Centers for Medicare & Medicaid Services
Federally Facilitated Marketplace

Contract HHSM-500-2014-00191C

FFM Plan Management Benefits and Service Area Module User Guide

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Approvals

Submitting Organization's Approving Authority:

Signature	Printed Name	Date Phone	Number

CMS's Approving Authority:

Signature	Printed Name	Date Phone	Number

Revision History

Version	Date	Organization/Point of Contact	Description of Changes
1.0	2/13/15	Accenture / Plan Management Team	Development for 2016 Plan Management Templates & System Functionality

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1 Introduction

This user guide provides the information necessary for Centers for Medicare and Medicaid Services (CMS) users and issuers to effectively use the features and processes in the Benefits & Service Area module of the Federally-Facilitated Marketplace (FFM). Only users with appropriate permissions, as governed by the user management rules, may access the Benefits & Service Area Module of the FFM.

2 Referenced Documents

The Center for Consumer Information and Insurance Oversight (CCIIO) has provided additional information detailing specific policy and submission criteria for each of the templates within the Benefits & Service Area Module. In addition, specific instructions are posted on the CMS zONE portal and the CCIIO webpage to aid issuers in completing the templates. To find referenced documentation, please use the following link:
http://cciio.cms.gov/programs/exchanges/qhp.html.

3 Overview

The Plan Management business area consists of business processes for acquiring plan-related data including Benefits, Service Areas, Provider Networks, and Prescription Drugs from issuers that offer plans within the Exchange. These areas are currently supported by a composite solution consisting of:

- User interfaces (UI) and services for issuers to submit, review, modify, and validate information uploaded or provided directly via the user interface to support the benefits collection process for the Federally-Facilitated Marketplace (FFM).
- Data submission templates (MS Excel-based) allowing issuers or their representatives to download, populate, validate, and upload data into the Plan Management system.

The Plan Management application design is supported by a scalable, n-Tiered environment running on the CMS cloud environment and leveraging a MarkLogic (XML) database. The user interface design is based on the CMS.gov web brand. It is Section 508 compliant.

3.1 Conventions

This document provides screenshots and corresponding narrative to describe how to use the Benefits & Service Area Module (Benefits Module).

Fields or buttons to be acted upon are indicated in ***bold italics***; links to be acted upon are indicated as links in underlined blue text.

Where fields are grayed out, they are considered read only, and the default values cannot be changed.

4 Getting Started

This section provides guidance on set-up and system access.

4.1 Set-Up Considerations

CMS screens are designed to be viewed at a minimum screen resolution of 1024 x 768, based on Health and Human Services (HHS) standards. To optimize your access to the Plan Management (PM) system:

1. Please ***disable pop-up blockers*** prior to attempting access to the Plan Management system.
2. Use the following browser for optimum usability:
   - Internet Explorer, Versions 9
   - Firefox, Version 28
   - Chrome, Version 33
3. Recommended Excel Versions include 2007 and 2010.

4.2 Accessing the System

All FFM users require an **Enterprise Portal ID** and **Health Insurance Oversight System (HIOS)** user role to access the system.

4.3 User Access Considerations

Users of the Benefits Module are assigned one or both of the following user roles:

- **Benefits Submitter**

  Users assigned the user access role of **Benefits Submitter** will submit the data and information necessary to complete the Benefits Module. They will also have the ability to cross validate *Final Submission* data elements to ensure consistency throughout the application.

- **Benefits Validator**

  Users assigned the user access role of **Benefits Validator** will be responsible for validating the correctness of the data and information necessary to complete the Benefits Module. They will have the ability to validate that Final Submission data elements are consistent throughout an application, and *Submit* the application after cross-validation has passed. Validators are also responsible for triggering the *resubmission* process, if necessary.

4.4 System Organization and Navigation

This section describes the Benefits Module organization and provides directions for navigating the system.

4.4.1 Benefits & Service Area Application

The Benefits & Service Area Module allows issuers to submit all necessary information using a web-based user interface and Microsoft Excel templates. The web-based application collects applicable supporting documents.

Excel templates collect information that is related to:

- Plans & Benefits
- Network ID
- Service Area
- Prescription Drug

NOTE: Excel template file names must be all lower-case and cannot contain spaces. For example, “service_area” is a valid template file name, but “Service_Area” or “service area” are not valid template file names.

The supplementary document types include:

- Form
- Statement of Variability
- Actuarial Certification
- EHB Variance Justification
- Other
  - Network Provider Data

Valid supporting documents must be in one of the following file formats:

- .doc
- .docx
- .jpg
- .ppt
- .pdf
- .rtf
- .jpeg
- .pptx
- .csv
- .txt

When a **Benefits Submitter** uploads the Plans & Benefits, Network ID, Service Area, and Prescription Drug templates, the system validates that the data and information in the templates is accurate. No system validation is run on the supplementary documents.

