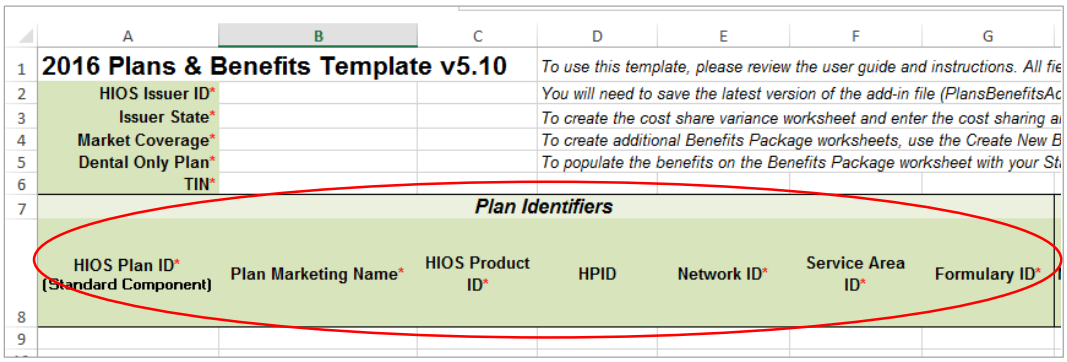
5. *TIN* (required). Enter the issuer's nine-digit Tax Identification Number (TIN).

4.3 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data on each plan, including its Plan ID and the network, service area, and formulary it uses (Figure 10-3). Complete this section for each standard plan you plan 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, and a benefits package is a group of plans that cover 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 you run out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans and Benefits** ribbon. Each benefits package may have up to 50 plans. If you have more than 50 plans associated with the same benefits package, you need to create a new benefits package with the identical benefits package structure.

Figure 10-3. Plan Identifiers Section



1. *HIOS Plan ID (Standard Component)*[#] (required). Enter the 14-character, HIOS-generated Plan ID number. (Plan IDs must be unique, even across different markets.)

2. *Plan Marketing Name*[#] (required). Enter the plan marketing name at the standard plan level. This plan name is associated with the standard plan and all cost-sharing reduction plan variations when displayed to the consumer. *Plan Marketing Name* cannot be edited at the plan variation level. CMS recommends that issuers take this template functionality into account when determining the marketing name for their standard plans and cost-sharing reduction plan variations.

3. *HIOS Product ID* (required). Enter the 10-character, HIOS-generated Product ID number.

4. *HPID* (optional). Enter the 10-digit national Health Plan Identifier (HPID).

5. *Network ID* (required). Click the **Import Network IDs** button on the menu bar under the **Plans and Benefits** ribbon, and select the completed Network Template Excel file to import a list of values from the Network Template; then select the appropriate one from the drop-down menu. (You must have completed and saved an Excel version of the Network Template before importing the Network IDs.)

6. *Service Area ID* (required). Click the **Import Service Area IDs** button on the menu bar under the **Plans and Benefits** ribbon, and select the completed Service Area Template Excel file to import a list of values from the Service Area Template; then select the appropriate one from the drop-down menu. (You must have completed and saved an Excel version of the Service Area Template before importing the Service Area IDs.)

7. *Formulary ID* (required). Click the **Import Formulary IDs** button on the menu bar under the **Plans and 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 one from the drop-down menu. (You must have completed and saved an Excel version of the Prescription Drug Template before importing the Formulary IDs.)

4.4 Plan Attributes

This section includes fields for inputting more specific data for each plan, including its type, its metal level, and other plan-level requirements.

1. *New/Existing Plan?* (required). Indicate whether this is a new or existing plan. Choose from the following:

   a. **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. These plans should use new HIOS Plan IDs that were not used for the 2015 plan year.

   b. **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. These plans should use the same HIOS Plan ID that was used for the 2015 plan year.

   Some issuers may be planning to modify a 2015 QHP with a larger service area to create several plans that cover smaller service areas. In this case, the plan with the greatest enrollment should use the same HIOS Plan ID that was used for the 2015 plan year (if it meets the conditions for being considered the "same plan" as described in 45 CFR 144.103). The other plans should use new HIOS Plan IDs that were not used for the 2015 plan year.

2. *Plan Type*[#] (required). Select the plan type. Choose from the following product network types:

   a. **Indemnity**

   b. **PPO (**preferred provider organization)

   c. **HMO** (health maintenance organization)

   d. **POS (**point-of-service)

   e. **EPO** (exclusive provider organization).

3. *Level of Coverage*[^#] (required). Select the metal level of the plan based on its actuarial value (AV). A de minimis variation of ±2 percentage points is allowed for standard metal-level plans (see Section 5.3). Choose from the following:

   a. **Bronze**—AV of 60 percent

   b. **Silver**—AV of 70 percent

   c. **Gold**—AV of 80 percent

   d. **Platinum**—AV of 90 percent

e. **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 (see Section 5.2).

4. *Unique Plan Design?* (required). Indicate whether the plan design is unique, meaning it cannot use the standard Actuarial Value Calculator (AVC) developed and made available for HHS for the given benefit year. For more information on determining whether or not a plan is unique, see Chapter 11. Choose from the following:

   a. **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 Chapter 16). 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.

      "Yes" also may be selected in some limited circumstances for plans compatible with the AVC (see Chapter 11, Section 5.1).

   b. **No**—if the plan design is <u>not</u> unique.

5. *QHP/Non-QHP* (required). Indicate whether the plan will only be offered outside of the Exchange or whether the plan will be offered both through and outside of the Exchange. (An "Exchange" is also known as a "Marketplace.") Choose from the following:

   a. **On the Exchange**—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 the "Both" option below unless an exception to guaranteed availability applies.

   b. **Off the Exchange**—if the plan will be offered only outside of 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).

   c. **Both**—if the plan will be offered both through and outside of the Exchange. A plan that is offered both through and outside of 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 Variance worksheet when the worksheet is created: one on-Exchange plan and one off-Exchange plan.

6. *Notice Required for Pregnancy* (required). Indicate whether or not the plan has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following:

a. **Yes**—if a notice is required.

b. **No**—if a notice is not required.

7. *Is a Referral Required for a Specialist?*[#] (required). Indicate whether a referral is required to see a specialist. Choose from the following:

   a. **Yes**—if a referral is required to see a specialist.

   b. **No**—if a referral is not required to see a specialist.

8. *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.

9. *Plan Level Exclusions* (optional). Enter any plan exclusions.

10. *Limited Cost Sharing Plan Variation—Est Advance Payment* (leave blank). This data element is not necessary this year because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Marketplaces will calculate the advance payment amounts for cost-sharing reductions for limited cost-sharing plan variations. Therefore, leave this field blank.

2016 Template Update: The fields *HSA Eligible, HSA/HRA Employer Contribution,* and *HSA/HRA Employer Contribution Amount* have been moved from the Benefits Package worksheet to the Cost Share Variances worksheet where they can now be completed for each plan variation.

11. *Does this plan offer Composite Rating* (required for all plans; the information will only be used for plans in the SHOP market: the field populates as "No" for plans in the individual market).

    Indicate whether plans' premiums will be available based on average enrollee premium amounts of enrollees. Choose from the following:

    a. **Yes**—if the plan offers composite rating.

    b. **No**—if the plan does not offer composite rating.

    Note: in the FF-SHOPs from offering qualified employer premiums based on average enrollee premium amounts, if the employer elects to offer employees a choice of plans at a specified level of coverage as described in 155.705(b)(3)(iv)(A) and 155.705(b)(3)(v)(B). Thus, in the FF-SHOPs, premiums based on average enrollee premium amounts will be available only to qualified employers that choose to offer their employees a single plan instead of employee choice. In addition, premiums based on average enrollee amounts will only be allowed for groups that have at least one adult age 21 or older enrolled in coverage.

When employers choose the single plan option, they will be able to decide whether to pay premiums using a per-member methodology or one based on average enrollee premium amounts. Employers will be able to search issuers by an indicator showing whether the issuer makes premiums available based on average enrollee premium amounts. If an employer selects the option to select issuers that make premiums available based on average enrollee amounts, only the issuers that have made this option available will be displayed.

Additional information on the FF-SHOP composite rating is available in the 2016 Letter to Issuers in the Federally-facilitated Marketplaces.

2016 Template Update: This field is new to this template for the 2016 plan year.

12. *Child-Only Offering* (required). 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); one option must be selected consistent with the requirements at 45 CFR 156.200. This does not apply if the plan's coverage level is catastrophic.

    Please note that FF-SHOP and the State Partnership Small Business Health Options Program (SP SHOP) do not accommodate child-only plans. Enrollment in FF-SHOP and SP SHOP must include an employee enrollment.

    Choose from the following:

    a. **Allows Adult and Child-Only**—if the plan allows adult and child-only enrollment and is offered at a child-only rate.

    b. **Allows Adult-Only**—if the plan does <u>not</u> allow child-only enrollment. This does not mean that only adults can enroll but that these plans require an adult as the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic).

    c. **Allows Child-Only**—if the plan is a child-only plan that only allows child subscribers.

13. *Child Only Plan ID* (required if "Allows Adult-Only" is entered for *Child-Only Offering* for plans that are not catastrophic). Enter the corresponding 14-character Plan ID if this plan does <u>not</u> allow child-only enrollment. The entered Plan ID must correspond to a plan in which *Child Only Offering* is equal to "Allows Adult and Child-Only" or "Allows Child-Only." The corresponding plan must have the same *Level of Coverage* as the plan for which you are entering data.

    2016 Template Update: This field is no longer required for catastrophic plans.

14. *Tobacco Wellness Program Offered* (required). Indicate whether, as required in order 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:

a. **Yes**—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act.

b. **No**—if the plan does not offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter "No" if either of the following applies: (1) The plan is offered in the individual market; or (2) the plan is offered in the small group market and does not rate for tobacco use.

15. *Disease Management Programs Offered*# (optional). Indicate whether the plan offers disease management programs. Choose one or more of the following:

    a. **Asthma**

    b. **Heart Disease**

    c. **Depression**

    d. **Diabetes**

    e. **High Blood Pressure & High Cholesterol**

    f. **Low Back Pain**

    g. **Pain Management**

    h. **Pregnancy**

    i. **Weight Loss Programs.**

    2016 Template Update: Weight Loss Programs has been added as a new drop-down option for the 2016 plan year.

    EHB Percent of Total Premium (required). 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 market except catastrophic plans. This value will be used to calculate advanced premium tax credits and is required to match the value entered in the Unified Rate Review Template (URRT). For detailed instructions for completing this field, refer to the URRT instructions.

