Chapter 15: Instructions for Stand-Alone Dental Plan Application

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1. Purpose

This chapter guides dental-only and dual product issuers through completing the Plans & Benefits Template for a stand-alone dental plan (SADP).

2. Overview

Pediatric dental is an essential health benefit (EHB) that must be offered by all issuers in the individual and small group markets. If the pediatric dental benefit is covered by a SADP on the Marketplace, qualified health plans (QHPs) in that Marketplace are not required to offer the pediatric dental EHBs. SADPs seeking Marketplace certification must meet all the applicable QHP certification standards described below.

An issuer that participates solely in the dental market—a dental-only issuer—or one that participates in both the medical and dental markets—a dual product issuer—may offer SADPs. For the QHP Application, an SADP issuer is a dental-only issuer if it has its own Employer Identification Number (EIN). An SADP issuer that shares an EIN with another entity is considered a dual product issuer.

Dental-only issuers and dual product issuers should use the QHP Application system to complete other relevant application sections and templates. Table 15-1 lists the chapters with instructions for how SADP issuers should complete other sections of the application.

Table 15-1. Instruction Chapters for Application Sections

Application Section	Instruction Chapter
Administrative	Chapter 1. Administrative
Program Attestation	Chapter 2. Program Attestation
State Licensure	Chapter 3. State Licensure
Good Standing	Chapter 4. Good Standing
Accreditation	Chapter 5. Accreditation
Network Adequacy	Chapter 6. Network Adequacy
Essential Community Providers	Chapter 7. Essential Community Providers
Network Identification	Chapter 8. Network Identification
Service Area	Chapter 9. Service Area
Business Rules	Chapter 13. Business Rules
Rates Table	Chapter 14. Rates Table
Plans & Benefits	Chapter 15. Stand-Alone Dental Plan
Actuarial Value Calculator	SADP issuers are not required to complete this section
Prescription Drug	SADP issuers are not required to complete this section

2.1 Key Template Updates

Figure 15-1 and Figure 15-2 identify the key changes made to the structure and content of the 2016 version of the Plans & Benefits template. These changes are also identified throughout the instructions whenever the phrase “2016 Template Update” is included.

Figure 15-1. 2016 Plans & Benefits Template Benefits Package Worksheet Updates

Key Changes to the Benefits Package Worksheet

- All template banners will be updated with the 2016 plan year identifier and version number; 2016 templates must be used for the 2016 QHP Certification submission.
- The field *Does this plan offer Composite Rating?* has been added to the template.
- The *Plan Effective Date* must be 1/1/2016 for 2016 plans offered as "on-Exchange" or "Both."
- The EHB reference table will be updated. The *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.

Figure 15-2. 2016 Plans & Benefits Template Cost Share Variances Worksheet Updates

Key Changes to the Cost Share Variances Worksheet

- 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.
- The *Family* fields for Maximum out of Pocket (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 4.18. Specifically, "No Charge" and "Not Applicable" should not be used interchangeably and have specific definitions and cases for when each should be used.

3. Data Requirements

Figure 15-3 shows key items for completing the Plans & Benefits application for an SADP.

Figure 15-3. Plans & Benefits for Stand-Alone Dental Plan Section Highlights

- Download the latest versions of the templates from 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.
- Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template (for the macros to run properly).
- Complete the Network and Service Area Templates and save them on your computer before filling out the Plans & Benefits Template.
- If you are a registered Health Insurance Oversight System (HIOS) user, your template may have prepopulated fields that cannot be changed.
- To complete the Plans & Benefits section of the QHP Application, complete a benefits package for each benefits package you want to offer and a row in an associated Cost Share Variances worksheet for each plan and variation.
- If you want 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.
- The Dental macro in the Plans & Benefits Template restricts data entry to dental-specific benefits, redefines *Level of Coverage* as **High** or **Low** (from metal levels plus catastrophic for QHPs), and prevents the integration of medical and drug MOOP values and deductibles.
- Dental-only issuers and dual product issuers that want to offer SADPs off the Marketplace but have them Marketplace-certified may do so by selecting **Off Exchange** for *QHP/Non-QHP.* (You only need to submit information SADPs to be sold off the Marketplace if you want Marketplace certification; otherwise, you do not need to submit off-Marketplace dental products to the Federally-facilitated Marketplace, [FFM].)
- In this document, data fields are in *italics*, and data entry options, buttons, and ribbons are **bold**.

The following are instructions for completing the Plans & Benefits Template as a dental-only and dual product issuer.