Once the Benefits Module has been submitted, it is available for validation. The Benefits Validator is responsible for validating the accuracy of the submitted data.

4.5 Exiting the System

To exit the system, click the **Logout** link located at the bottom right corner of the page header.

5 Using the System

The following sections provide instructions about using the various functions or features of the Benefits Module.

5.1 Benefits & Service Area Module

The Benefits Module pages are listed below:

Benefits Submitter Pages

- Benefits Submitter - Summary Page: This is the first page of the Benefits Module (see Figure 2). This page allows you to start a new submission, continue working on a pending submission, or view a completed submission.
- Benefits Submitter - Benefits & Service Area Page: Submitters can use this page (see Figure 3) to download the Plans and Benefits, Plans and Benefits Add-In File, Network ID, Service Area, and Prescription Drug templates. The templates contain macros that validate the completeness and accuracy of the data and information you entered. You can also upload the completed templates and supplementary documents to the system. This page provides you with information that the data was successfully uploaded.
- Benefits Submitter - Final Submission Page: This page (see Figure 14) allows the Submitter to cross-validate and initiate Final Submission.

Benefits Validator Pages

- Benefits Validator - Summary Page: This page (see Figure 8) is where Validators can start validation on a completed submission, resume validation on a completed submission, or edit an already validated submission.
- Benefits Validator - Benefits & Service Area Page: This page (see Figure 9) is where Validators can download the submitted templates and supplementary documents and validate that the information submitted in the templates and supplementary documents is correct. This page provides you with confirmation that the data and information was successfully validated. If the module is in the "**Cross Validated**" status, the page will provide an alert box with the option to re-open the application for resubmission (see Section 5.14).
- Benefits Validator Final Submission Page: This page (see Figure 14) is where Validators can cross validate Final Submission data elements within a submission and/or submit an application. Upon successful submission, the application will be flagged for evaluation to become a certified QHP.

5.2 Benefits Submitter - Summary Page

The Submitter Summary page, shown in Figure 1, is where you can start a new submission, continue working on an existing submission, or view a completed submission. You must be assigned the role of **Benefits Submitter** to access this page.