    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.

a. If the plan is a QHP offered in the Federally Facilitated Marketplace or State-Based Marketplace, 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. Since subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion.

b. If the plan is not a QHP offered in the Federally Facilitated Marketplace or State-Based Marketplace, but rather is only offered in the outside market, the percentage of premium associated with abortion services should be included in the EHB percentage.

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 inside or outside of the Exchange.

2016 Template Update: This field is new to this template for the 2016 plan year.

4.5 Stand-Alone Dental Only

The fields in this section, *EHB Apportionment for Pediatric Dental* and *Guaranteed vs. Estimated Rates,* apply to SADPs only. To complete an application for an SADP, see Chapter 15, Instructions for Stand-Alone Dental Plan Applications.

4.6 AV Calculator Additional Benefit Design

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

1. *Maximum Coinsurance for Specialty Drugs*^ (optional). Indicates 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.

2. *Maximum Number of Days for Charging an Inpatient Copay?*^ (optional). Indicates 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.

3. *Begin Primary Care Cost-Sharing After a Set Number of Visits?*^ (optional). Indicates 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.

4. *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?*^ (optional). Indicates 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.

4.7 Plan Dates

This section contains fields for the effective date and expiration date for each plan. The FFM and FF-SHOP rating engine uses the effective dates in the rate tables templates, not the Plans & Benefits Template.

1. *Plan Effective Date* (required). This should be the effective date for the upcoming 2016 plan year—even for existing plans offered on the Marketplace in 2015. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2016, for all plans that will be offered through the FFM and FF-SHOP.

2. *Plan Expiration Date* (optional). Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (it must be December 31, 2016, 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.

4.8 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations.

1. *Out of Country Coverage* (required). Indicate whether care obtained outside the country is covered under the plan. Choose from the following:

    a. **Yes**—if the plan covers care obtained out of the country.

    b. **No**—if the plan does <u>not</u> cover care obtained out of the country.

2. *Out of Country Coverage Description* (required if "Yes" is entered for *Out of Country Coverage*). Enter a short description of the care obtained outside the country that the plan covers.

3. *Out of Service Area Coverage* (required). Indicate whether care obtained outside the service area is covered under the plan. Choose from the following:

    a. **Yes**—if the plan covers care obtained outside the plan service area.

    b. **No**—if the plan does <u>not</u> cover care obtained outside the plan service area.

4. *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.

5. *National Network*[#] (required). Indicate whether a national network is available. Choose from the following:

    a. **Yes**—if a national network is available.

    b. **No**—if a national network is <u>not</u> available.

4.9 URLs

2016 Template Update: The fields *URL for Summary of Benefits & Coverage* and *Plan Brochure* have been moved from the Benefits Package worksheet to the Cost Share Variances worksheet where they can now be completed for each plan variation.

1. *URL for Enrollment Payment* (optional). Enter the website location 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 complies with the latest payment redirect business service description (see https://www.REGTAP.info). URLs must start with "http://" or "https://" to work properly for the consumer.

4.10 Benefit Information

After completing the sections of the template discussed above, issuers complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans.

First, click the **Refresh EHB Data** button on the menu bar under the **Plans and Benefits** ribbon. If this benefits package has multi-state plans using an alternate benchmark, click **Yes** to the pop-up. Otherwise, click **No**. The add-in file has been updated to accurately reflect the current EHB benchmark data. Scroll down the worksheet to the Benefit Information section (Figure 10-4). The following fields may auto-populate, depending on the state, market type, and EHB benchmark:

1. *EHB*
2. *State-Required Benefit*
3. *Is this Benefit Covered?*
4. *Quantitative Limit on Service*
5. *Limit Quantity*
6. *Limit Unit*
7. *Minimum Stay*
8. *Benefit Explanation.*

Figure 10-4. Benefit Information Section

23						
59	***Benefit Information***					
60	Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit
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					
66	Hospice Services					
67	Non-Emergency Care When Traveling Outside the U.S.					
68	Routine Dental Services (Adult)					
69	Infertility Treatment					
70	Long-Term/Custodial Nursing Home Care					
71	Private-Duty Nursing					
72	Routine Eye Exam (Adult)					
73	Urgent Care Centers or Facilities					

Clicking the **Refresh EHB Data** button after filling out the Benefit Information, General Information, or Out of Pocket Exceptions sections causes the default values to return and all inputs, including any added benefits, to be deleted.

1. *EHB* (required). 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.

2. *State-Required Benefit* (required). This field is auto-populated if a state requires coverage of a benefit in a particular market. To determine whether this benefit needs to be covered, issuers should refer to the list of state-required benefits (http://www.cciio.cms.gov/resources/data/ehb.html) for their state. Issuers cannot edit this field.

   In certain cases, issuers may need to update the Benefits Package worksheet to more accurately reflect their coverage of EHB benchmark benefits. For example, the state-required benefit may apply only to individual market plans or HMOs (see the EHB Variance Reason instructions below for more information).

3. To add a benefit not listed on the template, click the **Add Benefit** button on the menu bar under the **Plans and Benefits** ribbon.

   a. Look through the drop-down menu to see whether the benefit already exists as an option, and select it if it does. If the benefit is not on this menu, click the **Custom** button and type in the benefit name. The benefit name may not be identical to any other benefit's name.

   b. A row for this benefit then appears below the last row in the Benefit Information section.

c. If a benefit is mistakenly added, it cannot be deleted, but you may do one of the following:

   i. Select "Not Covered" under the *Is this Benefit Covered?* column (described below).

   ii. Click the **Refresh EHB Data** button on the menu bar under the **Plans and Benefits** ribbon. This deletes the added benefit, <u>but you also lose any other data you have entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections</u>.

d. 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 "Above EHB" as the *EHB Variance Reason*.

e. 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*.

f. If the benefit added is a state-required benefit enacted after December 2011, select "Above EHB" as the *EHB Variance Reason*.

g. For more information on how to select the correct *EHB Variance Reason*, see Section 5.6.

h. 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 *Limit Quantity* and *Limit Unit* for each of the network types. (See the Limit Quantity instructions in Section 4.11 for details on handling multiple limits.)

4.11 General Information

This section contains fields that give more information on each benefit in the benefits package, such as whether it is covered, whether it has any limits, and any applicable exclusions or benefit explanations (Figure 10-5).

Figure 10-5. General Information Fields

	Benefit Information			General Information							
60	Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	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										
66	Hospice Services										
67	Non-Emergency Care When Traveling Outside the U.S.										
68	Routine Dental Services (Adult)										

1. *Is this Benefit Covered?* (required). This field is auto-populated with "Covered" for benefits identified in the template as EHB or as a state-required benefit. 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* data field, step 8, and Chapter 16). 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:

a. **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).

b. **Not Covered**—if this benefit is not 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.

2. *Quantitative Limit on Service?* (required if "Covered" is entered for *Is this Benefit Covered?*). This field is auto-populated for benefits identified in the template as EHBs. If you change this data element, you must provide an EHB variance reason and associated supporting documents. For any benefits not identified as EHBs, choose from the following:

   a. **Yes**—if this benefit has quantitative limits.

   b. **No**—if this benefit does not have quantitative limits.

3. *Limit Quantity*# (required if "Yes" is entered for *Quantitative Limit on Service?*). This field is auto-populated for benefits in the template identified as EHBs. If you change this data element, you 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., if you have a limit of two specialist visits per year, enter "2" here).

4. *Limit Unit*# (required if "Yes" is entered for *Quantitative Limit on Service?*). This field is auto-populated for benefits in the template identified as EHBs. If you change this data element, you must 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 you place 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:

   a. **Hours per week**

   b. **Hours per month**

   c. **Hours per year**

   d. **Days per week**

e. **Days per month**

f. **Days per year**

g. **Months per year**

h. **Visits per week**

i. **Visits per month**

j. **Visits per year**

k. **Lifetime visits**

l. **Treatments per week**

m. **Treatments per month**

n. **Lifetime treatments**

o. **Lifetime admissions**

p. **Procedures per week**

q. **Procedures per month**

r. **Procedures per year**

s. **Lifetime procedures**

t. **Dollar per year**

u. **Dollar per visit**

v. **Days per admission**

w. **Procedures per episode.**

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 (e.g., a limit of one hearing aid per ear every 48 months for subscribers up to age 18).

If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB Benchmarks on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). The 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).

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 FFM website in these columns and put all other quantitative limits in the *Benefit Explanation* field (e.g., Outpatient Rehabilitative Services—90 days per year in the *Limit Quantity* and *Limit Unit* columns; two treatments per year in the benefit explanation).

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 in 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 within the higher-level benefit category.

5. *Minimum Stay* (optional). This field is auto-populated for benefits in the template identified as EHBs. If you change this data element, you must provide an EHB variance reason and associated supporting documents, if applicable. For any benefits not identified as EHBs, enter a numerical value representing the minimum stay.

   a. If there is a minimum stay, list the minimum stay in hours for this benefit.

   b. If there is no minimum stay, leave this field blank.

6. *Exclusions*[#] (optional). Enter any benefit-level exclusions.

   a. If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions.

   b. If no services or diagnoses are excluded, leave this field blank.

7. *Benefit Explanation*[#] (optional). Enter any benefit explanations.

   a. 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.

      2016 Template Update: An EHB variance reason is no longer needed if this cell is edited.

8. *EHB Variance Reason* (required if you changed *Is this Benefit Covered?*, *Limit Units*, *Limit Quantity*, or *Minimum Stay* or if the benchmark has an unallowable limit or exclusion under the Affordable Care Act).

   Note: EHB-benchmark plans are based on 2012 plan designs and therefore do not necessarily reflect requirements effective for plan years beginning on or after January 1, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2016, issuers may need to design plan benefits,

including coverage and limitations, to comply with these requirements and limitations. For additional information, see the "Guide to Reviewing Essential Health Benefits Benchmark Plans" document on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html).

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 you add a new benefit that is an EHB and also change its limits, the EHB variance reason you should select is "Additional EHB Benefit" instead of "Substantially Equal."

