Chapter 15: Instructions for Stand-Alone Dental Plan Applications

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1. 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 stand-alone dental plan (SADP) on the Marketplace, qualified health plans (QHPs) in that Marketplace are not required to offer the pediatric dental EHB. 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.

2. Purpose

This chapter guides issuers through completing the QHP Application for an SADP.

3. Application Instructions

Dental-only issuers and dual product issuers should use the QHP Application system to complete the relevant application sections and templates. Figure 15-1 shows key items in these instructions for completing the application for an SADP.

Figure 15-1. 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 2015 in the banner.
- Dual product issuers should note the following:
  - Use the same Administrative, ECP, and Service Area Templates for your QHPs and SADPs. Only one of each of these templates is allowed per issuer.
  - Create separate Network IDs for your medical and dental plans.
  - Create separate Service Area IDs for your medical and dental plans.
- Dental only issuers and dual product issuers must respond to all program attestation groupings:
  - Respond **Yes** for the entire grouping if you want to attest **Yes** to each individual attestation in a grouping.
    - If you **do not** participate in the SHOP market, select **Yes** to attest that you offer no SHOP plans.

(continued on next page)

- Respond **No** for the entire grouping if you want to respond **No** to one or more of the individual attestations in a grouping. If you select **No** to any grouping, you must submit a Statement of Detailed Attestation Responses. You must provide a justification for a No response to any attestation listed in Chapter 2 with an asterisk (*) (see Chapter 2). All other attestations are required.
- Save the document using the following naming convention: [Issuer ID] [Title of Document], for example: "12345_Statement of Detailed Attestation Responses.doc."
- Upload the document by clicking the **Other** upload option in the Benefits & Service Area Module of the QHP Application system.

- Dental-only issuers are not required to be accredited. Dual product issuers are not required to have their SADP offerings accredited.
- 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 autopopulated.
- 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 maximum out-of-pocket (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 dental-only and dual product issuers completing an SADP application.

4. Issuer Module

4.1 Administrative Section

Dental-only and dual product issuers must provide information about the insurance company and any holding company associated with the issuer submitting an application, including contact information. Some data collected in the Administrative Template is also contained in HIOS. The data displayed on www.healthcare.gov for the individual market is pulled from the data contained in HIOS, and not the Administrative Template. Therefore, it is imperative that you ensure the information contained in HIOS is correct and the data fields are populated (see Chapter 1, Section 4.2 for specific fields displayed on www.healthcare.gov). However, you must still submit a completed Administrative Template with your application.

The *Issuer Marketing Name* displayed for the Federally-facilitated Small Business Health Options Programs (FF-SHOP) plan is pulled from the Administrative Template. Issuers who offer plans in the FF-SHOP will need to ensure that their *Issuer Marketing Name* is updated both in HIOS and on the Administrative Template. If the issuer has not provided an *Issuer Marketing Name*, the *Issuer Legal Name* will be displayed.

If you are dual product issuer, complete only one Administrative Template for your proposed QHPs and SADPs. Because only one Administrative Template may be submitted, dual product issuers must decide which contact information (medical or dental) to submit in Section 9 (individual market customer service line) or Section 10 (small group customer service line).

(The *Pharmacy Benefit Manager* and *Reinsurance Contact* data elements do not apply to SADPs; they are optional data elements in the Administrative Template.)

(See Chapter 1 for more information on completing this application section.)

4.2 Program Attestations Section

Dental-only and dual product issuers must attest to compliance with FFM standards as well as programmatic requirements necessary for FFM operational success. You attest to groups of attestation as identified by the attestation headings (such as General Issuer Attestations), not to each individual attestation in the electronic QHP Application. If you want to attest **Yes** to each individual attestation in a grouping, respond **Yes** for the entire grouping. If you want to respond **No** to one or more of the individual attestations in a grouping, respond **No** for the entire grouping. The Centers for Medicare & Medicaid Services (CMS) considers a **No** response to certain attestations acceptable and gives issuers the opportunity to submit a statement to support the **No** response.

If you respond **No** to one or more groupings of attestations, you must complete a single Statement of Detailed Attestation Responses document (available at http://cciio.cms.gov/programs/exchanges/qhp.html) to detail how you respond to each of the individual attestations in each grouping. No separate document covers SADPs. For any attestation with an asterisk (*) in Chapter 2 to which you respond **No**, CMS accepts a justification as to why you are not attesting.

Once the Statement of Detailed Attestation Responses document is complete, upload it into the **Other** file upload in the Benefits & Service Area module of the HIOS QHP Application system.