4. Application Instructions

4.1 Getting Started

In this section of the application, issuers supply information for each dental plan, including plan identifiers, attributes, dates, geographic coverage, URLs, benefit information, and cost-sharing information. Dental-only and dual product issuers should complete the Plans & Benefits

Template. Activate the Dental macro to customize this template by selecting **Yes** for the *Dental Only Plan* field located in the upper left corner of the template.

The Plans & Benefits Template contains two worksheets in which issuers provide information about their plans: the Benefits Package worksheet and the Cost Share Variances worksheet. To reflect EHB benchmark plan coverage requirements, the Plans & Benefits Add-In file populates state-specific benchmark information in the Benefits Package worksheet.

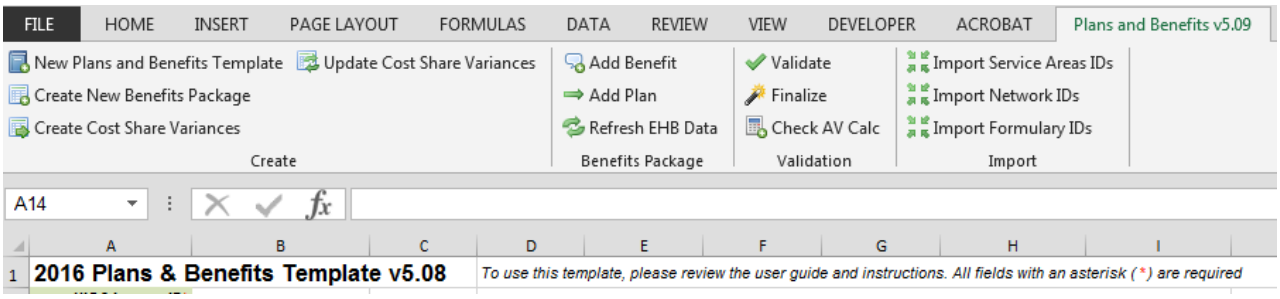
In the Benefits Package worksheet, issuers provide information on each set of plans and list covered benefits with any quantitative limits or exclusions. All plans defined within a benefits package share the same set of benefits and limits, but they may differ in cost sharing.

In the Cost Share Variances worksheet, issuers provide cost-sharing information for each submitted plan, including deductibles and MOOP, copay, and coinsurance values. Each Cost Share Variances worksheet correlates to a Benefits Package worksheet.

Before using this template, enable macros in Microsoft Excel. To do so, 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.

Complete the Plans & Benefits Template (Figure 15-4) using the instructions that follow to provide information on each dental plan you wish to submit. You need to submit a separate template for plans you intend to offer in an FFM for the individual market and those in a Federally-facilitated Small Business Health Options Program (FF-SHOP) for the small group market. The elements in these instructions are in the same order as in the template. Enter information using the drop-down menus when available.

Figure 15-4. Plans and Benefits Ribbon and Plans & Benefits Template



To ensure proper functionality, do the following:

- Download the latest versions of the Plans & Benefits Template and Add-In file from http://cciio.cms.gov/programs/exchanges/qhp.html.
- Delete any older versions of the Plans & Benefits Add-In file.
- Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template (for the macros to run properly).

- Complete the Network and Service Area Templates and save them on your computer before filling out the Plans & Benefits Template. This template requires issuers to assign a network and service area to each plan on the basis of the IDs already created in these templates. Dental-only issuers should see Chapter 8 for more information on the Network Template and Chapter 9 for more information on the Service Area Template.

The activated Dental macro prevents many fields in the Plans & Benefits Template from accepting data entry. The following instructions only address fields to be completed as part of an SADP submission.

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. This information must be entered in the first Benefits Package worksheet; it then auto-populates any additional Benefits Package worksheets generated by the issuer.

1. *HIOS Issuer ID* (required). Enter the five-digit 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.

4. *Dental Plan Only* (required). **Yes** must be selected for SADPs. When "Yes" is selected, the template grays out areas that do not apply to SADPs.

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

4.3 Plan Identifiers

Complete the following for each plan you want to create for this benefits package. 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 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 and a new row appears for the additional plan. 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.

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. This plan name is associated with the standard plan and all plan variations when displayed to the consumer.

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; 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.)

4.4 Plan Attributes

The Plan Attributes section includes fields for inputting more specific data for each plan, including its type 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. These plans should use new HIOS Plan IDs that were <u>not</u> used for the 2015 plan year.

   b. **Existing**—if this plan was offered last year and recertification guidance in the 2016 Letter to Issuers is followed. These plans should use <u>the same</u> HIOS Plan ID that was used for the 2015 plan year.