It is important that you enter the correct *EHB Variance Reason* because it has implications for non-discrimination and EHB reviews as well as cost-sharing requirements for EHBs and non-EHBs related to cost-sharing reduction plan variations (see Section 5.5). Select from the following *EHB Variance Reasons* if this benefit differs from the state's benchmark:

a. **Above EHB**—if this benefit is not an Essential Health Benefit. For example:

   i. 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 you should set the *EHB Variance Reason* to "Above EHB." This benefit is not considered an EHB.

   ii. If a benefit auto-populated as "Yes" in the EHB column, but you have received guidance from CMS or the state indicating that it should not be considered an EHB (e.g., non-emergency care outside the United States), set the *EHB Variance Reason* to "Above EHB." This benefit is not considered an EHB.

b. **Substituted**

   i. 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 "Additional EHB Benefit," and the issuer must provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see Chapter 16).

c. **Substantially Equal**

   i. 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*.

   ii. 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.

d. **Using Alternate Benchmark**

   i. Multi-state plans us 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.

e. **Other Law/Regulation—**if a benefit is required by 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 not EHB and for those the issuer should use "Above EHB" as the variance reason instead.)

   i. 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."

f. **Additional EHB Benefit**—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state.

   i. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are. 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.

g. **Dental Only Plan Available**

   i. 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."

   ii. For example, you may offer SADPs to cover pediatric dental benefits, so you do not cover pediatric dental as part of your medical plans. You 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 "Covered" EHB.

4.12 Out of Pocket Exceptions

2016 Template Update: The fields *Subject to Deductible [Tier 1]* and *Subject to Deductible [Tier 2]* have been removed from the Plans & Benefits Template for the 2016 plan year. Subject to Deductible values for the AVC will be mapped from the actual copay and coinsurance drop-down values. See Section 4.25: Covered Benefits for more information on the definitions for copay and coinsurance drop-down values and how they relate to whether a benefit is subject to the deductible. See Chapter 11 for more information about how the Plans & Benefits Template

facilitates an automated actuarial value calculation using the Actuarial Value Calculator and the data entered into the template.

This section is for indicating 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.

In this section, issuers must complete the following fields:

1. *Excluded from In Network MOOP* (required). Indicate whether this benefit is excluded from the in-network MOOP. Only benefits not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following:

    a. **Yes**—if this benefit is excluded from the in-network MOOP.

    b. **No**—if this benefit is <u>not</u> excluded from the in-network MOOP.

2. *Excluded from Out of Network MOOP* (required). Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following:

    a. **Yes**—if this benefit is excluded from the out-of-network MOOP.

    b. **No**—if this benefit is <u>not</u> excluded from the out-of-network MOOP.

Complete this section as follows:

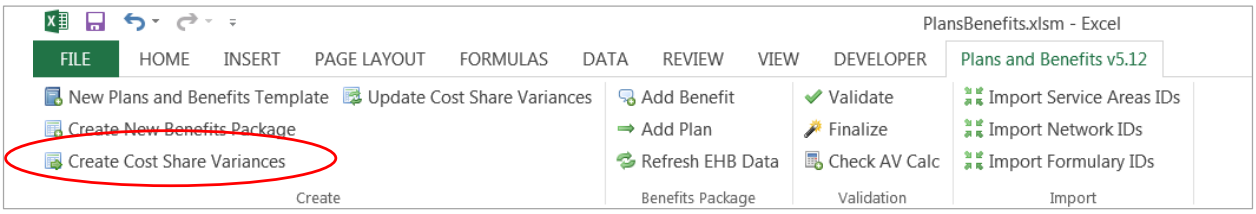
1. If the plans only have a combined (no separate in-network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP.*

2. If *Is this Benefit Covered?* for a benefit is "Not Covered," or blank, leave *Excluded from In Network MOOP* and *Excluded from Out of Network MOOP* blank.

3. If the plans do not have an out-of-network MOOP, set *Excluded from Out of Network MOOP* equal to "Yes."

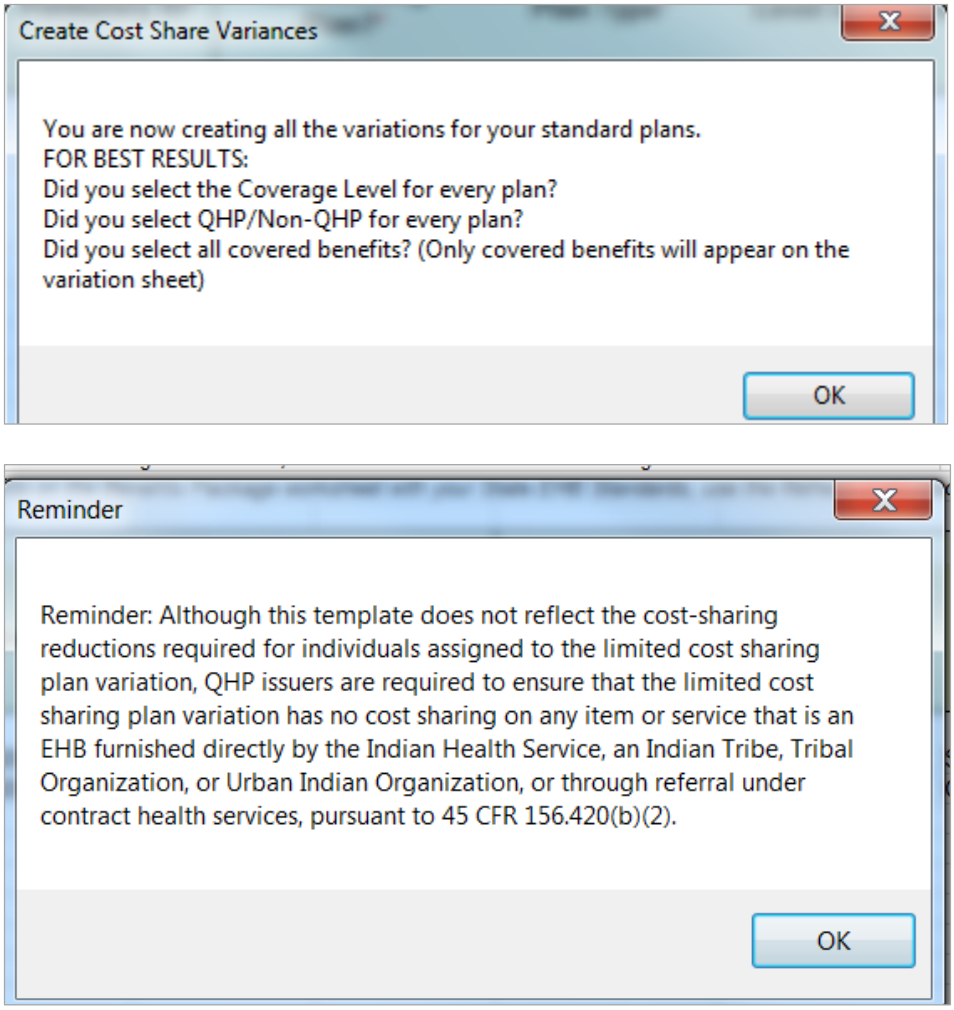
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon (Figure 10-6). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated cost-sharing reduction plan variations.

Figure 10-6. Create Cost Share Variances Button



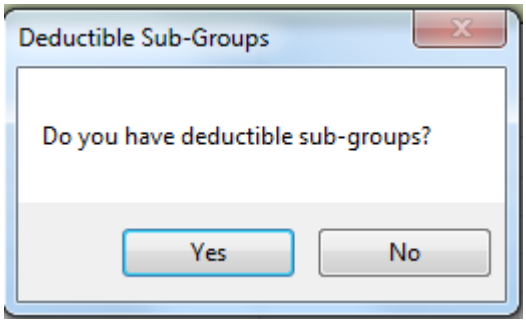
Click **OK** after reading the warnings (Figure 10-7), and make any necessary changes.

Figure 10-7. Warnings Pop-Up Box



The following questions pop up regarding deductible subgroups (Figure 10-8). Deductible subgroups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible subgroups are not separate deductibles outside of any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible subgroups.

Figure 10-8. Deductible Sub-Groups



1. Do you have any deductible subgroups?

   a. **Yes**—if the plan contains deductible subgroups.

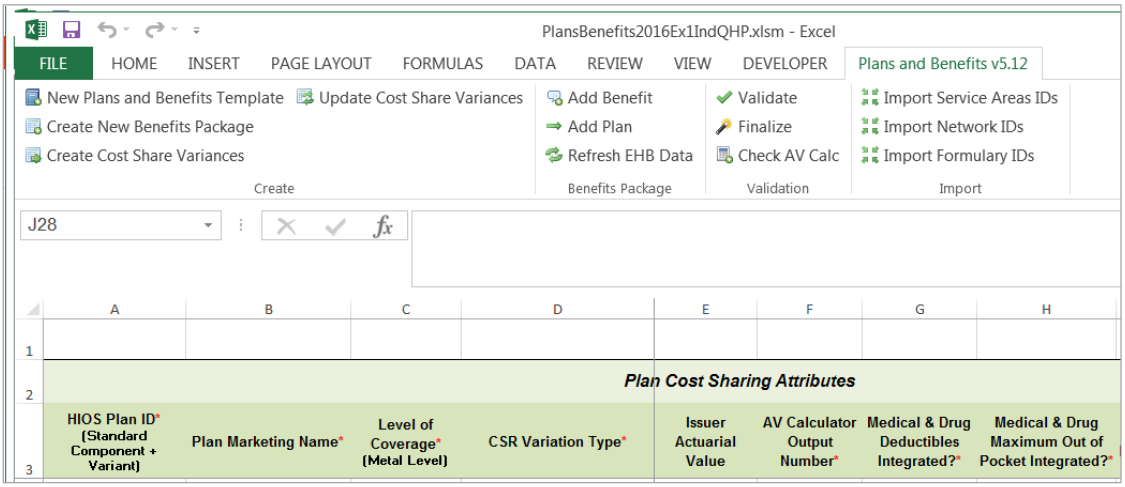
   b. **No**—if the plan does not contain deductible subgroups.