If you attest **Yes** to each attestation grouping, you do not need to submit the Statement of Detailed Attestation Responses document.

Respond to all attestation groupings in the electronic QHP Application, and if you submit a Statement of Detailed Attestation Responses, answer each question individually. Attestations are worded to apply to all issuers generally to accommodate SADPs, allowing you to attest **Yes** but not be held to the specific attestation if it is not feasible for you. The following is an example:

1. "Applicant attests that it will approve of the use of the following information for display on the FFE Web site for consumer education purposes: information on rates and premiums, information on benefits, the provider network URL(s) provided in this application, the URL(s) for the summary of benefits and coverage provided in this application, the URL(s) for payment provided by this application, information on whether the issuer is a Medicaid managed care organization, and quality information, as applicable, derived from the accreditation survey, including accreditation status and CAHPS data."

    a. Attest **Yes** to the attestation, which CMS interprets to mean that the dental-only issuer or dual product issuer approves information that has been collected for the FFM website (such as information on benefits); however, because SADPs are not subject to accreditation, the attestation itself does not require you to furnish accreditation information.

To verify the compliance plan and organizational chart attestation responses, upload your compliance plan and organizational chart, including the QHP Issuer Compliance Plan and Organizational Chart Cover Sheet Template. The cover sheet is available at http://cciio.cms.gov/programs/exchanges/qhp.html.

(See Chapter 2 for more information on completing this application section.)

4.3 State Licensure Section

Dental-only and dual product issuers must indicate their licensure status and provide documentation that shows they satisfy licensure requirements for the applicable QHP markets, service areas, and products. To verify the licensure information, upload a copy of your state license, certificate of authority (COA), certificate of compliance, or an equivalent form or document for each state in which you seek QHP certification. You may still apply for certification if you have not yet obtained a license or COA from the state department of insurance (DOI), but you must submit evidence of licensure during the application resubmission window.

A separate dental license may be uploaded for SADPs.

(See Chapter 3 for more information on completing this application section.)

4.4 Good Standing Section

Dental-only and dual product issuers must demonstrate compliance with all applicable state solvency and regulatory requirements. You must be licensed in order to satisfy the good standing standard. If you do not comply with the state solvency requirements or are under corrective

action related to financial review, you must provide supporting documentation and supply a justification.

Separate good standing documents may be uploaded for SADPs.

(See Chapter 4 for more information on completing this application section.)

4.5 Accreditation Section

Dental-only and dual product issuers are not required to be accredited for their SADPs. Dental-only issuers should select **No** to the question "*Are any of the health plans you are currently offering in the commercial and/or Medicaid market in this State accredited by NCQA and/or URAC?*," review the Accreditation Terms and Conditions, and check the attestation box to submit the Accreditation section and continue to the next section of the application. Dual product issuers are not required to complete this section for their SADPs.

(See Chapter 5 for more information on completing this application section.)

4.6 Network Adequacy Section

Dental-only and dual product issuers are required to maintain a network that is sufficient in number and types of providers to assure that all services will be accessible to enrollees without unreasonable delay.

Dental-only issuers should indicate **Yes** in the *Dental Only* field in the Issuer Information Section.

Dual product issuers should select **Both** in the *Dental Only* field. This option allows you to enter both QHP and dental provider data in the same template. If **Both** is not selected, you will need to provide separate templates for your QHP and dental provider data.

Dual product issuers should create separate Network IDs for their medical and dental networks using the Network Template (See Chapter 8 for more information.)

You must assign networks the same numbers as those assigned in the Network and Plans & Benefits Templates.

When entering dental networks only use the **Create Individual Tab** button to create tabs to enter dental network information. Use of the **Create Pharmacy & Facility Tab** button should be used only if dental facilities are included in the network.

Issuers must respond to Network Adequacy attestations in the Issuer Module of the QHP Application System in order to complete the Network Adequacy section of the QHP application.

(See Chapter 6 for more information on completing this application section.)

4.7 Essential Community Provider Section

Dental-only and dual product issuers are required to have a sufficient number and geographic distribution of essential community providers (ECPs), where available. See the Department of Health and Human Services (HHS) list of ECPs, generally Federally Qualified Health Centers (FQHCs), that provide dental services (http://cciio.cms.gov/programs/exchanges/qhp.html) to

identify the ECPs in your networks or write in other providers that meet the ECP definition, as defined in the 2015 Letter to Issuers in the Federally-facilitated Marketplaces.