2. *Plan Type* (required). Select the plan type. Choose from the following:

   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 level of coverage of the plan on the basis of its actuarial value (AV). A de minimis variation of ±2 percentage points is used for SADPs.

This AV should be calculated on the basis of the portion of pediatric dental benefits that are EHBs:

a. **High**—AV of 85 percent

b. **Low**—AV of 70 percent.

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

   a. **On Exchange**—if the plan will be offered only inside of the Exchange. Issuers that offer a plan through the Exchange should select the "Both" option below.

   b. **Off Exchange**—if the plan will be offered only outside of the Exchange. Select "Off Exchange" if you are seeking Exchange certification but will only be offering coverage outside of the Exchange. If you select this option, you are indicating that your plan will not be sold on the Exchange.

   c. **Both**—if the plan will be offered both on and off the Exchange. Selecting this option creates two separate plan variations in the Cost Share Variances worksheet when the worksheet is created: one on-exchange plan and one off-exchange plan.

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

6. *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 of 45 *Code of Federal Regulations* (CFR) 156.200.

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

Choose from the following:

a. **Allows Adult and Child-Only**—if the plan allows child-only subscribers, adult-only subscribers, and mixed subscribers.

b. **Allows Adult-Only**—does not apply to SADPs because they must have the option of being offered to child-only subscribers; do not select this option unless the SADP is offered in the FF-SHOP or SP SHOP.

c. **Allows Child-Only**—if the plan only allows child subscribers. Do not select this option for SADP plans offered in the FF-SHOP and SP SHOP.

4.5 Stand-Alone Dental Only

The Stand-Alone Dental Only section contains fields that have additional input data that are only relevant for SADPs.

1. *EHB Apportionment for Pediatric Dental*. Enter the dollar amount of the portion of the expected monthly premium allocated for the pediatric dental EHB. The premium may not exceed the premium for a child-only plan. *EHB Apportionment for Pediatric Dental* should not be higher than the 0-20 age band or Family Option *Rates* entered in the Rates Table Template. The dollar amount should reflect (not necessarily equal) the statewide average amount for that plan. This number is used to determine the amount of the advance payment of the premium tax credit under 45 CFR 155.340(e)(2). This value must not exceed the lowest monthly premium for the plan in any rating area. Issuers must also submit the "Stand-Alone Dental Plans—Description of EHB Allocation" form as a supporting document (see Chapter 15b). This amount may not be changed after certification, even if the rate is estimated.

2. *Guaranteed vs. Estimated Rate*. This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the rate tables and the Business Rules Template. By indicating the rate is a "Guaranteed Rate," the issuer commits to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers' geographic location, age, and other permissible rating factors provided for in the Rates Table and Business Rules Templates. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported. Please note that on-Exchange FF-SHOP and SP SHOP SADPs may not estimate rates, and must have guaranteed rates in order to be offered on-Exchange.

   Select whether this plan offers guaranteed or estimated rates:

   a. **Guaranteed Rate**—if the plan offers a guaranteed rate.

   b. **Estimated Rate**—if the plan offers an estimated rate.

4.6 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 Rates Table Template, 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. (This must be December 31, 2016, for the individual market.) In the context of the FF-SHOP, the plan is for a 12-month plan

year. The plan expiration date is 12 months after the original employer coverage effective date.

4.7 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 outside the country.

    b. **No**—if the plan does not cover care obtained outside 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 covered under the plan.

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 not 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 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 not available.

4.8 URLs

2016 Template Update: The fields *Plan Brochure* and *URL for Summary of Benefits & Coverage* have been moved from the Benefits Package Worksheet to the Cost Share Variances worksheet, where it 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 www.REGTAP.info). URLs must start with "http://" or "https://" to work properly for the consumer.

4.9 Benefit Information

After entering the information above, 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 EHB benchmark. Scroll down the worksheet to the Benefit Information section (Figure 15-5). The following fields may auto-populate, depending on the state:

- *EHB*
- *State-Required Benefit*
- *Is this Benefit Covered?*
- *Quantitative Limit on Service*
- *Limit Quantity*
- *Limit Unit*
- *Benefit Explanation.*

Figure 15-5. Benefit Information Section

Benefit Information				
Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service
Routine Dental Services (Adult)				
Dental Check-Up for Children				
Basic Dental Care – Child				
Orthodontia – Child				
Major Dental Care – Child				
Basic Dental Care – Adult				
Orthodontia – Adult				
Major Dental Care – Adult				
Accidental Dental				

Dental-only and dual product issuers can only enter coverage information for the following benefits:

- Routine Dental Services (Adult)
- Dental Check-Up for Children
- Basic Dental Care—Child
- Orthodontia—Child

- Major Dental Care—Child
- Basic Dental Care—Adult
- Orthodontia—Adult
- Major Dental Care—Adult
- Accidental Dental.