2. How many deductible subgroups do you have? Enter the correct number, and click **OK**.

3. What is the name of this deductible subgroup? Enter the name of each subgroup, and click **OK** after each. You must use a different name for each subgroup.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (Figure 10-9). 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 10-9. Cost Share Variances Worksheet



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

4.13 Plan Cost Sharing Attributes

This section has fields with basic information on each plan and cost-sharing reduction 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.

1. *HIOS Plan ID [Standard Component + Variant]* (required). The HIOS-generated number auto-populates for each cost-sharing plan variation.

    a. Standard plans to be offered on the Marketplace (also known as the Exchange) have a Plan ID variant suffix of "-01," and standard plans to be offered off of the Marketplace have a Plan ID variant suffix of "-00."

    b. For the individual market, each metal-level plan (except for catastrophic) has two cost-sharing reduction plan variations: 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.

    c. In addition, in the individual market, each silver plan has an additional three cost-sharing reduction 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.

    d. For more information on the requirements for the plan variations, see Section 5.5.

2. *Plan Marketing Name*# (required). The name of the plan auto-populates for all standard plans and plan variations with the standard plan's plan marketing name. This field cannot be edited on the Cost Share Variances worksheet. The issuer may update or edit the Plan Marketing Name on the Benefits Package worksheet and then select the **Update Cost Share Variances** button on the **Plans and Benefits** ribbon; it updates on the Cost Share Variances worksheet. The Plan Marketing Name cannot be edited for the plan variations. CMS recommends that issuers take this template functionality into account when determining the marketing name for their standard plans and cost-sharing reduction plan variations.

3. *Level of Coverage*^ (required). The coverage level for the plan auto-populates for standard plans.

4. *CSR Variation Type*^ (required). 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 cost-sharing reduction plan variations explained in this section.

5. *Issuer Actuarial Value* (required if **Yes** is entered for *Unique Plan Design*). Enter the issuer-calculated AV. This only applies to health plans that indicate they are a unique plan for AV purposes.

6. *AV Calculator Output Number* (required). Clicking the **Check AV Calc** button on the **Plans and 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 filled in before clicking this button. (For more information, see Chapter 11. For all AV requirements, see Section 5.3.)

7. *Medical & Drug Deductibles Integrated?^* (required). Indicate whether the medical and drug deductible is integrated. An integrated deductible means that both medical and drug charges contribute to a total plan-level deductible. A separate deductible means medical and drug charges contribute to separate plan-level deductibles. Choose from the following:

    a. **Yes—**if the medical and drug deductible is integrated. If "Yes" is entered, issuers should not enter information in the following sections: *Medical Deductible* and *Drug Benefits Deductible*.

    b. **No**—if the medical and drug deductible is not integrated. If "No" is entered, issuers should not enter information in the following section: *Combined Medical & Drug Deductible*.

8. *Medical & Drug Maximum Out of Pocket Integrated?^* (required). Indicate whether the medical and drug MOOP is integrated. An integrated MOOP means that both medical and drug charges contribute to a total plan-level MOOP. A separate MOOP means medical and drug charges contribute to separate plan-level MOOP values. Choose from the following:

    a. **Yes**—if the medical and drug MOOP is integrated. If "Yes" is entered, issuers should not enter information in the following sections: *Maximum Out of Pocket for EHB Benefits* and *Maximum Out of Pocket for Drug Benefits.*

    b. **No**—if the medical and drug deductible MOOP is not integrated. If "No" is entered, issuers should not enter information in *Maximum Out of Pocket for EHB and Drug Benefits (Total).*

9. *Multiple In Network Tiers?^* (required). Indicate whether there are multiple in-network provider tiers, meaning that the plan applies 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:

    a. **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.

    b. **No**—if there are not 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.

10. *1st Tier Utilization*^ (required). 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.)

11. *2nd Tier Utilization*^ (required). 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 if the answer to *Multiple In Network Tiers?* is "No." If so, it is locked and cannot be edited. (All plan variations have the same 2nd tier utilization as the standard plan.)

4.14 SBC Scenario

2016 Template Update: The fields in this section are now required for medical QHPs.

This section contains fields for basic information on two summary of benefits and coverage (SBC) scenarios. Additional information containing SBC scenario coverage examples and further resources for completing the scenarios can be found in the Summary of Benefits and Coverage and Uniform Glossary section of the website found here: http://www.cms.gov/cciio/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. Fill out the following data fields for both coverage examples (*Having a Baby* and *Having Diabetes*):

1. *Deductible*# (required). Enter the numerical value for the deductible.

2. *Copayment*# (required). Enter the numerical value for the copayment.

3. *Coinsurance*# (required). Enter the numerical value for the coinsurance.

4. *Limit*# (required). Enter the numerical value for the benefit limits or exclusion amount.

Until the Summary of Benefits and Coverage and Uniform Glossary proposed rule is finalized, issuers should complete the SBC scenario fields using the existing standards. If, when the proposed rule is finalized, there are changes to the SBC that affect the SBC scenario fields for plans available for the 2016 plan year, then issuers should expect to update the Plans & Benefits Template accordingly. This should occur before the final deadline for submission.

4.15 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 fields *Medical & Drug Deductibles Out of Pocket Integrated?* and *Medical & Drug Maximum Out of Pocket Integrated?* (For guidance filling out the MOOP and Deductible sections of the template, and ensuring all requirements are met, see Section 5.1.)

2016 Template Update: The *Family* fields for *In Network, In Network (Tier 2),* and *Out of Network* MOOP and deductibles will now have additional options. When you select these fields,

a pop-up will appear allowing you 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 within 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:[1]

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan ($6,850) and for the specific cost-sharing reduction plan variations. See Section 5.5 for more details about the individual MOOP limits for the different cost-sharing reduction 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; you may not enter "Not Applicable" for all these cells in all *Family* fields. The only exception is if a given plan is only available to consumers as self-only coverage.

4.16 Maximum Out of Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in Figure 10-10.

Figure 10-10. Maximum Out of Pocket Fields

T	U	V	W	X	Y	Z	AA	AB	AC
Maximum Out of Pocket for Medical EHB Benefits									
In Network		In Network (Tier 2)		Out of Network		Combined In/Out Network		In Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*	*Individual*	*Family*
$0	$0 per person | $0 per group	$0	$0 per person | $0 per group	$0	$0 per person | $0 per group	$0	$0 per person | $0 per group	$0	$0 per person | $0 per group

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

1. *In Network—Individual*^#. If MOOPs are <u>not</u> integrated, enter the dollar amount for Medical In Network Individual Maximum Out of Pocket for EHB Benefits.

2. *In Network—Family*#. If MOOPs are <u>not</u> integrated, enter the per-person and per-group dollar amount for Medical In Network Family Maximum Out of Pocket for EHB Benefits.

3. *In Network (Tier 2)—Individual*^. If MOOPs are <u>not</u> integrated and the plan has multiple in-network tiers, enter the dollar amount for Medical In Network (Tier 2) Individual

[1] Expected requirements under the current proposal. Their finalization depends on the final rule on HHS Notice of Benefit and Payment Parameters for 2016.

Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

4. *In Network (Tier 2)—Family*. If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar 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 is grayed out and cannot be edited.

5. *Out of Network—Individual*. If MOOPs are not integrated, enter the dollar amount for Medical Out of Network Individual Maximum Out of Pocket for EHB Benefits.

6. *Out of Network—Family*. If MOOPs are not integrated, enter the per-person and per-group dollar amount for Medical Out of Network Family Maximum Out of Pocket for EHB Benefits.

7. *Combined In/Out Network—Individual*^#. If MOOPs are not integrated, enter the dollar amount for Medical Combined In/Out of Network Individual Maximum Out of Pocket for EHB Benefits.

8. *Combined In/Out Network—Family*#. If MOOPs are not 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.

4.17 Maximum Out of Pocket for Drug EHB Benefits

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

1. *In Network—Individual*^#. If MOOPs are not integrated, enter the dollar amount for In Network Individual Maximum Out of Pocket for Drug EHB Benefits.

2. *In Network—Family*#. If MOOPs are not integrated, enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for Drug EHB Benefits.

3. *In Network (Tier 2)—Individual*^. If MOOPs are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field is grayed out and cannot be edited. (If the issuer only has multiple tiers for medical EHB benefits and not drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Individual* field.)

4. *In Network (Tier 2)—Family.* If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar 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 is grayed out and cannot be edited. (If the issuer only has multiple

tiers for medical EHB benefits and not drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Family* field.)

5. *Out of Network—Individual*. If MOOPs are not integrated, enter the dollar amount for Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.

6. *Out of Network—Family*. If MOOPs are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.

7. *Combined In/Out of Network—Individual*^#. If MOOPs are not integrated, enter the Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.

8. *Combined In/Out of Network—Family*#. If MOOPs are not 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.

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

This section is used for inputting MOOP values for medical and drug EHB benefits and is required only if the medical and drug MOOP is integrated ("Yes" is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOP is not integrated ("No" is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank and the fields will be grayed out, will be locked, and cannot be edited. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for medical and drug EHB benefits in the following areas on the template:

1. *In Network—Individual*^#. If MOOPs are integrated, enter the dollar amount for the Total In Network Individual Maximum Out of Pocket.

2. *In Network—Family*#. If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total In Network Family Maximum Out of Pocket.

3. *In Network (Tier 2)—Individual*^. If 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 is grayed out and cannot be edited.

4. *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 is grayed out and cannot be edited.

5. *Out of Network—Individual*. If MOOPs are integrated, enter the dollar amount for the Total Out of Network Individual Maximum Out of Pocket.

6. *Out of Network—Family*. If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Out of Network Family Maximum Out of Pocket.

7. *Combined In/Out Network—Individual*^#. If MOOPs are integrated, enter the dollar amount for the Total Combined In/Out of Network Individual Maximum Out of Pocket.

8. *Combined In/Out Network—Family*#. If 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.

4.19 Medical EHB Deductible

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

1. *In Network—Individual*^#. If deductibles are not integrated, enter the dollar amount for In Network Individual Medical EHB Deductible.

2. *In Network—Family*#. If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Medical EHB Deductible.

3. *In Network—Default Coinsurance*^. If deductibles are not integrated, enter the numerical value for the in network coinsurance. Note: If deductibles are not integrated, this is a required field for the AV calculation for those plans using the AVC.