If you do not meet the percentage thresholds for a dental-only network, you can submit a supplemental ECP response form into the **Other** file upload in the Benefits & Service Area Module of the QHP Application system. A blank supplemental response form is available at http://cciio.cms.gov/programs/exchanges/qhp.html.

Dental-only issuers must complete the ECP Template for their dental providers and respond to the ECP question/attestation in the QHP Application system (HIOS) The percentage thresholds apply at the network level for all networks in a given service area. As with other networks, if you do not meet the percentage threshold for a dental-only network, you can submit a supplemental ECP response form describing why you are unable to meet the threshold. A blank supplemental response form is available at http://cciio.cms.gov/programs/exchanges/qhp.html. The supplemental response form should indicate that the issuer is a dental-only issuer.

(See Chapter 7 for more information on completing this application section.)

4.8 Network Identification Section

Dual product issuers must create separate Network IDs for their QHP and dental networks.

Dual product issuers must use the word "dental" in the network name for their dental network to distinguish the QHP network from the dental network.

(See Chapter 8 for more information on completing this application section.)

5. Benefits & Service Area Module

5.1 Service Area

Dental-only and dual product issuers are required to identify proposed service areas by state and county in the Service Area Template. In almost all situations, HHS only approves service areas covering full counties. In the rare case in which the issuer asks to cover a service area containing a partial county, it must provide the included ZIP codes, a justification for why the entire county will not be served, and a detailed description that illustrates why the request is not discriminatory.

If you plan to serve a partial county, you must submit a detailed justification document with your application. In column G of the Service Area Template, enter the justification document file name. After creating your justification, upload the document as follows:

a. Name the justification file using the following naming convention: [Issuer ID]-Partial County-[Service Area ID]-[County Name] (for example: "12345-Partial CountyMDS001-Montgomery.doc").

b. Upload the justification document using the **Other** upload function in the Benefits and Service Area module of the QHP Application system.

Using a single Service Area Template, dual product issuers must create two different Service Area IDs for use with the two plan types regardless of whether the service area is intended to serve both QHPs and dental plans. Dual product issuers must use the word "dental" in the service area name for their dental service area to distinguish the QHP service area from the dental service area.

You may not change your service area after your initial submission except via petition to CMS. Changes must be approved by the state, and only under very limited circumstances (such as data errors in the initial submission).

(See Chapter 9 for more information on completing this application section.)

5.2 Plans & Benefits

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 maximum out-of-pocket (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.

5.2.1 Plans & Benefits Data Requirements

To complete this section, you need the following:

1. HIOS-generated five-digit Issuer ID
2. Tax Identification Number (TIN)
3. HIOS-generated Product ID for SADPs
4. HIOS-generated Plan ID

5. Plan marketing name

6. Child-Only Plan ID

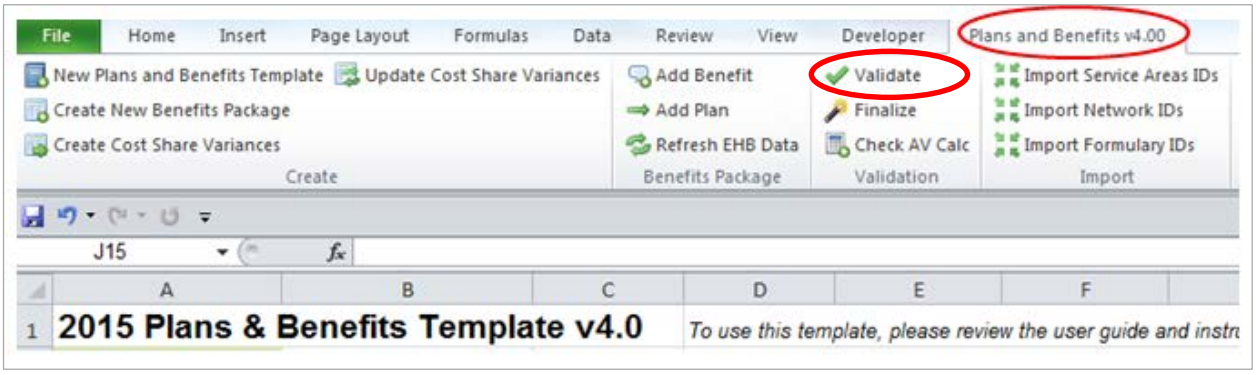
7. Plan type

8. Benefits packages and cost-sharing information.

5.2.2 Plans & Benefits Template Instructions

Complete the Plans & Benefits Template (Figure 15-2) 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 15-2. 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. Section 5.1 contains instructions for the Service Area section. For dental-only issuers, see Chapter 8 for more information on the Network 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.