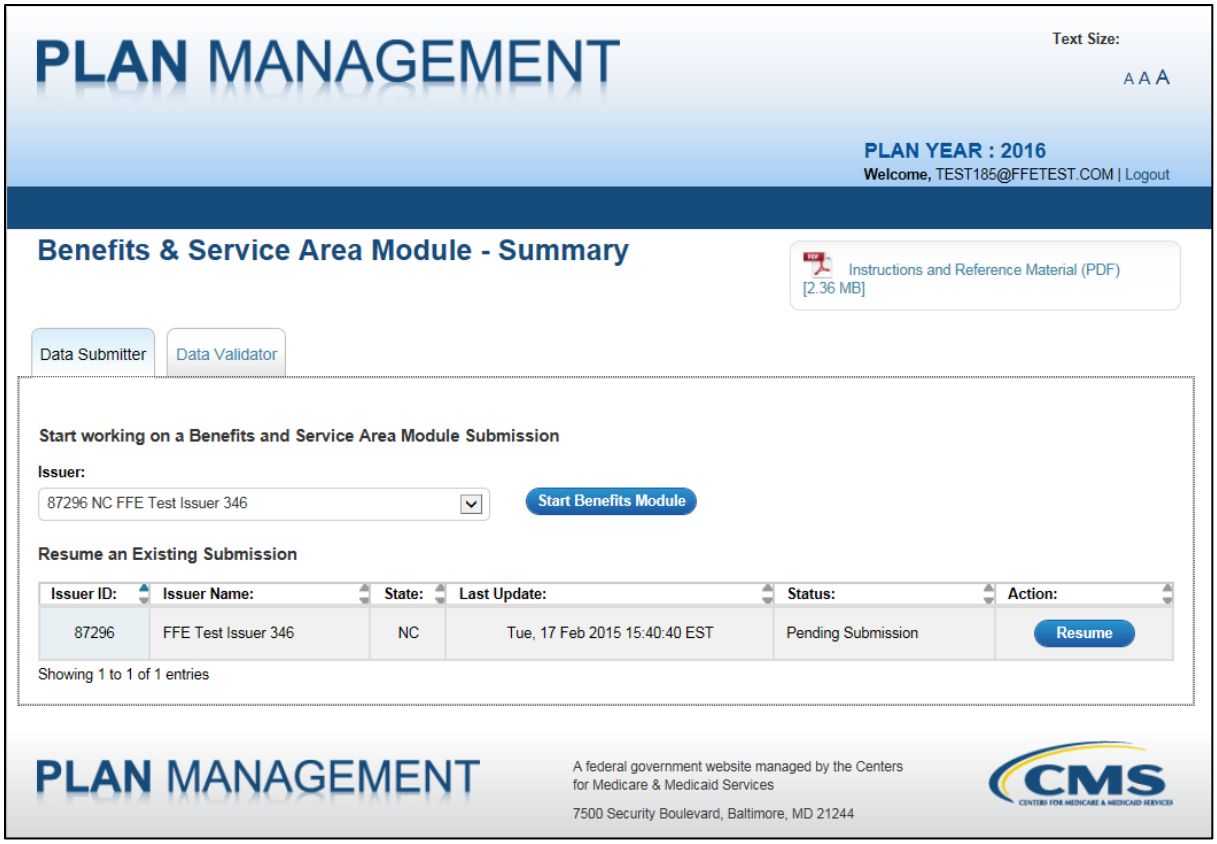


Figure 1: Benefits Submitter - Summary Page

To start a new application, select an issuer from the **Issuer** drop-down list and click the ***Start Benefits Module*** button. The Benefits Submitter - Benefits & Service Area page is displayed.

To resume an existing submission, click the ***Resume*** button that corresponds with an issuer in the Resume an Existing Submission table. You can also click ***View*** and proceed to the read-only access of the Benefits & Service Area page for completed submissions (see Figure 1).

NOTE: All columns are sortable by ascending or descending order, using the up and down carets.

Table 1 describes the fields in the Benefits Submitter Summary page and provides instructions about how to enter data in these fields.

Table 1: Benefits Submitter - Summary Page Fields

Name	User Action	Description
Issuer Drop-down	Select from drop-down list	Each drop-down entry contains the Issuer ID, Issuer Name, and State of Issuer. Drop-down is pre-populated with HIOS Issuer ID's associated with the user.

Name	User Action	Description
Start Benefits Module	Click button	Navigates to the Benefits & Service Area page for the selected Issuer. On click, submission will be added to the Resume Existing Submission table with a status of "Pending Submission".
Resume	Click button	Navigates to the Benefits & Service Area page for the selected, existing submission. ***Resume*** button should appear only when submissions have a status of "Pending Submission".
View	Click button	Navigates to Benefits & Service Area page for the selected submission with read-only access. ***View*** button should appear only when submissions have statuses of "Submission Completed", "Pending Validation", or "Validation Completed".
Resume Existing Submission Table		Statuses w/ appropriate actions: • Pending Submission - Resume • Submission Completed - View • Pending Validation - View • Validation Completed - View • Returned for Changes – Resume • Cross Validation Completed – View

5.3 Benefits Submitter - Benefits & Service Area Page

The Benefits Submitter - Benefits & Service Area page (see Figure 2) allows you to download templates, upload completed template .xml files, upload supplementary documentation, and view the validation statuses and/or error messages for your submission. The templates that are available on this page are Plans & Benefits, Network ID, Service Area, and Prescription Drugs. You must also download the Plans & Benefits template add-in file, which contains all the macros for the Plans & Benefits template. The AV Calculator (Excel,1.42MB) is an additional required file, found on the CCIIO website, which is used to calculate and import an Actuarial Value for each medical plan in the Plans & Benefits template.

NOTE: It is recommended that you save the Plans & Benefits Add-in file in the same folder as the Plans & Benefits template. To ensure proper functionality, please download the latest Plans & Benefits Add-In file and AV Calculator and save to a new folder. Do **not** rename the add-in file. See Appendix B for enabling the Add-In file and Appendix C for guidance on working with dual template versions.

The *Upload Documentation table* is where you will upload the completed template-generated .xml files and supplementary documents. The documents required for submission are marked with a red asterisk (*). You may upload multiple instances of the same supplementary documentation. If uploading a second version of a **template .xml file**, the newest upload will replace the previously uploaded version; however, new versions of **supporting documentation** will not replace old versions.