4. *In Network (Tier 2)—Individual*^. If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Medical EHB Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

5. *In Network (Tier 2)—Family*. If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Medical EHB Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

6. *In Network (Tier 2)—Default Coinsurance*^. If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

7. *Out of Network—Individual*. If deductibles are not integrated, enter the dollar amount for Out of Network Individual Medical Deductible.

8. *Out of Network—Family*. If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Medical EHB Deductible.

9. *Combined In/Out Network—Individual*^#. If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Medical EHB Deductible.

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

4.20 Drug EHB Deductible

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

1. *In Network—Individual*^[#]. If deductibles are not integrated, enter the dollar amount for In Network Individual Drug EHB Deductible.

2. *In Network—Family*[#]. If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Drug EHB Deductible.

3. *In Network—Default Coinsurance*^. If deductibles are not integrated, enter the numerical value for the in-network coinsurance.

4. *In Network (Tier 2)—Individual*^. If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Drug EHB Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited. (If the issuer only has multiple tiers for medical EHB benefits and not drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Individual* field.)

5. *In Network (Tier 2)—Family.* If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Drug EHB Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited. (If the issuer only has multiple tiers for medical EHB benefits and not drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Family* field.)

6. *In Network (Tier 2)—Default Coinsurance*^. If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field is grayed out and cannot be edited. (If the issuer only has multiple tiers for medical EHB benefits and not drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Default Coinsurance* field.)

7. *Out of Network—Individual*. If deductibles are not integrated, enter the dollar amount for Out of Network Individual Drug EHB Deductible.

8. *Out of Network—Family*. If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Drug EHB Deductible.

9. *Combined In/Out Network—Individual*^#. If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Drug EHB Deductible.

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

4.21 Combined Medical and Drug EHB Deductible

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

1. *In Network—Individual*^#. If deductibles are integrated, enter the dollar amount for In Network Individual Combined Medical and Drug EHB Deductible.

2. *In Network—Family*#. If deductibles are integrated, enter the per-person and per-group dollar amount for In Network Family Combined Medical and Drug EHB Deductible.

3. *In Network—Default Coinsurance*^. If 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.)

4. *In Network (Tier 2)—Individual*^. If 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 is grayed out and cannot be edited.

5. *In Network (Tier 2)—Family*. If 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 is grayed out and cannot be edited.

6. *In Network (Tier 2)—Default Coinsurance*^. If deductibles are integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

7. *Out of Network—Individual*. If deductibles are integrated, enter the dollar amount for Out of Network Individual Combined Medical and Drug EHB Deductible.

8. *Out of Network—Family*. If deductibles are integrated, enter the per-person and per-group dollar amount for Out of Network Family Combined Medical and Drug EHB Deductible.

9. *Combined In/Out Network—Individual*^#. If deductibles are integrated, enter the dollar amount for Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible.

10. *Combined In/Out Network—Family*#. If 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.

4.22 Other Deductible

Complete this section if you have deductible subgroups; you can add an unlimited number of deductible subgroups 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 of any maximums allowed, and they still contribute to the MOOP and deductible limits.)

1. *In Network—Individual*. If deductibles are not integrated, enter the dollar amount for In Network Individual Other Deductible.

2. *In Network—Family*. If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Other Deductible.

3. *In Network Tier 2—Individual*. If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Other Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

4. *In Network Tier 2—Family*. If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Other Deductible. If there are not multiple in-network tiers, this field is grayed out and cannot be edited.

5. *Out of Network—Individual*. If deductibles are not integrated, enter the dollar amount for Out of Network Individual Other Deductible.

6. *Out of Network—Family*. If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Other Deductible.

7. *Combined In/Out of Network—Individual*. If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Other Deductible.

8. *Combined In/Out of Network—Family*. If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Other Deductible.

4.23 HSA/HRA Detail

2016 Template Update: The fields in this section have been moved from the Benefits Package worksheet here to the Cost Share Variances worksheet. This allows you to complete the fields for each plan variation in addition to the standard plans.

1. *HSA-Eligible* (required). Indicate whether the plan meets all of the requirements to be a health savings account (HSA)–eligible plan. Choose from the following:

    a. **Yes**—if the plan meets all of the HSA requirements.

    b. **No**—if the plan does not meet all of the HSA requirements.

2. *HSA/HRA Employer Contribution*^ (required for Small Group only; must be blank for individual market). Indicate whether the employer contributes to an HSA/health reimbursement arrangement (HRA). Choose from the following:

    a. **Yes**—if the plan has an HSA/HRA employer contribution.

    b. **No**—if the plan does not have an HSA/HRA employer contribution.

    HSA/HRA Employer Contribution Amount^ (required if "Yes" is entered for *HSA/HRA Employer Contribution*; must be blank for individual market). Enter a numerical value representing the employer contribution amount to HSA/HRA. The template does not permit an individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 *Federal Register* (FR) 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 only be used 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

2016 Template Update: The fields in this section have been moved from the Benefits Package worksheet here to the Cost Share Variances worksheet. This allows you to complete the fields for each plan variation in addition to the standard plans.

This section contains fields for URLs for applicable websites. URLs must start with "http://" or "https://" to work properly for the consumer. To give consumers access to all relevant plan information needed to compare and select plans, CMS asks that issuers ensure their 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.

Issuer URLs should link directly to each SBC and each plan brochure, respectively, for the standard plan or plan variation in question. The primary reason is that this will provide consumers with the best and most accurate shopping experience when searching for available plans through Federally-facilitated Marketplaces (FFMs). 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.

As part of the ongoing compliance monitoring, CCIIO may compare the benefits coverage and cost-sharing information inputted in the Plan & Benefits Template to the information you provide to consumers on the plan's SBC and plan brochure. Please take care to review the

information you submit on this template, as well as what coverage is represented on the plan's SBC and the plan brochure to ensure that all of this information is aligned with actual terms of coverage prior to submission.

Complete the following:

1. *URL for Summary of Benefits & Coverage*[#] (optional). 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 not be displayed to consumers if this field is not completed.

2. *Plan Brochure*[#] (optional). 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.

   CMS expects that issuers submit SBC and plan brochure URLs by the final deadline for submission of QHP data so that the FFM can meet its responsibility to provide consumers access to the appropriate SBCs through its website (see 45 CFR 155.205). CMS expects that these links to be active and directly route the user to the appropriate document by the time the issuer has signed its QHP agreements. 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 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.

2016 Template Update: There is now a drop-down option of "Not Applicable" for all cost-sharing fields. This value should be used:

1. If issuer charges only a copay or a coinsurance for a benefit, enter "Not Applicable" for the other. For example, if you wish to charge a $20 copay for a benefit, you would enter "$20" for the copay and "Not Applicable" for the coinsurance. Please note "No Charge" was used for this scenario in previous templates in past years, but "Not Applicable" is the correct option in the 2016 template. If issuers are copying and pasting entered template data from past years, special attention should be paid to updating these fields to help ensure proper display of cost-sharing information to consumers on Plan Compare.

2. If issuer has multiple in-network tiers, for any benefit category that does not have tiers, enter "Not Applicable" for the *In Network (Tier 2)* copay and coinsurance. For example, if the issuer only has 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. Again, if issuers are copying and pasting entered template data

from past years special attention should be paid to updating these fields to help ensure proper display of cost-sharing information to consumers on Plan Compare.

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. For further instructions on how to coordinate the prescription drug data entered in both the Plans & Benefits Template and the Prescription Drug Template, see Section 5.8.

3. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, see Chapter 11.

4. There are many cost-sharing requirements for the cost-sharing reduction silver plan variations and the zero and limited cost-sharing plan variations (see Section 5.5).

5. If cost sharing varies on the basis of 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 utilized); in the *Benefit Explanation* field, add appropriate and brief detail to communicate the cost sharing in the scenarios other than the most common one already entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) also should clearly communicate any cost-sharing information that may vary on the basis of place of service or provider type.

6. Figure 10-11 shows an example of how the fields for each benefit are laid out.

Figure 10-11. Benefit Information Fields

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

Fill in the following information for each covered benefit on the benefits package sheet:

1. *Copay—In Network (Tier 1)^#*. If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter "Not Applicable." Choose from the following:

   a. **No Charge**—no cost sharing is charged (this indicates that this benefit is <u>not</u> subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a coinsurance is charged.

b. **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).

c. **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

d. **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is only responsible for the copay (this indicates that this benefit is subject to the deductible).

e. **$X Copay before 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).

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

2. *Copay—In Network (Tier 2)*^#. 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 also for the field *Coinsurance—In Network (Tier 2).* This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. Choose from the following:

a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a coinsurance is charged.

b. **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).

c. **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

d. **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is only responsible for the copay (this indicates that this benefit is subject to the deductible).

e. **$X Copay before 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).

f. **Not Applicable**—the consumer only pays 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 not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

3. *Copay—Out of Network*[#]. If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter "Not Applicable." Choose from the following:

   a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a coinsurance is charged.

   b. **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).

   c. **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

   d. **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is only responsible for the copay (this indicates that this benefit is subject to the deductible).

   e. **$X Copay before 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).

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

4. *Copay—In Network (Tier 1)*, *Copay—In Network (Tier 2)*, and *Copay—Out of Network*, for Inpatient benefits. The following options are the only available options for the benefits *Inpatient Hospital Services (e.g., Hospital Stay)* and *Skilled Nursing Facilit*y. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure all variations follow the same "per day" or "per stay" cost-sharing structure. If no copayment is charged, enter "Not Applicable."

   The benefits *Mental/Behavioral Health Inpatient Services* and *Substance Abuse Disorder Inpatient Services* include these options as well as those described in the section *Copay—In Network (Tier 1)* above. Choose from the following:

   a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a coinsurance is charged.

   b. **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).

a. **$X Copay per Day**—the consumer pays a copayment per day (this indicates that this benefit is not subject to the deductible).

b. **$X Copay per Stay**—the consumer pays a copayment per stay (this indicates that this benefit is not subject to the deductible).

c. **$X Copay per Day after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is only responsible for the copay per day (this indicates that this benefit is subject to the deductible).

d. **$X Copay per Stay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is only responsible for the copay per stay (this indicates that this benefit is subject to the deductible).

e. **$X Copay per Day before 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).

f. **$X Copay per Stay before 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).

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

For *Inpatient Hospital Services (e.g., Hospital Stay)* and *Skilled Nursing Facilit*y covered benefits, DO NOT 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.