5.2.2.1 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.

5.2.2.2 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.)

5.2.2.3 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 not offered last year. These plans should use new HIOS Plan IDs not used for the 2014 plan year.

   b. **Existing**—if this plan was offered last year and the recertification guidance in the 2015 Letter to Issuers is followed. These plans should use the same HIOS Plan ID used for the 2014 plan year.

   Some issuers may plan to modify a 2014 QHP with a larger service area to create several plans that cover smaller service areas. In this case, one of the plans submitted for 2015 QHP certification may use the same HIOS Plan ID used for the 2014 plan year (assuming any modification to that plan is consistent with the uniform modification of coverage standards). The other plans should use new HIOS Plan IDs not used for the 2014 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 <u>on</u> and <u>off</u> 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 does 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.

5.2.2.4 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. (Because this is a

proportion of the premium, the value may not exceed the premium for a child-only plan.) The dollar amount should reflect 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). Issuers must also submit the "Stand-Alone Dental Plans—Description of EHB Allocation" form as a supporting document (see Chapter 16). 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.

5.2.2.5 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 2015 plan year—even for existing plans offered on the Marketplace in 2014. Enter the effective date of the plan, using the mm/dd/yyyy format. This must be January 1, 2015, for 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, 2015, 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.

5.2.2.6 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.

5.2.2.7 URLs

This section contains fields for optional URLs for applicable websites. URLs must start with "http://" or "https://" to work properly for the consumer. Complete the following:

1. *URL for Summary of Benefits & Coverage* (optional). Enter the website location for the summary of benefits and coverage (SBC). While this is identified as optional, issuers are required to submit it by the deadline for final submission of QHP Application data (September 4, 2014).

2. *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).

3. *Plan Brochure* (optional). Enter the website location for the plan brochure. These documents should clearly communicate any cost-sharing information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage.

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 SBCs and plan brochures when possible.

5.2.2.8 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**. Scroll down the worksheet to the Benefit Information section (Figure 15-3). The following fields may autopopulate, depending on the state:

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

Figure 15-3. Benefit Information Section

Benefit Information					
Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
Primary Care Visit to Treat an Injury or Illness	Yes		Covered		
Specialist Visit	Yes		Covered		
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Yes	Covered		
Outpatient Surgery Physician/Surgical Services	Yes		Covered		
Hospice Services	Yes		Covered		
Non-Emergency Care When Traveling Outside the U.S.					
Routine Dental Services (Adult)					
Infertility Treatment					
Long-Term/Custodial Nursing Home Care					
Private-Duty Nursing					
Routine Eye Exam (Adult)	Yes		Covered	Yes	1

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

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 16 do not apply to SADPs.

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

The autopopulation of the *Benefit Information*, *General Information*, or *Deductible and Out of Pocket Exceptions* sections may not be accurate. See the Revised Benchmark Benefits Spreadsheet to determine the most up-to-date information for your state and how to incorporate these changes into the Plans & Benefits Template. This is document is available at http://cciio.cms.gov/programs/exchanges/qhp.html or http://www.serff.com/hix.htm. CMS will notify issuers when that document and instructions are available for use as they complete the Plans & Benefits Template.

1. *EHB* (required). This field is autopopulated 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 autopopulated 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, Sections 5.6 and 5.11).

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 Deductible and 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.

g. 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.)

5.3 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 explanations.

1. *Is this Benefit Covered?* (required). This field is autopopulated 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 autopopulated 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 autopopulated 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 autopopulated 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 autopopulate in the *Limit Unit* field but does autopopulate in the *Benefit Explanation* field.

If a benefit has quantitative limits that span several types of services, they do not autopopulate. 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 autopopulate. 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, 2014. Therefore, when designing plans that are substantially equal to the EHB-benchmark plan beginning January 1, 2014, 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 autopopulated 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 autopopulates 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 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 *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 not 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 autopopulated list by state.

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

5.4 Deductible and MOOP Exceptions

This section is for indicating whether each benefit is subject to the deductible or excluded from the MOOP. All plans in a benefits package must have the same deductible and MOOP structure.

- All plans in a benefits package must exclude the same benefits from the MOOP.
- All plans in a benefits package must subject the same benefits to the deductible.

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. *Subject to Deductible [Tier 1]* (required). Indicate whether the benefit is subject to a deductible in-network Tier 1. Choose from the following:

   a. **Yes**—if the enrollee is required to pay a deductible for this benefit.

   b. **No**—if the enrollee is not required to pay a deductible for this benefit.