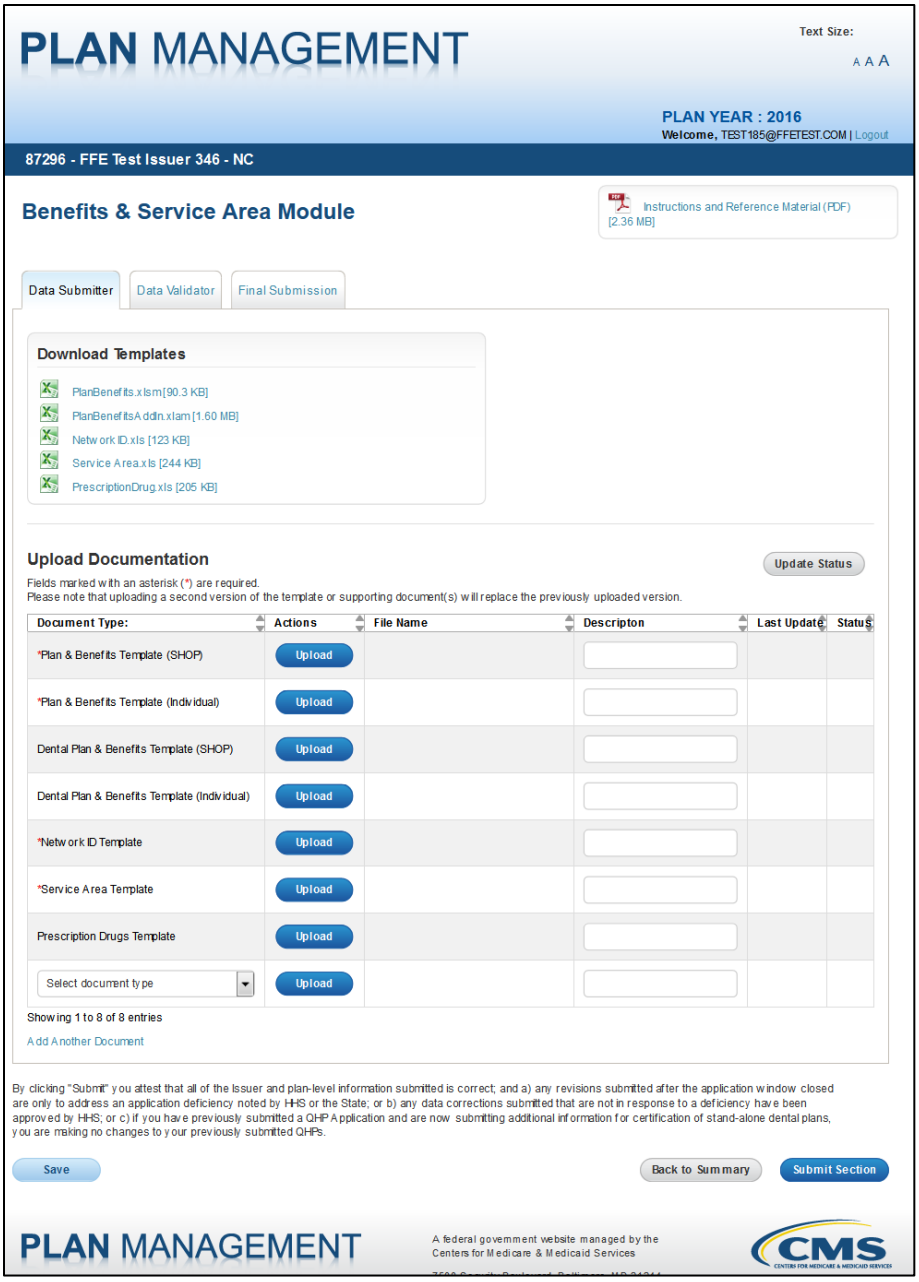


Figure 2: Benefits Submitter - Benefits & Service Area Page

Table 2 describes the fields in the Benefits Submitter Benefits & Service Area page and provides instructions about how to enter data in these fields.

Table 2: Submitter Benefits & Service Area Page Fields

Name	User Action	Description
Instructions	Click link	Benefits Module instructions file for download.
PlanBenefits template	Click link	Plans & Benefits template for download.

Name	User Action	Description
PlanBenefits template Add-In	Click link	Plans & Benefits template add-in file for download.
Network ID template	Click link	Network ID template for download.
Service Area template	Click link	Service Area template for download.
Prescription Drug template	Click link	Prescription Drug template for download.
Actuarial Certification	Upload (optional)	A signed and dated certification that the calculation was performed by a qualified actuary and complies with all applicable federal and state laws and all applicable Actuarial Standards of Practice. An Actuarial Certification should be submitted for each unique plan design.
Form	Upload (optional)	Document used to create the policy, contract or certificate of coverage for a plan.
Statement of Variability	Upload (optional)	Document describing each value for the variable item (identified by brackets in the Form) for the plan.
EHB Variance Justification	Upload (optional)	Additional supporting documentation.
Other	Upload (optional)	Any other supporting document that is not listed.
Update Status	Click button	Triggers a refresh of the page, listing updated (if applicable) template validation statuses for the uploaded templates.
Upload Documentation table		Table lists the following Document Type values: • Plan & Benefits template (SHOP) • Plan & Benefits template (Individual) • Dental Plan & Benefits template (SHOP) • Dental Plan & Benefits template (Individual) • Network ID template • Service Area template • Prescription Drugs template • Select a document type [drop-down] o Actuarial Certification o EHB Variance Justification o Form o Statement of Variability o Other Supplementary documents cannot be replaced or deleted in the table. To upload revisions, click Add Another Document.
Upload	Click button	A file upload popup will appear.