5. *Coinsurance—In Network (Tier 1)*^#. If an in-network coinsurance is charged, enter the percentage the consumer will pay here. 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:

   a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a copay is charged.

   b. **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).

c. **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).

d. **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

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

6. *Coinsurance—In Network (Tier 2)*^#. If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay here. 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, and also for the field *Copay—In Network (Tier 2).* This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. Choose from the following:

   a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a copay is charged.

   b. **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).

   c. **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).

   d. **X%**— the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

   e. **Not Applicable**—the consumer only pays a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are "Not Applicable," this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

7. *Coinsurance—Out of Network*#. 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:

a. **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that "Not Applicable," not "No Charge," should be used if only a copay is charged.

b. **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).

c. **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).

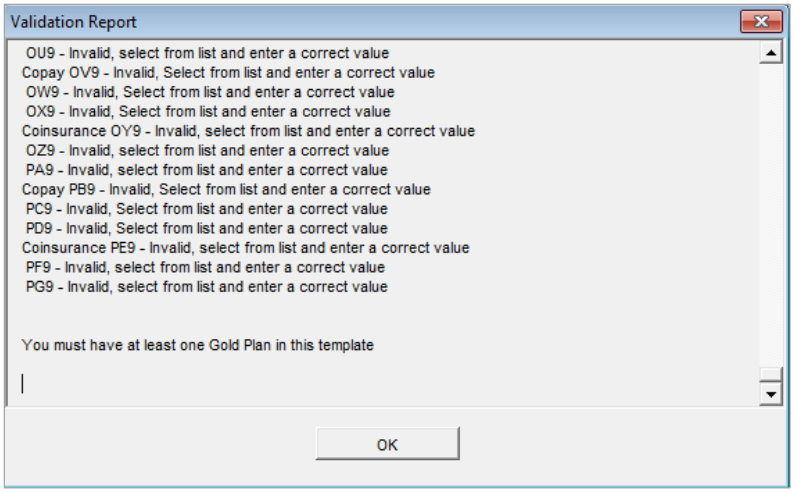
d. **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

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

4.26 Completed Plans & Benefits Template

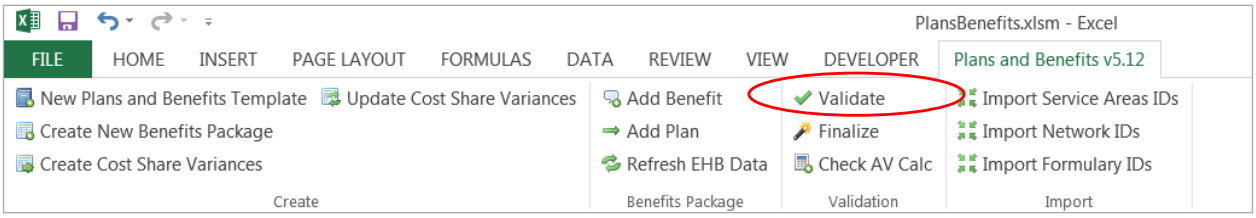
Once the entire template, including all Benefits Package and Cost Sharing Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans and Benefits** ribbon. If there are validation errors, a Validation Report (Figure 10-12) will appear showing the data element and cell location of each error. You must correct these errors in order for your Plans & Benefits Template to be accepted.

Figure 10-12. Error Report



Once the validation is successful, click the **Finalize** button on the menu bar under the **Plans and Benefits** ribbon (Figure 10-13), to save the template as an XML file. Upload the saved file in the Benefits and Service Area module. Before closing the template, save an XLSM version of the Excel file onto your computer for future reference.

Figure 10-13. 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.[2] When entering the MOOP values, ensure the following limits are met for the in-network EHB MOOP. (See the 2016 HHS Notice of Benefit and Payment Parameters 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 $6,850 for an individual (self-only) or $13,700 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 $5,450 for an individual (self-only) or $10,900 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 $2,250 for an individual (self-only) or $4,500 for a family (other than self-only).

    e. For the zero cost sharing plan variations, 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.

[2] See the proposed rule on HHS Notice of Benefit and Payment Parameters for 2016 (79 FR 70674; November 26, 2014). Issuers must comply with policies that are incorporated into the final rule on HHS Notice of Benefit and Payment Parameters for 2016.

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 the following limits are taken into consideration (See the 2016 HHS Notice of Benefit and Payment Parameters for more details on the annual limit on cost sharing.)

   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 ($13,700) discussed above, as well as the annual limitation on cost sharing for self-only coverage.

      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 ($6,850) and for the specific cost-sharing reduction plan variations as detailed in the annual limitation on cost sharing discussion immediately above.[3]

   b. 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:

[3] Ibid.

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 Affordable Care Act and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can only be offered 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 Affordable Care Act and in the HHS Notice of Benefit and Payment Parameters for 2016. For plan year 2016, this limit is $6,850 for individuals (self-only) and $13,700 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/out-of-network MOOP, the combined in/out-of-network deductible and combined in/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/out-of-network deductible and in/out-of-network MOOP but no specific in-network deductible or in-network MOOP, the combined in/out-of-network deductible and combined in/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 Section 5.10 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 ±2 percentage points is used for standard plans.

    a. The AV for a bronze plan must be between 58 and 62 percent.

    b. The AV for a silver plan must be between 68 and 72 percent.

    c. The AV for a gold plan must be between 78 and 82 percent.

    d. The AV for a platinum plan must be between 88 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 and 74 percent.

b. The AV for the 87 percent AV silver plan variation must be between 86 and 88 percent.

c. The AV for the 94 percent AV silver plan variation must be between 93 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. Refer to Chapter 11, Section 7 for more details.

(For more information on how the cost-sharing information from the Plans & Benefits Template translates into inputs for the stand-alone AVC, see Chapter 11.)

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 Variance 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 and Benefits** ribbon. Doing so deletes the added benefit, but the issuer also loses any other data it has entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.

      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, it will not update 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 and Benefits** ribbon and generate a new worksheet. The updated worksheet then reflects the changes made to the Benefits Package worksheet.

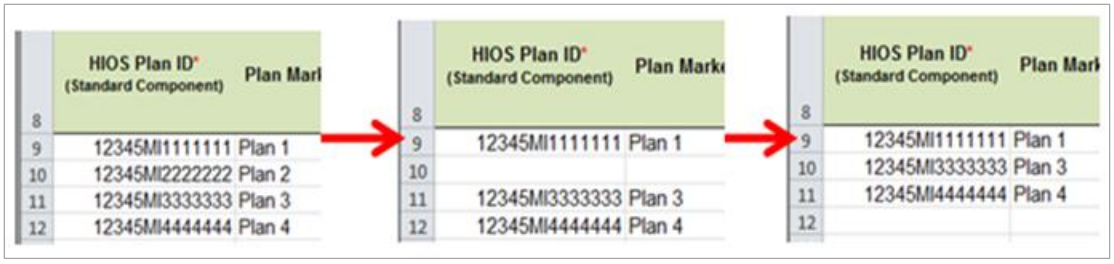
3. Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:

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 and Benefits** ribbon. This adds the new plan to the Cost Share Variances worksheet.

b. To delete a plan on the Benefits Package worksheet, delete all data for that plan's row. If any plans are below that row, cut these rows and paste them into the empty row (see below). This is an important step because if the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below this blank row and their corresponding data are deleted from the Cost Share Variances worksheet.

   Example: To delete Plan 2 (Figure 10-14), delete all data from the plan's row, cut and paste Plan 3 from row 11 to row 10, and then copy 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 10-14. Deleting a Plan



c. If the issuer changes any benefits package data on a specific plan that already exists, the only changes that will be reflected on the Cost Share Variances worksheet when you click the **Update Cost Share Variances** button include the following: Plan Marketing Names will be updated, plans added to the Benefits Package worksheet will be added to the Cost Share Variance worksheet, and plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet. 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.

5.5 Requirements for Cost-Sharing Reduction Plan Variations

Cost-sharing reduction plan variations fall into three types: silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations. 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.[4] However, if the associated standard plan does not cover out-of-network services, the zero cost sharing plan variation is not required to cover them either. (See Section 5.6 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 Section 5.7 for further explanation and examples of successive cost sharing.)

g. Tier utilization must be the same as the associated standard plan.

2. The requirements for limited cost sharing plan variations are as follows:

   a. The template automatically generates a limited cost sharing plan variation for all metal-level plans (except catastrophic) on the individual market.

   b. The AV of the limited cost sharing plan variation must be greater than or equal to the associated standard plan's AV.

   c. All MOOP values for EHB must be the same as the associated standard plan's MOOP values for EHB.

   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 Section 5.6).

   f. For benefits which are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see Section 5.7).

[4] 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 excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

g. Tier utilization must be the same as the associated standard plan.

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 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 and 88 percent.

   d. The AV for the 94 percent AV silver plan variation must be between 93 and 95 percent.

   e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to $5,450 for an individual (self-only) or $10,900 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 $2,250 for an individual (self-only) or $4,500 for a family (other than self-only).

   g. All MOOP values must follow successive cost sharing for all plan variations (see Section 5.7).

   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.

5.6 EHB Variance Reason and EHB Designation

As explained in Section 5.5, 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 two fields *EHB* and *EHB Variance Reason* for the benefit on the Benefits Package worksheet as outlined in Section 4.11. Table 10-1 explains when a benefit is considered an EHB on the basis of different inputs.

Table 10-1. EHB Designation

EHB field value	*EHB Variance Reason* field value	Evaluated as an EHB?
"Yes"	Anything other than "Above EHB"	Yes
Blank	"Additional EHB Benefit" or "Other Law/Regulation"	Yes
"Yes"	"Above EHB"	No
Blank	Anything other than "Additional EHB Benefit" or "Other Law/Regulation"	No

5.7 Successive Cost-Sharing Guidance

As explained in Section 5.5, 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. (See the HHS Notice of Benefits and Payment Parameters for 2014 and 2015 for details on the cost-sharing regulatory requirements for cost-sharing reduction plan variations.)

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 be worse off and pay increased cost sharing. 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 10-2 through Table 10-8 show the compliant and noncompliant data entry options for the different cost-sharing fields discussed, as well as numerous examples.