2. *Subject to Deductible [Tier 2]* (required). Indicate whether the benefit is subject to a deductible in-network Tier 2. Choose from the following:

   a. **Yes**—if the enrollee is required to pay a deductible for this benefit.

   b. **No**—if the enrollee is not required to pay a deductible for this benefit.

3. *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 not excluded from in-network MOOP.

4. *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 not 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*.

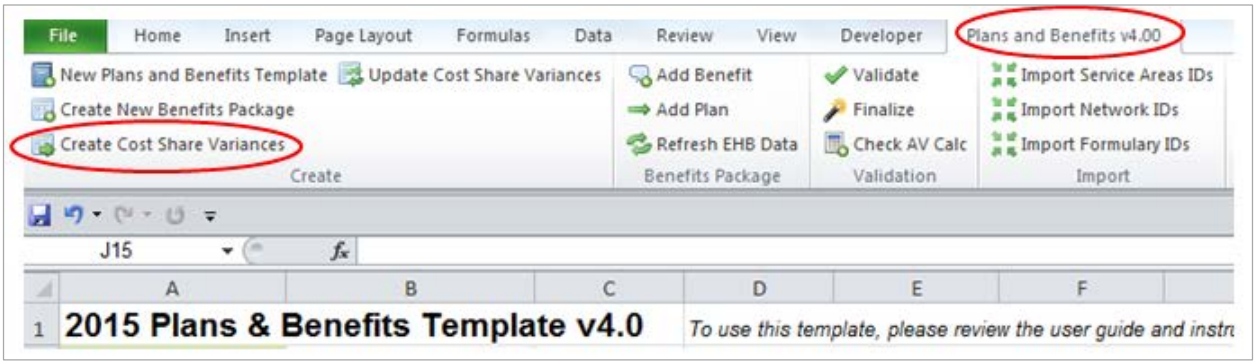
2. If the plans do not have multiple in-network tiers, set *Subject to Deductible [Tier 2]* equal to *Subject to Deductible [Tier 1]*.

3. If *Is this Benefit Covered?* for a benefit is "Not Covered" or blank leave *Subject to Deductible [Tier 1]*, *Subject to Deductible [Tier 2]*, *Excluded from In Network MOOP*, and *Excluded from Out of Network MOOP* blank.

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

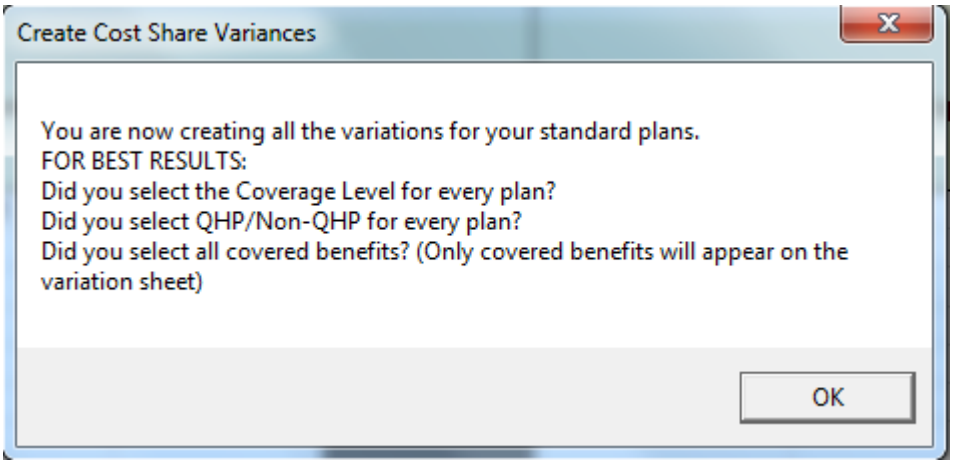
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon (Figure 15-4). The Cost Share Variances worksheet is designed to collect more detailed cost-sharing benefit design information for all plans in the corresponding benefits package and their associated plan variations.

Figure 15-4. Create Cost Share Variances Button



Click **OK** after reading the warning (Figure 15-5) and make any necessary changes.

Figure 15-5. 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 15-6). 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 autopopulated cells; verify that the information in each is accurate.