Name	User Action	Description
Description	Enter a description	Please put information in description fields describing the type of supporting document and the HIOS Product and Plan IDs associated with it Description fields are locked for a row until you upload a file into that row.
Add Another Document	Click link	Populates a new/blank row to the bottom of the Upload Documentation table. You can add additional blank rows as necessary to upload all of your supplementary documents.

5.4 Benefits Submitter - Document Submission

Once you download and complete the templates, upload the supplementary documents and .xml files created by the templates by clicking on the corresponding ***Upload*** button in the Upload Documentation table. The system will prompt you with a file dialog box to browse your local computer to select your file.

NOTE: You must submit a separate Plans & Benefits template for each market and plan type:

- Health Small Group Health Options (SHOP)
- Health Individual
- Dental Small Group Health Options (SHOP)
- Dental Individual

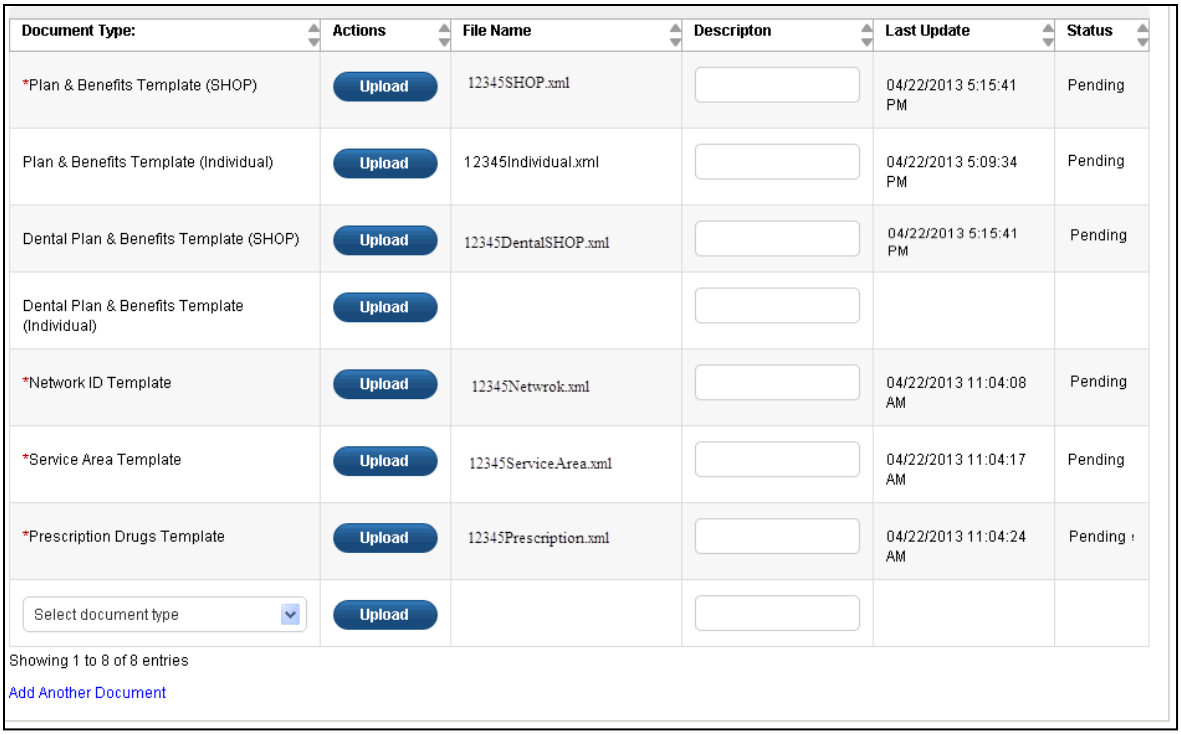
Each template should include all your plans that fall within that category. Only one Plans & Benefits template is required to be in completed status to be eligible for submission, but you have the ability to submit all four.

Templates will default to a status of "**Pending**" upon upload, and will remain in a Pending status until system validation has been completed. To check the status of system validation, click the ***Update Status*** button (pictured in Figure 2) or refresh the page. (Note the changes in status from *Pending* to *Complete* between Figure 3 and Figure 4.) Closing the window will not interrupt the system validation process.