Table 10-2. Compliant and Noncompliant Successive Cost-Sharing Data Entry Options for MOOP or Deductible Values

First Plan (lower AV) MOOP/Deductible Value	Compliant Second Plan (higher AV) MOOP/Deductible Values	Noncompliant Second Plan (higher AV) MOOP/Deductible Values
$X	• $Y (when $Y ≤ $X)	• Not Applicable • $Y (when $Y > $X)
Not Applicable	• Not Applicable	• $Y

Table 10-3. Examples of Compliant (Green) and Noncompliant (Red) Successive Cost-Sharing MOOP/Deductible Values

Examples	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 10-4. Compliant and Noncompliant Successive Cost-Sharing Options for Coinsurance Values

First Plan (lower AV) Coinsurance Value	Compliant Second Plan (higher AV) Coinsurance Values	Noncompliant Second Plan (higher AV) Coinsurance Values
No Charge	• No Charge • 0% Coinsurance • Not Applicable	• No Charge After Deductible • Y% Coinsurance (when greater than 0) • Y% Coinsurance After Deductible (all values)
No Charge After Deductible	• No Charge • No Charge After Deductible • 0% Coinsurance • 0% Coinsurance After Deductible • Not Applicable	• Y% Coinsurance (when greater than 0) • Y% Coinsurance After Deductible (when greater than 0)
X% Coinsurance	• No Charge • Y% Coinsurance (when Y% ≤ X%) • Not Applicable	• No Charge After Deductible • Y% Coinsurance (when Y% > X%) • Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	• No Charge • No Charge After Deductible • Y% Coinsurance (when Y% ≤ X%) • Y% Coinsurance After Deductible (when Y% ≤ X%) • Not Applicable	• Y% Coinsurance (when Y% > X%) • Y% Coinsurance After Deductible (when Y% > X%)
Not Applicable	• Not Applicable • No Charge	• No charge after deductible • Y% Coinsurance (all values) • Y% Coinsurance After Deductible (all values)

Table 10-5. 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%	

Table 10-5. Examples of Compliant and Noncompliant Successive Cost-Sharing Coinsurance Values

Plan	Coinsurance	Compliance
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	

Plan	Coinsurance	Compliance
Lower AV Plan	25%	Compliant
Higher AV Plan	20%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	25% Coinsurance After Deductible	

Plan	Coinsurance	Compliance
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	

Plan	Coinsurance	Compliance
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	30%	

Table 10-6. 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	• No Charge • $0 Copay • Not Applicable	• No Charge After Deductible • $Y Copay (when greater than 0) • $Y Copay After Deductible (all values) • $Y Copay Before Deductible (all values)
No Charge After Deductible	• No Charge • No Charge After Deductible • $0 Copay • $0 Copay After Deductible • Not Applicable	• $Y Copay (when greater than 0) • $Y Copay After Deductible (when greater than 0) • $Y Copay Before Deductible (all values)
$X Copay	• No Charge • $Y Copay (when $Y ≤ $X) • Not Applicable	• No Charge After Deductible • $Y Copay (when $Y > $X) • $Y Copay After Deductible (all values) • $Y Copay Before Deductible (all values)
$X Copay After Deductible	• No Charge • No Charge After Deductible • $Y Copay (when $Y ≤ $X) • $Y Copay After Deductible (when $Y ≤ $X) • Not Applicable	• $Y Copay (when $Y > $X) • $Y Copay After Deductible (when $Y > $X) • $Y Copay Before Deductible (all values)
$X Copay Before Deductible	• No Charge • $0 Copay • $Y Copay Before Deductible (when $Y ≤ $X) • No Charge After Deductible • Not Applicable	• $Y Copay (when greater than 0) • $Y Copay After Deductible (all values) • $Y Copay Before Deductible (when $Y > $X)
Not Applicable	• Not Applicable • No Charge	• No Charge After Deductible • $Y Copay (all values) • $Y Copay After Deductible (all values) • $Y Copay Before Deductible (all values)

Table 10-7. Compliant and Noncompliant Successive Cost-Sharing Data Entry Options for Inpatient Specific Copay Values

First Plan (lower AV) Copay Value	Compliant Second Plan (higher AV) Copay Values	Noncompliant Second Plan (higher AV) Copay Values
$X Copay per Day	• $Y Copay per Day (when $Y ≤ $X) • $Y Copay per Stay (when $Y ≤ $X) • No Charge • Not Applicable	• $Y copay per day (when $Y > $X) • $Y copay per stay (when $Y > $X) • $Y copay per day before deductible (all values) • $Y copay per day after deductible (all values) • $Y copay per stay before 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 before deductible (all values)
$X Copay per Stay	• $Y Copay per Stay (when $Y ≤ $X) • $0 Copay per Day • No Charge • Not Applicable	• $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 before 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 before deductible (all values)
$X copay per day before deductible	• $Y copay per day before deductible (when $Y < $X) • $Y copay per stay before deductible (when $Y < $X) • No charge • No charge after deductible • $0 copay per day • $0 copay per stay • Not applicable	• $Y copay per day before deductible (when $Y > $X) • $Y copay per day (when greater than 0) • $Y copay per day after deductible (all values) • $Y copay per stay before 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 before deductible (all values)

Table 10-7. 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 stay before deductible	• $Y copay per stay before deductible (when $Y < $X) • $0 copay per day before deductible • No charge • No charge after deductible • $0 copay per stay • $0 copay per day • Not applicable	• $Y copay per stay before deductible (when $Y > $X) • $Y copay per stay (when greater than 0) • $Y copay per stay after deductible (all values) • $Y copay per day before 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 before deductible (all values)
$X copay per day after deductible	• $X copay per day after deductible ($Y < $X) • $X copay per stay after deductible ($Y < $X) • $X copay per day ($Y < $X) • $X copay per stay ($Y < $X) • No charge • No charge after deductible • Not applicable	• $Y copay per day before deductible (all values) • $Y copay per day after deductible (when $Y > $X) • $Y copay per day (when $Y > $X) • $Y copay per stay before 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 before deductible (all values)
$X copay per stay after deductible	• $X copay per stay after deductible ($Y < $X) • $X copay per stay ($Y < $X) • $0 per day after deductible • $0 per day • No charge • No charge after deductible • Not applicable	• $Y copay per stay before deductible (all values) • $Y copay per stay after deductible (when $Y > $X) • $Y copay per stay (when $Y > $X) • $Y copay per day before 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 before deductible (all values)

Table 10-7. 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
No charge after deductible	• No charge after deductible • No charge • $0 per day • $0 per stay • $0 per day after deductible • $0 per stay after deductible • Not applicable	• $Y copay per stay before 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 before 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 before deductible (all values)
No charge	• No charge • $0 per day • $0 per stay • Not applicable	• $Y copay per stay before deductible (all values) • $Y copay per stay after deductible (all values) • $Y copay per stay (when greater than 0) • $Y copay per day before 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 before deductible (all values)

Table 10-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Examples	Copay	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	$0	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	$40	

Table 10-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Examples	Copay	Compliance
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 Before Deductible	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	$45 Copay After Deductible	

Examples	Copay	Compliance
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	

Examples	Copay	Compliance
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay Before Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	

Table 10-8. Examples of Compliant and Noncompliant Successive Cost-Sharing Copay Values

Examples	Copay	Compliance
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay Before Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	

Examples	Copay	Compliance
Lower AV Plan	$40 Copay per Day	Compliant
Higher AV Plan	$30 Copay per Day	
Lower AV Plan	$40 Copay per Stay	Compliant
Higher AV Plan	$40 Copay per Stay	
Lower AV Plan	$40 Copay per Day	Not Compliant
Higher AV Plan	$35 Copay per Stay	

Examples	Copay	Compliance
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 Before Deductible	

Examples	Copay	Compliance
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 Before Deductible	

5.8 Suggested Coordination of Drug Data Between Templates

This section describes some options on how to coordinate the prescription drug data entered in both 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 as follows:

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 *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 *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, in the Plans & Benefits Template, "tiers" refer to provider and pharmacy networks. If the issuer has multiple in-network tiers for medical benefits, it may use the tiered cost-sharing field for drugs to represent preferred and nonpreferred pharmacies on the Plans & Benefits Template. Following this approach, the issuer 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. If the issuer does not have multiple in-network tiers for its medical benefits, representing non-preferred pharmacy cost sharing under the *Tier 2* fields on the Plans & Benefits Template is not necessary.

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*.

Cost-sharing reduction 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 cost-sharing reductions (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 being 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 being utilized in the AV calculation.

5.9 Anticipated Template Data Elements To Be Shown on Plan Compare

Throughout this chapter, 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 10-9 and 10-10 list the Plans & Benefit 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 10-9. Anticipated Plan Compare Data Elements-Plan Summary View

Plan Summary View		
Plan Compare Label Name	Template Value	Template Source
Deductibles and Maximum Out of Pocket Rules:	• 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 View. (The Drug amount displays in the prescription drug details section.) • If there is only one person in the enrollment group, the Individual 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 per-person deductible will display on the Plan Summary View. The dollar amount will display followed by "Per Person."	Plans & Benefits Template

Table 10-9. Anticipated Plan Compare Data Elements-Plan Summary View

Plan Summary View		
Plan Compare Label Name	Template Value	Template Source
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
	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 & Coverage	Plans & Benefits Template
Insurance Company + Plan Marketing Name + Plan Type *Issuer Legal Name (HIOS) will display if Issuer Marketing Name is null.*	Issuer Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care (Adult) Major Dental Care – Adult Note: All three must be available to show Adult Dental Included.	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child Note: All three must be available to show Pediatric Dental Included.	Plans & Benefits Template
National Provider Network Offered/National	National Network	Plans & Benefits Template
Health Care Costs	Derived from “Level of Coverage”	Plans & Benefits Template
Reduced Costs	Indicates whether or not plan is a CSR Variant	Based on Consumer Eligibility information

Table 10-10. Anticipated Plan Compare Data Elements-Plan Detail View

Plan Detail View (All data displayed in the "Plan Summary View" above is also displayed in the "Plan Detail View")		
Plan Compare Label Name	Template Value	Template Source
Plan Brochure	Plan Brochure URL	Plans & Benefits Template
Benefit Data Rules *This data displays for each covered benefit below when "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
Heath Savings Account Eligible Plan	HSA—Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template

Table 10-10. Anticipated Plan Compare Data Elements-Plan Detail View

Plan Detail View (All data displayed in the "Plan Summary View" above is also displayed in the "Plan Detail View")		
Plan Compare Label Name	Template Value	Template Source
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 "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 "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
National Provider Network	National Network	Plans & Benefits Template
Referral required to see a specialist	Referral required to see a specialist	Plans & Benefits Template
Hospital Based Services		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient Hospital Services (e.g., Hospital Stay)	Plans & Benefits Template
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
Coverage Examples		
Total cost of having a baby	SBC Scenario – Having a Baby. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template
Total cost of managing diabetes	SBC Scenario – Managing Diabetes. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template

Table 10-10. Anticipated Plan Compare Data Elements-Plan Detail View

Plan Detail View (All data displayed in the "Plan Summary View" above is also displayed in the "Plan Detail View")		
Plan Compare Label Name	Template Value	Template Source
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care – Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care – Adult	Plans & Benefits Template
Orthodontia	Orthodontia – Adult	Plans & Benefits Template
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
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

Table 10-10. Anticipated Plan Compare Data Elements-Plan Detail View

Plan Detail View (All data displayed in the "Plan Summary View" above is also displayed in the "Plan Detail View")		
Plan Compare Label Name	Template Value	Template Source
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

Below is a summary of the anticipated deductible, MOOP, copay, and coinsurance cost-sharing display logic for Plan Compare for individual market coverage effective started January 1, 2016. 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.