If you need to enter information on a benefit not on this list, see the section on how to add a benefit, which follows shortly in this chapter.

The dental benefits entered should be detailed enough to give consumers the information needed to choose plans and allow CMS to ensure SADPs comply with all applicable rules and regulations.

Affordable Care Act (ACA) provisions related to preventive services and the SHOP Participation Provision Supporting Documentation and Justification in Chapter 17a do not apply to SADPs.

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 according to the state EHB benchmark. Issuers cannot edit this field.

2. *State-Required Benefit* (required). This field is auto-populated if a state in a particular market has a state-required benefit for at least one type of plan. To determine whether this benefit needs to be covered, issuers should refer to the list of state-required benefits (http://cciio.cms.gov/programs/exchanges/qhp.html) for their state. Issuers cannot edit this field.

   In certain cases, issuers may need to update the Benefits Package worksheet to reflect accurate EHB benchmark benefits. For example, the state-required benefit may apply only to individual market plans or HMOs (see Chapter 10).

3. To add a benefit not on 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, but you also lose any other data you have entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.

d. If the benefit added is not an EHB found in the state's benchmark, and it 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 an EHB found in the state's benchmark, and it 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 mandate enacted after December 2011, select "Above EHB" as the *EHB Variance Reason*.

   For more information on how to select the correct *EHB Variance Reason*, see Chapter 10, Section 5.6.

   i. A benefits package should not have duplicate benefit 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 Chapter 10 for details on handling multiple limits.)

4.10 Benefit 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 explanations.

1. *Is this Benefit Covered?* (required). This field is auto-populated for benefits identified in the template as covered for an EHB or a state-required benefit. If this data element is changed to "Not Covered" for an EHB, the issuer must substitute another benefit or combination of benefits 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 7, 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 (for example, 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.

For more information on how to select the appropriate *EHB Variance Reason* see Chapter 10, Section 5.6.

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. (For example, if you have a limit of two dental checkups for children 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. (For example, if the plans have a limit of two dental checkups for children per year, enter "Visits per year" here.) Annual limits are not permitted for pediatric dental benefits. 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. Dollars per year

u. Dollars 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.

If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB Benchmarks on the Center for Consumer Information and Insurance Oversight (CCIIO) website (http://www.cciio.cms.gov/resources/data/ehb.html). The message "Quantitative limit units apply, see EHB benchmark" appears in the *Benefit Explanation* field.

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.

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. *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.

6. *Benefit Explanation* (optional). Enter any benefit explanations.

   a. Examples of explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed description of service provided, and alternate cost-sharing structures, if they depend on provider type or place of service.

7. *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 ACA).

   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, 2015. 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).

   For more details and examples of using the *EHB Variance Reason*, see Chapter 10, Section 5.6. Enter the correct *EHB Variance Reason* because it has implications for cost-sharing requirements for EHBs. 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 if:

      i. 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. 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, 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 Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see Chapter 10c).

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 *EHB 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 *EHB Variance Reason*.

d. **Using Alternate Benchmark**

   i. Multi-state plans utilize 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 enacted after December 31, 2011, are <u>not</u> EHBs, and the issuer should use "Above EHB" as the variance reason for those 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 EHB benchmark but is not included in the auto-populated list by state.

g. **Dental Only Plan Available**—Not applicable for SADPs. Do not use.

4.11 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 dropdown values. Please see Chapter 11 for more information.

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 deductible or 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 the 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 in-network MOOP.

    b. **No**—if this benefit is <u>not</u> excluded from 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:

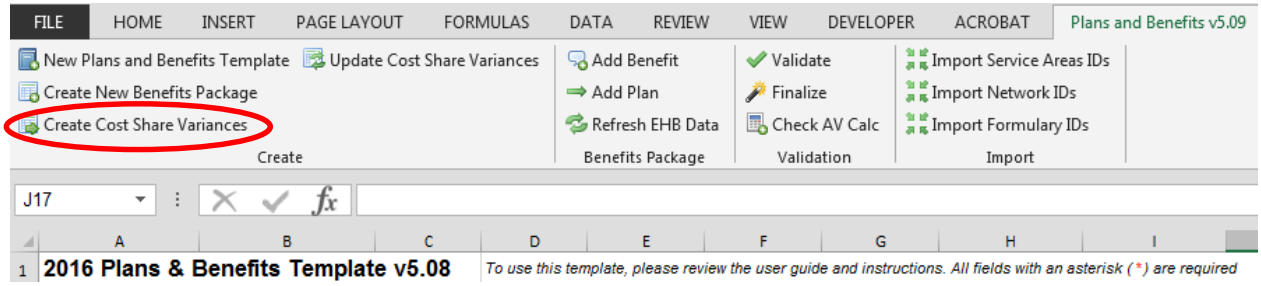
1. If the plans only have a combined (no separate in-network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP*.