Once the system validates a template, the template' status will change to either "**Complete**" or "**Failed**." A template is "**Complete"** if it passes all system validations and "**Failed**" if there are errors identified during the system validation process. The "**Failed**" status indicator will appear as a link that, when clicked, provides an error report for download. You must download the report, fix all errors listed in the report, and re-upload the corrected template .xml. You cannot submit the module successfully if any of the template statuses are "**Failed**" or "**Pending**." Because system validation is not run on supplementary documents, they will default to a status of "**Complete**" upon upload.

Once all required documents have a "**Complete**" status, you can complete the Benefits & Service Area section of your QHP application by clicking ***Submit***.

Figure 3 shows the Upload Documentation table after documents have been uploaded.



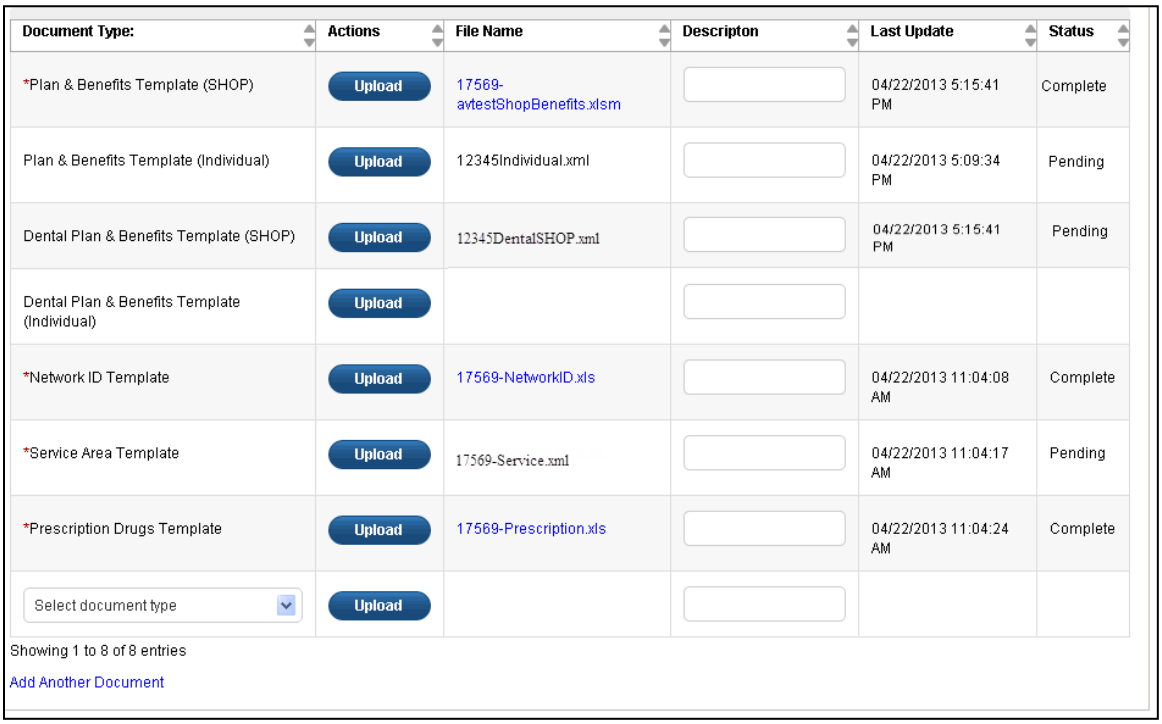
Document Type:	Actions	File Name	Descripton	Last Update	Status
*Plan & Benefits Template (SHOP)	Upload	12345SHOP.xml		04/22/2013 5:15:41 PM	Pending
Plan & Benefits Template (Individual)	Upload	12345Individual.xml		04/22/2013 5:09:34 PM	Pending
Dental Plan & Benefits Template (SHOP)	Upload	12345DentalSHOP.xml		04/22/2013 5:15:41 PM	Pending
Dental Plan & Benefits Template (Individual)	Upload				
*Network ID Template	Upload	12345Netwrok.xml		04/22/2013 11:04:08 AM	Pending
*Service Area Template	Upload	12345ServiceArea.xml		04/22/2013 11:04:17 AM	Pending
*Prescription Drugs Template	Upload	12345Prescription.xml		04/22/2013 11:04:24 AM	Pending
Select document type	Upload				

Showing 1 to 8 of 8 entries

Add Another Document

Figure 3: Upload Documentation Table - Documents Uploaded

Figure 4 shows the *Upload Documentation* table after documents have been uploaded and statuses are refreshed. Notice how some of the files have changed from **Pending** to **Complete.**