Figure 15-6. 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	

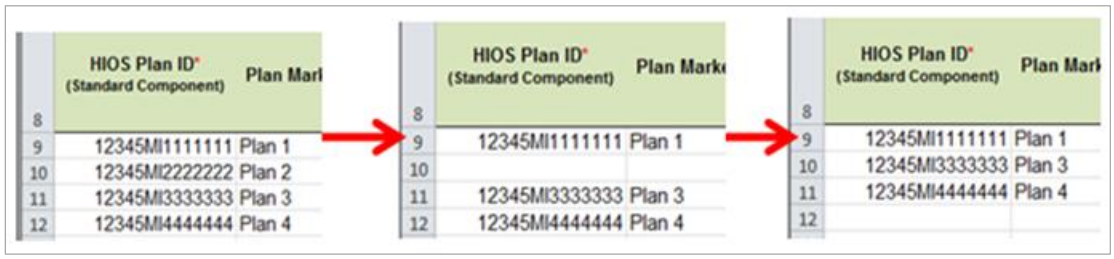
Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:

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 (Figure 15-7). 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 15-7), 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 15-7. 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.

5.5 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 autopopulates for each SADP.

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

3. *Level of Coverage*. The coverage level for the plan autopopulates.

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

    a. Issuers must submit 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 16 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 autopopulates to "100%."

5.6 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 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. 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.

5.7 MOOP 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 dollar amount for In Network Family Maximum Out of Pocket for EHB Benefits.

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

4. *Out of Network—Family*. Enter the dollar amount for Out of Network Family Maximum Out of Pocket for EHB Benefits.

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

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

5.8 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 Deductible.

2. *In Network—Family*. Enter the dollar amount for In Network Family Dental Deductible.

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

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

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

6. *Out of Network—Family*. Enter the dollar amount for Out of Network Family Dental Deductible.

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

8. *Combined In/Out of Network—Family*. Enter the dollar amount for Combined In/Out of Network Family Dental Deductible.

5.9 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 dollar amount for In Network Family Other Deductible.

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

4. *Out of Network—Family*. Enter the dollar amount for Out of Network Family Other Deductible.

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

6. *Combined In/Out of Network—Family*. Enter the dollar amount for Combined In/Out of Network Family Other Deductible.

6. Covered Benefits

This section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet. Fill in information for each of the benefits as follows:

1. If you have multiple in-network tiers, for any benefit category that does not have tiers, enter the same value for *Tier 2* as you enter for *Tier 1*.

2. If you have plans that do not have out-of-network benefits for a given category, enter "$0" or "No Charge" for the out-of-network copay fields and "100%" for the out-of-network coinsurance fields.

3. Figure 15-8 shows an example of how the fields for each benefit are laid out.

Figure 15-8. 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:

4. *Copay—In Network (Tier 1)*. If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter "No Charge." Choose from the following:

    a. **No Charge**—if no copayment is charged (*Subject to Deductible* for this benefit should be "No").

    b. **No Charge after deductible**—if the consumer first pays the deductible, and after the deductible is met, no copayment is charged (*Subject to Deductible* for this benefit should be "Yes").

    c. **$X Copay**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (*Subject to Deductible* for this benefit should be "No").

    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 (*Subject to Deductible* for this benefit should be "Yes").

    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 (*Subject to Deductible* for this benefit should be "Yes").

5. *Copay—Out of Network*. If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter **No Charge.** Choose from the following:

    a. **No Charge**—if no copayment is charged (*Subject to Deductible* for this benefit should be "No").

    b. **No Charge after deductible**—if the consumer first pays the deductible, and after the deductible is met, no copayment is charged (*Subject to Deductible* for this benefit should be "Yes").

    c. **$X Copay**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (*Subject to Deductible* for this benefit should be "No").

    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 (*Subject to Deductible* for this benefit should be "Yes").

    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 (*Subject to Deductible* for this benefit should be "Yes").

6. *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 "No Charge," 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%." (The coinsurance percentage reflects the consumer's portion of the payment, not the issuer's portion.) Choose from the following:

a. **No Charge**—if no coinsurance is charged (*Subject to Deductible* for this benefit should be "No").

b. **No Charge after deductible**—if the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (*Subject to Deductible* for this benefit should be "Yes").

c. **X% Coinsurance after deductible**—if the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (*Subject to Deductible* for this benefit should be "Yes").

d. **X%**—if the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (*Subject to Deductible* for this benefit should be "No").

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 "No Charge," 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%." (The coinsurance percentage reflects the consumer's portion of the payment, not the issuer's portion.) Choose from the following:

   a. **No Charge**—if no coinsurance is charged (*Subject to Deductible* for this benefit should be "No").