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."

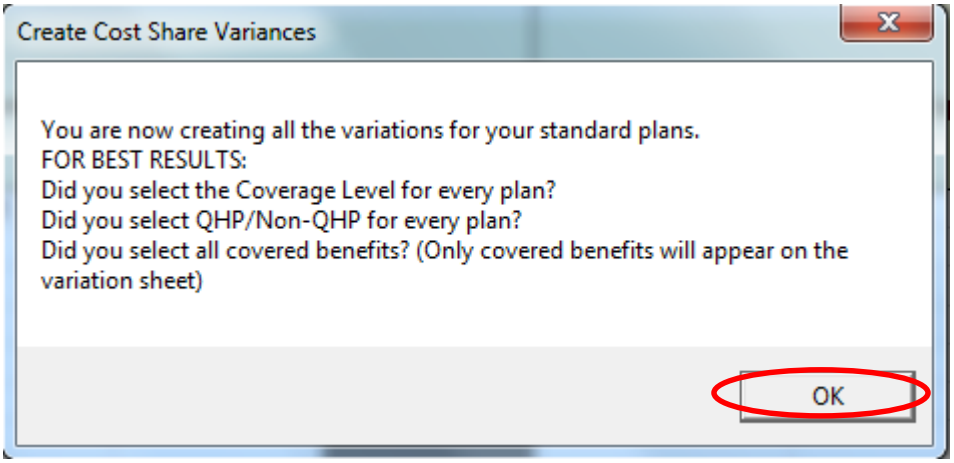
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon (Figure 15-6). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated plan variations.

Figure 15-6. Create Cost Share Variances Button



Click **OK** after reading the warning (Figure 15-7) and make any necessary changes.

Figure 15-7. Warning Pop-Up Box



The following questions pop up regarding deductible subgroups. 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.

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 15-8). Corresponding worksheets are labeled with the same number. For example, enter

information on Cost Share Variances 2 for benefits on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 15-8. Cost Share Variances Worksheet

		Plan Cost Sharing Attributes	
Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value
Sample Dental Plan	High	Standard High Off Exchange Plan	
	High	Standard High On Exchange Plan	

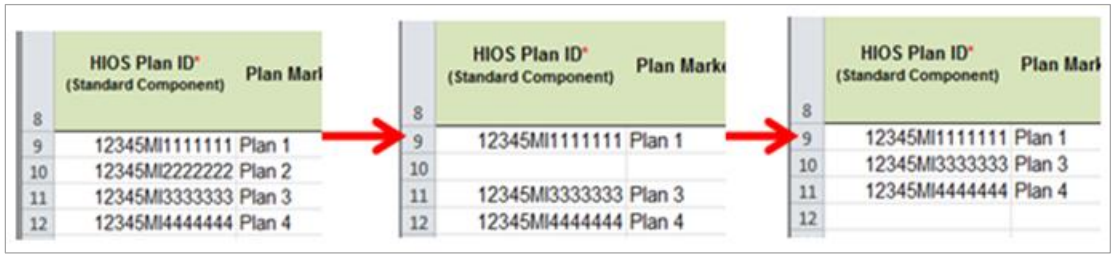
Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:

1. 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.

2. 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. This is an important step because if the **Update Cost Share Variances Plan** button is clicked when there is an empty row between plans, all the plans below this blank row and their corresponding data are deleted from the Cost Share Variances worksheet.

   Example: To delete Plan 2 (Figure 15-9), 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 15-9. Deleting a Plan



If you change 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 Plan Marketing Names will be updated, plans added to the Benefits Package worksheet will be added to the Cost Share Variances 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, you 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.

4.12 Cost-Sharing Reduction Information

The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans submitted by the issuer. However, cost-sharing reductions do not apply to SADPs.

1. *HIOS Plan ID [Standard Component + Variant]* (required). The HIOS-generated number that auto-populates for each SADP.