Document Type:	Actions	File Name	Descripton	Last Update	Status
*Plan & Benefits Template (SHOP)	Upload	17569-avtestShopBenefits.xlsm		04/22/2013 5:15:41 PM	Complete
Plan & Benefits Template (Individual)	Upload	12345Individual.xml		04/22/2013 5:09:34 PM	Pending
Dental Plan & Benefits Template (SHOP)	Upload	12345DentalSHOP.xml		04/22/2013 5:15:41 PM	Pending
Dental Plan & Benefits Template (Individual)	Upload				
*Network ID Template	Upload	17569-NetworkID.xls		04/22/2013 11:04:08 AM	Complete
*Service Area Template	Upload	17569-Service.xml		04/22/2013 11:04:17 AM	Pending
*Prescription Drugs Template	Upload	17569-Prescription.xls		04/22/2013 11:04:24 AM	Complete
Select document type	Upload				

Showing 1 to 8 of 8 entries

Add Another Document

Figure 4: Upload Documentation Table - Statuses Refreshed

5.5 Benefits Submitter - Benefits & Service Area page - Submission Failed

If you submit the Benefits & Service Area page without uploading any or all required documents, the system will return an error message listing the specific documents to upload.

Figure 5 shows the Benefits Submitter Benefits & Service Area page after a Failed Submission.