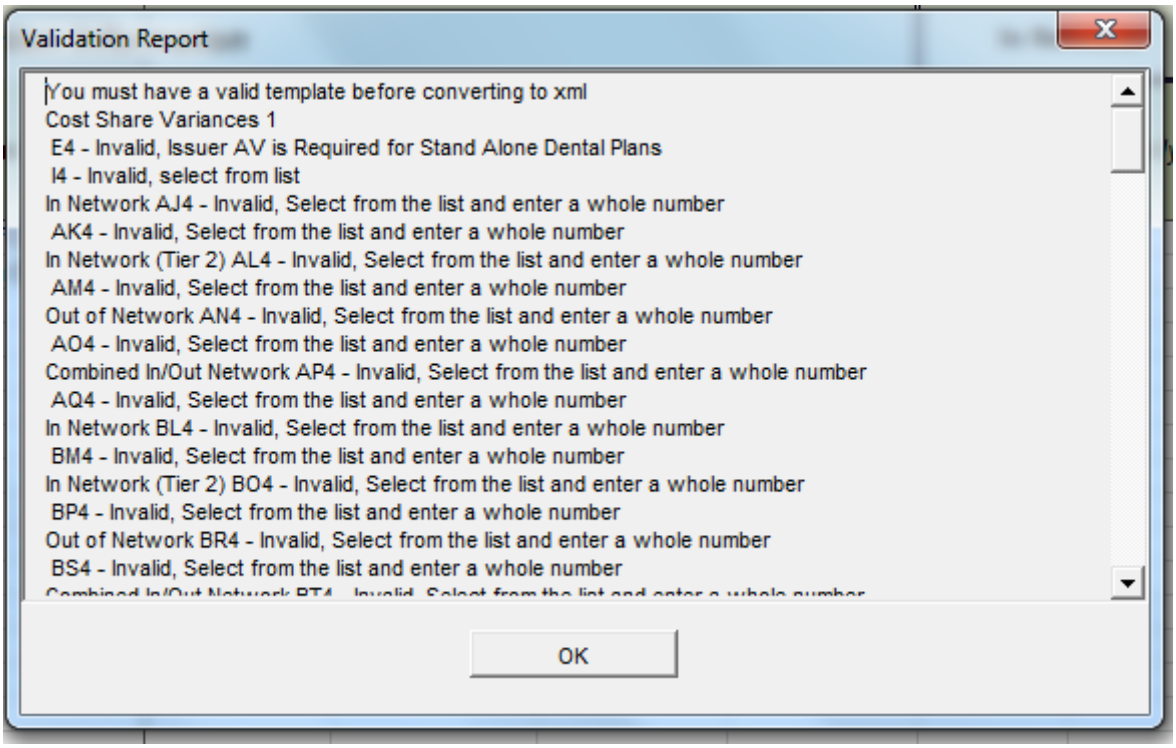
   b. **No Charge after deductible**—if the consumer first pays the deductible, and after the deductible is met, no is coinsurance charged (*Subject to Deductible* for this benefit should be "Yes").

   c. **X% Coinsurance after deductible**—if the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (*Subject to Deductible* for this benefit should be "Yes").

   d. **X%**—if the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (*Subject to Deductible* for this benefit should be "No").

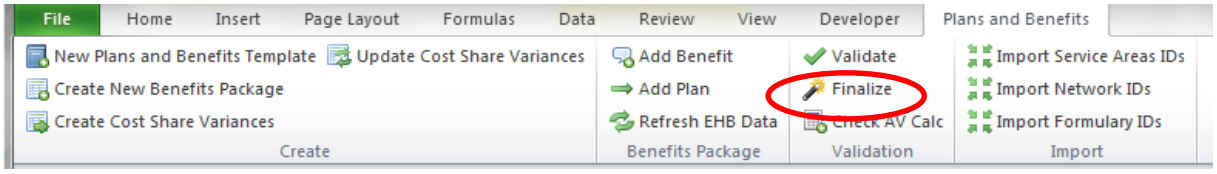
Once the entire template, including all Benefits Package and Cost Sharing Variances worksheets, has been completed, click the **Validate** button on the **Plans and Benefits** ribbon. Resolve any identified errors and click **Validate** again. Repeat until errors are resolved. Review the errors (Figure 15-9), and click **OK**.

Figure 15-9. Error Report



Click the **Finalize** button on the **Plans and Benefits** ribbon (Figure 15-10) after the **Validation** button returns no errors. This function creates an XML file. It is also recommended to save the template to your hard drive as an XLSM.

Figure 15-10. Finalize Button



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 16 for a suggested format.) The allocation should be monthly on only the pediatric EHB portion of a child-only plan.