2. *Plan Marketing Name* (required). The name of the plan auto-populates for plans. This field may not be edited.

3. *Level of Coverage*. The coverage level for the plan auto-populates.

4. *Issuer Actuarial Value* (required). Enter the issuer-calculated AV.

    a. Issuers must submit the "Stand-Alone Dental Plan Actuarial Value" supporting documentation certifying that their actuarial value was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methods. (See Chapter 15a for a suggested format.)

5. *Multiple In Network Tiers?* (required). Indicate whether there are multiple in-network provider tiers, meaning that the plan applied 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 *In Network—Family* and *In Network—Individual* sections and Tier 2 information into the *In Network (Tier 2)—Family* and *In Network (Tier 2)—Individual* sections.

    b. **No**—if there are <u>not</u> multiple in network provider tiers. You should not enter information into *In Network (Tier 2)—Family* and *In Network (Tier 2)—Individual* sections.

6. *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 utilized in this tier. If the answer to *Multiple In Network Tiers?* is "No," the field auto-populates to "100%."

4.13 MOOP and Deductible Requirements and Guidance

Several requirements must be met for the MOOP and deductible values. Complete the MOOP and deductible sections of the template as follows:

1. When entering the MOOP and deductible values, ensure the following limits are met:

    a. The MOOP values must be equal to or below the required limits of $350 for one covered child (considered the "individual" limit) and $700 for two or more covered children (considered the "family" limit).

    b. The deductible value may not be higher than the MOOP value.

2. To include multiple children in child-only plans, use the "family" fields. (For SADPs, an individual is considered one child and a family is considered two or more children.)

3. 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, you must adhere to the following guidelines:

    a. If the plan does <u>not</u> 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. If the *Out of Network* field has no restrictions: it can be either a dollar value or "Not Applicable."

    b. 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."

c. To represent a plan with no in-network deductible, enter "$0" in the relevant *In Network* or *In Network Tier 2* fields (Dental EHB). Issuers must enter "0" rather than "Not Applicable": entering "Not Applicable" in the *In Network* deductible fields implies that in-network service costs accumulate toward the *Combined In/Out of Network* deductible. If the *In Network* and *Combined In/Out of Network* deductible fields are equal to "Not Applicable," the template returns an error when calculating the plan's AV.

4.14 Maximum Out of Pocket for Dental EHB Benefits

This template section is for inputting MOOP values for dental EHB benefits. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for EHB benefits in the following areas on the template:

1. *In Network—Individual*. Enter the dollar amount for In Network Individual Maximum Out of Pocket for EHB Benefits.

2. *In Network—Family*. Enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for EHB Benefits.

3. *In Network (Tier 2)—Individual*. Enter the dollar amount for In Network Individual Maximum Out of Pocket for EHB Benefits.

4. *In Network (Tier 2)—Family*. Enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for EHB Benefits.

5. *Out of Network—Individual*. Enter the dollar amount for Out of Network Individual Maximum Out of Pocket for EHB Benefits.

6. *Out of Network—Family*. Enter the per-person and per-group dollar amount for Out of Network Family Maximum Out of Pocket for EHB Benefits.

7. *Combined In/Out of Network—Individual*. Enter the dollar amount for Combined In/Out of Network Individual Maximum Out of Pocket for EHB Benefits.

8. *Combined In/Out of Network—Family*. Enter the per-person and per-group dollar amount for Combined In/Out of Network Family Maximum Out of Pocket for EHB Benefits.

4.15 Dental EHB Deductible

This template section is for inputting deductible values for dental EHB benefits. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* dental deductible data elements in the following areas on the template:

1. *In Network—Individual*. Enter the dollar amount for In Network Individual Dental EHB Deductible.

2. *In Network—Family*. Enter the per-person and per-group dollar amount for In Network Family Dental EHB Deductible.

3. *In Network—Default Coinsurance*. Enter the numerical value for the in network coinsurance.

4. *In Network (Tier 2)—Individual*. Enter the dollar amount for In Network Individual Dental EHB Deductible.

5. *In Network (Tier 2)—Family*. Enter the per-person and per-group dollar amount for In Network Family Dental EHB Deductible.

6. *In Network (Tier 2)—Default Coinsurance*. Enter the numerical value for the in-network coinsurance.

7. *Out of Network—Individual*. Enter the dollar amount for Out of Network Individual Dental EHB Deductible.

8. *Out of Network—Family*. Enter the per-person and per-group dollar amount for Out of Network Family Dental EHB Deductible.