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 detail page.

- If only one person is in the enrollment group, the individual MOOP and deductible amount displays both 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, a Family Per Group deductible amount displays on the plan summary page if the issuer entered either $0 or a positive dollar amount for the family per-group data field. 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 per-person deductible will display on the Plan Summary View. The dollar amount will display followed by "Per Person."

- On the plan details page, both the Family Per Group and Family Per Person deductible and MOOP amounts will appear.

- The out-of-network deductible and MOOP are not displayed on Plan Compare.

Covered Benefit Plan Compare Display Logic

- Generally speaking, 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% coinsurance" for a specialist visit, "20%" will display on Plan Compare.

- **2016 Template Update:** As described above, there is now a drop-down option of "Not Applicable" for all cost-sharing fields. This value should be used:

    - If issuer charges only a copay <u>or</u> a coinsurance for a benefit, enter "Not Applicable" for the other. For example, if you wish to charge a $20 copay for a benefit, you would enter "$20" for the copay and "Not Applicable" for the coinsurance. The $20 copay will then display on Plan Compare. Please note, "No Charge" was used for this scenario in previous templates in past years, but "Not Applicable" is the correct option in the 2016 template. If issuers are copying and pasting entered template data from past years, special attention should be paid to updating these fields to help ensure proper display of cost-sharing information to consumers on Plan Compare.

    - If issuer has multiple in-network tiers, for any benefit category that does not have tiers, enter "Not Applicable" for the *In Network (Tier 2)* copay and coinsurance. "Not Applicable" will appear for the Tier 2 cost sharing on Plan Compare. For example, if the issuer only has multiple in-network tiers for their inpatient hospital covered benefits, then they would enter Tier 2 cost sharing. For other covered benefits without multiple in-network tiers, issuers should enter "Not Applicable" for the *In Network (Tier 2)* copay and coinsurance. Again, if issuers are copying and pasting entered template data from past years, special attention should be paid to updating these fields to help ensure proper display of cost-sharing information to consumers 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:

  - “No Charge After Deductible” is entered for both 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 all include “0,” “No Charge,” or “Not Applicable.” Similarly, if any of the aforementioned values include a copay or coinsurance qualifiers of “After Deductible,” then “No Charge After Deductible” is displayed.

- When both copay and coinsurance are greater than zero, both are displayed.

5.11 Troubleshooting the Plans & Benefits Add-In File

When you open the 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 you try to enter data into the template or click buttons on the **Plans and 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 only one copy of the Add-In file is on your computer; delete all extra copies, and when downloading a new one, always “Replace” the old version.

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

1. Open Excel only (no template or file). The Excel ribbon should not have a **Plans and Benefits** ribbon. If the **Plans and Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-ins > Go > uncheck Plansbenefitsaddin > OK (Figures 10-16 through 10-18). In Excel 2007, the labels may differ slightly.

Figure 10-15. Excel Options Window

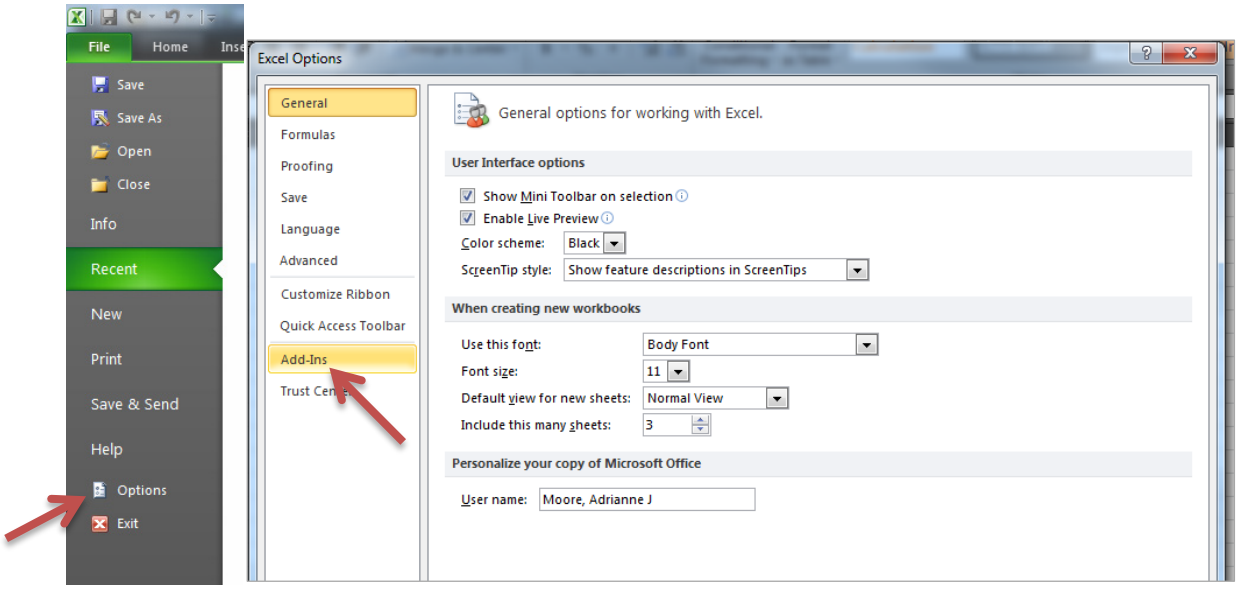


Figure 10-16. Add-Ins Tab in Excel Options Window

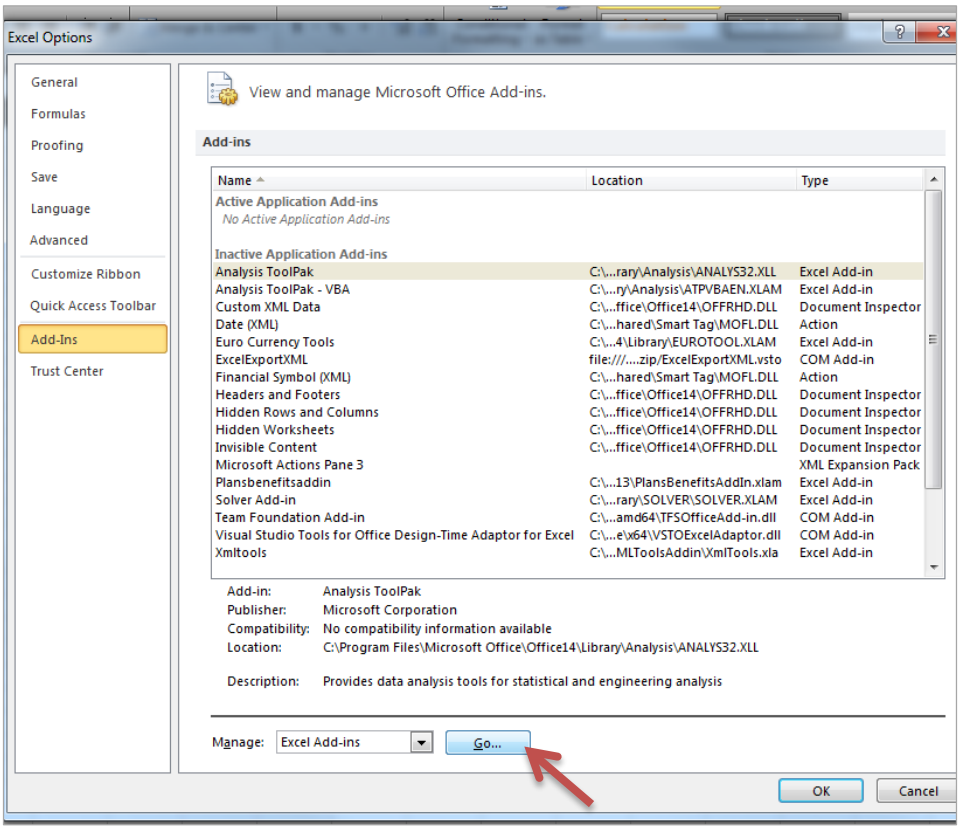
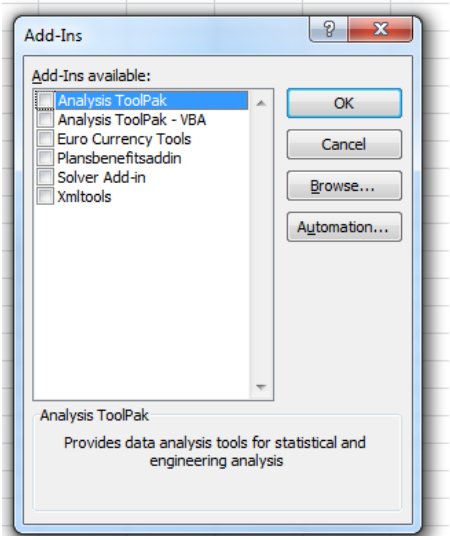


Figure 10-17. Add-Ins Window



2. Verify that the **Plans and 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.