7. Rate Review Template Instructions

Dental-only and dual product issuers of SADPs need not submit the Unified Rate Review template. (Dual product issuers must submit information on their medical plans to the Unified Rate Review template, but not their dental plans.)

8. Rating Module Instructions

8.1 Business Rules Section

Dental-only issuers and dual product issuers are required to enter business rules that are used to calculate rates and determine if a consumer is eligible for coverage under a plan. This template, in conjunction with the Rates Table Template, is used to calculate the premium for each enrollment group. Dual product issuers should use the same template for both their SADPs and QHPs. Rules associated with both individual and SHOP plans should be entered into one Business Rules Template. Please note that FF-SHOP and SP SHOP SADPs may not exceed 3 dependents in their rates. On-Exchange FF-SHOP and SP SHOP SADPs may not estimate rates, and must have guaranteed rates in order to be offered on-Exchange.

Issuers offering SADPs should note that the Business Rules Template imposes the following restrictions for all issuers regardless of whether they are entering business rules at the issuer, product or plan level, and regardless of whether the plan being offered is an SADP or QHP:

1. Issuers may rate up to a maximum of three underage (age 21) dependents in quoting the rate of a two-parent family. This field is not applicable to pediatric-only SADPs, for which any selection for this field will be valid for this type of plan and will not affect eligibility or rating.

2. Issuers may rate up to a maximum of three underage (age 21) dependents in quoting the rate of a single parent family. This field is not applicable to pediatric-only SADPs, for which any selection for this field will be valid for this type of plan and will not affect eligibility or rating.

3. If Issuers report a maximum age of a dependent, a value of 21 or higher must be entered. Please note that the age entered is inclusive <u>through</u> that age. For example, a value of 21 is through age 21, up to age 22.

SADPs that meet the definition of excepted benefits are not subject to the market rating rules for QHPs. SADPs may adjust for rating factors not present in this template, increase the maximum number of children rated on a single contract, or remove this maximum altogether. In the plan attributes section of the Plans & Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments. The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that in order to be offered on-Exchange, FF-SHOP and SP SHOP SADPs may not exceed 3 dependents in their rates, and all on-Exchange FF-SHOP and SP SHOP SADPs rates are guaranteed.

(See Chapter 13 for more information on completing this application section.)

8.2 Rates Table Section

Dental-only issuers and dual product issuers are required to complete the Rates Table Template which defines the premium rate that an issuer charges for each type of subscriber that a plan covers. Based on variables such as *Rate Effective Date*, *Expiration Date*, *Age*, *Rating Area ID* and *Tobacco*, Issuers enter the applicable rates for each type of subscriber type offered within these parameters. This template, in conjunction with the Business Rules Template, is used to calculate the premiums for each enrollment group. Dual product issuers should use the same template for both of their SADPs and QHPs.

Please note that all FF SHOP SADPs must follow all rules shown here. On-Exchange FF-SHOP and SP SHOP SADPs may not estimate rates, and must have guaranteed rates in order to be offered on-Exchange. SADP issuers offering plans in the FF-SHOP or SP SHOP must use individual age rating under the "Age" column (e.g., do not select "Family Option" to enter family tier rates) in order for their plans to display in on the Exchange.

Issuers offering SADPs should note that the Rates Table Template imposes the following restrictions for all issuers regardless of whether they are entering rate information for an SADP or QHP:

1. Plans whose rates vary on the basis of tobacco use may not have tobacco rates more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.

2. Plans that are rated on the basis of individual (age) rating may not enter a rate that is more than 3 times the rate of the age 21 rate.

3. Plans that are rated on the basis of individual rating must enter rate information for the 0-20 age band. The rates for 19 and 20 year olds must be incorporated into the 0-20 age band for purposes of submitting the Rates Table Template.

SADPs that meet the definition of excepted benefits are not subject to the market rating rules for QHPs. SADPs may adjust for rating age bands that are not present in this template. In the *Plan Attributes* section of the Plans & Benefits Template, issuers have the option to elect whether they are voluntarily complying with the rating rules in this template, or if the issuer reserves the right to make further premium adjustments. The plan display will then indicate to consumers whether the displayed SADP premium is a guaranteed rate or an estimated rate. Please note that in order to be offered on-Exchange, FF-SHOP and SP SHOP SADPs may not exceed 3 dependents in their rates, and all on-Exchange FF-SHOP and SP SHOP SADPs rates are guaranteed.

(See Chapter 14 for more information on completing this application section.)