9. *Combined In/Out of Network—Individual*. Enter the dollar amount for Combined In/Out of Network Individual Dental EHB Deductible.

10. *Combined In/Out of Network—Family*. Enter the per-person and per-group dollar amount for Combined In/Out of Network Family Dental EHB Deductible.

4.16 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*. Enter the dollar amount for In Network Individual Other Deductible.

2. *In Network—Family*. Enter the per person and per group dollar amount for In Network Family Other Deductible.

3. *In Network (Tier 2)—Individual*. Enter the dollar amount for In Network Individual Other Deductible.

4. *In Network (Tier 2)—Family*. Enter the per-person and per-group dollar amount for In Network Family Other Deductible.

5. *Out of Network—Individual*. Enter the dollar amount for Out of Network Individual Other Deductible.

6. *Out of Network—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.

7. *Combined In/Out of Network—Individual*. 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 Out of Network Family Other Deductible.

4.17 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 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—when active for open enrollment and special enrollment periods—link directly to up-to-date, accurate, and easily accessible information 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. CMS recommends that issuers provide URLs that link directly to plan-specific plan brochures.

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 plan brochure. Please take care to review the information you submit on this template to ensure that it is aligned with the plan's plan brochure prior to submission.

Complete the following:

1. *Plan Brochure*[#] (optional). Enter the URL that goes directly to the plan-specific website for the plan brochure. 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.

4.18 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 dropdown option of "Not Applicable" for all cost-sharing fields. This value should be used as follows:

1. 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. 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.

3. If you have plans that do not have out-of-network benefits for a given category, enter "Not Applicable" for the out-of-network copay fields and "100%" for the out-of-network coinsurance fields.

Figure 15-10 shows an example of how the fields for each benefit are laid out.

Figure 15-10. Benefit Information

Dental Check-Up for Children					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*

Fill in the following information for each covered benefit on the Benefits Package worksheet:

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 this option, 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 <u>not</u> subject to the deductible).

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

e. **$X Copay before deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible. After the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).

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

2. *Copay—In Network (Tier 2)^ #*. 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 this option, 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 <u>not</u> subject to the deductible).

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

   e. **$X Copay before deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible. After the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).

   f. **Not Applicable**—the consumer pays only a coinsurance or there are not multiple teirs 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 <u>not</u> subject to the deductible). Note that "Not Applicable," not this option, 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 responsible only 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. After the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible).

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

4. *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 this option, 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%**—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).

   d. **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).

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

5. *Coinsurance—In Network (Tier 2)*. 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 this option, 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%**—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).

d. **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).

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

6. *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 <u>not</u> subject to the deductible). Note that "Not Applicable," not this option, 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%**—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is <u>not</u> subject to the deductible).

   d. **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).

   e. **Not Applicable**—the consumer pays only a copay. If both copay and coinsurance are "Not Applicable," this indicates that this benefit is not subject to the deductible and

no cost sharing is charged to the consumer for any services received related to this covered benefit.

5. Finalizing Template

Once the entire template has been completed, including all Benefits Package and Cost Sharing Variances worksheets, follow these steps to finalize the template.

- Click the **Validate** button in the **Plans and Benefits** ribbon. (Figure 15-11). The validation process will identify any data issues that need to be resolved. If no errors are identified proceed directly to the 3rd bullet.

- If the template has any errors, a Validation Report will appear within a pop-up box (Figure 15-12) indicating the data element and cell location of each error. Correct any identified errors and click **Validate** again. Continue this process until all errors are resolved. Once the template is valid, proceed to the next bullet.

- Click the **Finalize** button in the template. The **Finalize** function creates the XML file of the template that you need to upload in the applicable QHP application system.

- **Save** the XML template. It is recommended you save the validated template to your computer as both a standard Excel.XLSM file, and the finalized.XML file on your local computer in the same folder that contains the template.

- Upload the saved file in the Benefits and Service Area Module of the QHP Application system.

Figure 15-11. Validate and Finalize Button

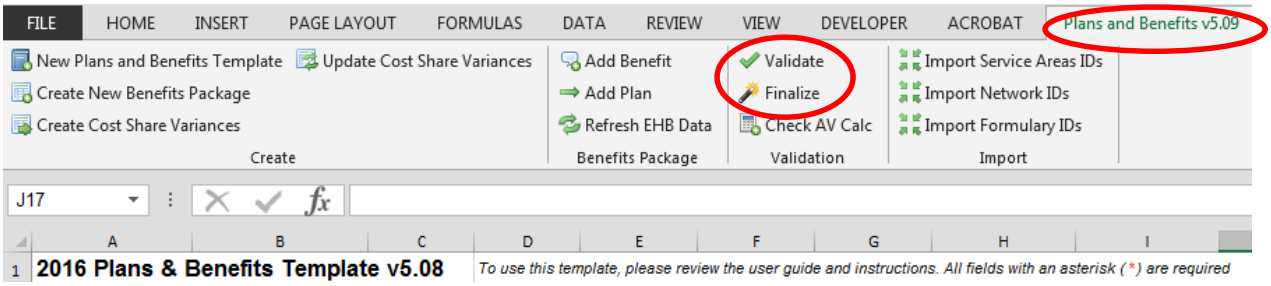
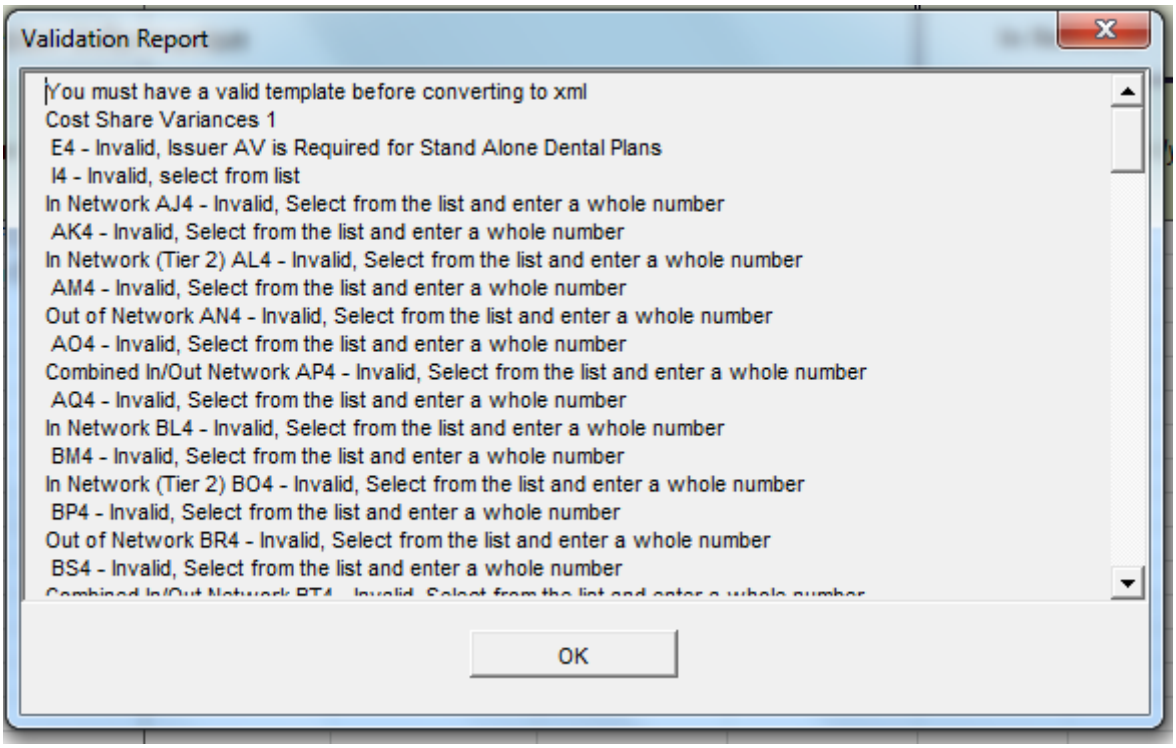


Figure 15-12. Error Report



Follow the HIOS instructions to upload your completed template and supporting documents into HIOS, if applicable.

Dental-only and dual product issuers must also submit a "Stand-Alone Dental Plan—Description of EHB Allocation." This supporting document must be submitted to the Marketplace annually. It must include a detailed description of the methods and specific bases used to perform the EHB apportionment for pediatric dental, in order to meet the requirement of 45 CFR 156.470(e). It must also include an attestation that the determination of the apportionment was performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methods. (See Chapter 15b for a suggested format.) The allocation should be monthly on only the pediatric EHB portion of a child-only plan.

6. Supporting Documentation and Justification

Supporting documentation and justification documents are located along with the QHP Application Instructions at http://cciio.cms.gov/programs/exchanges/qhp.html. Please refer to the list below for specific supporting documentation and justification for this specific chapter.

- EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification
- Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification
- Stand-Alone Dental Plan—Description of EHB Allocation

For additional information regarding supporting documents, please consult Chapter 16.