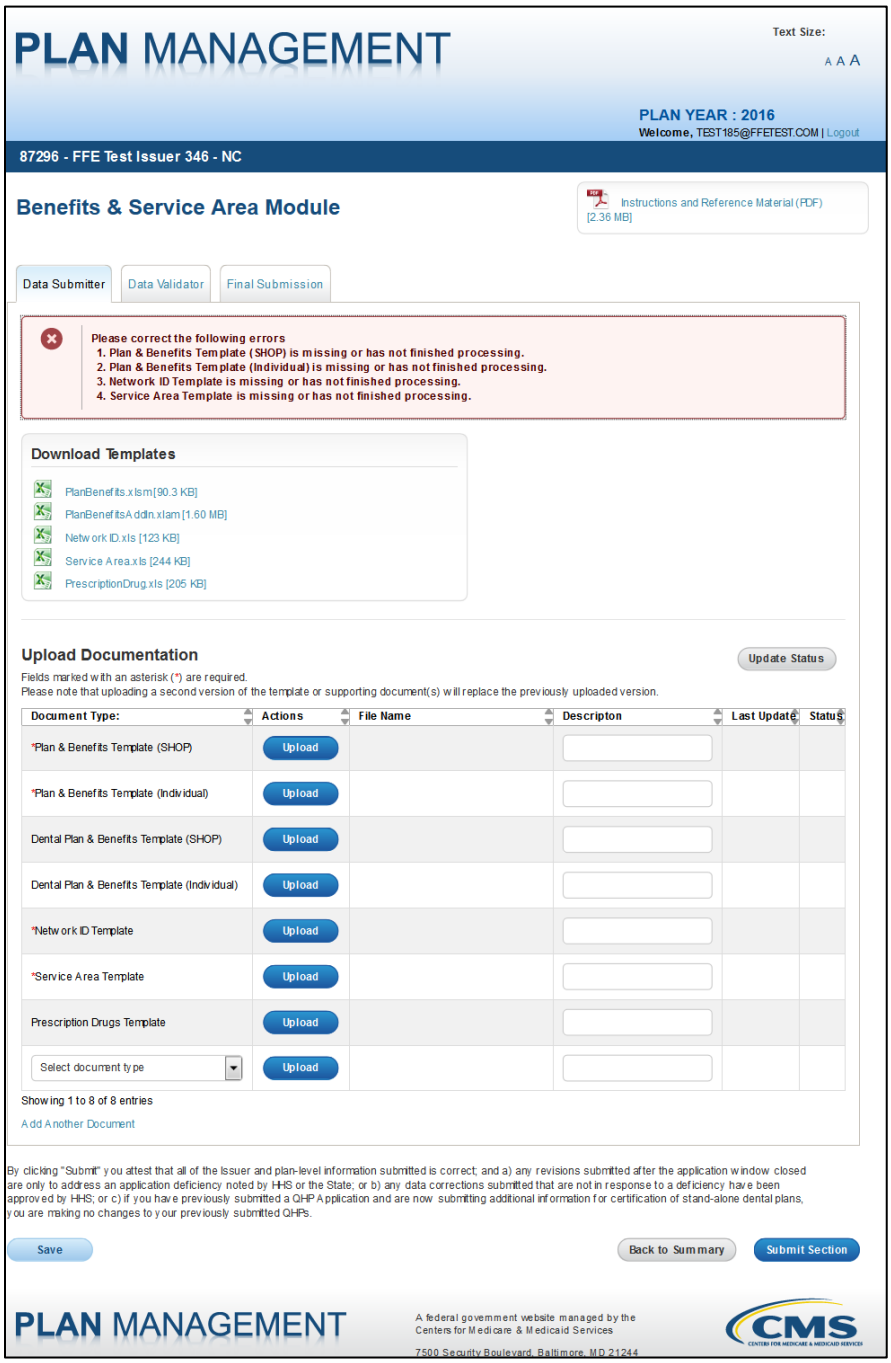


Figure 5: Benefits Submitter - Benefits & Service Area Page - Submission Failed

5.6 Benefits Submitter - Benefits & Service Area Page - Submission Successful

Once you submit all required documents with no validation errors, a successful submission message will appear on screen.

NOTE: The uploaded data will become read-only after successful submission and cannot be changed. Please make sure that you are uploading the correct .xml.

Figure 6 shows the Benefits Submitter Benefits & Service Area page after a successful submission.

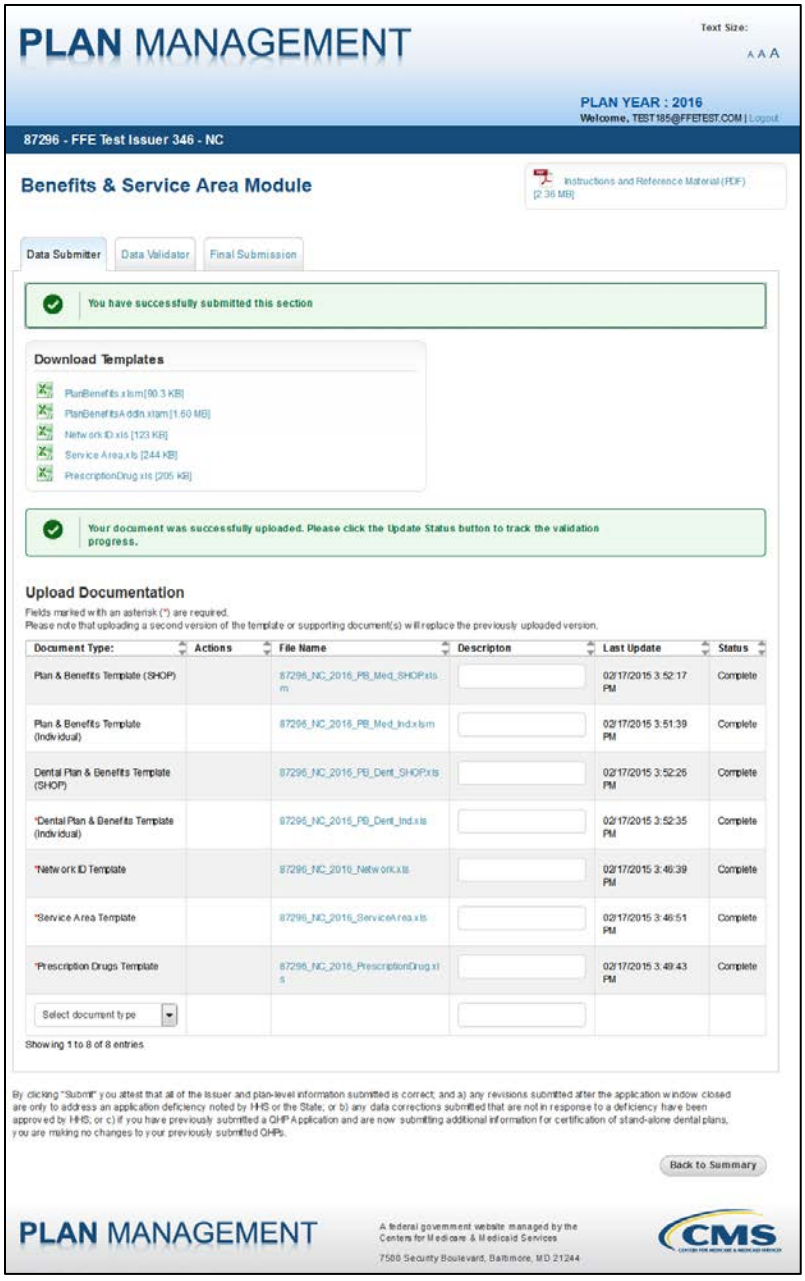


Figure 6: Benefits Submitter - Benefits & Service Area Page - Submission Successful

5.7 Benefits Validator - Summary Page

The Benefits Validator Summary page displays a list of all completed submissions and their statuses. You can start or resume validation for a completed submission or edit the validation for a submission that was already validated. You must be assigned the role of Benefits Validator to access this page.

Figure 7 shows the Benefits Validator Summary page.

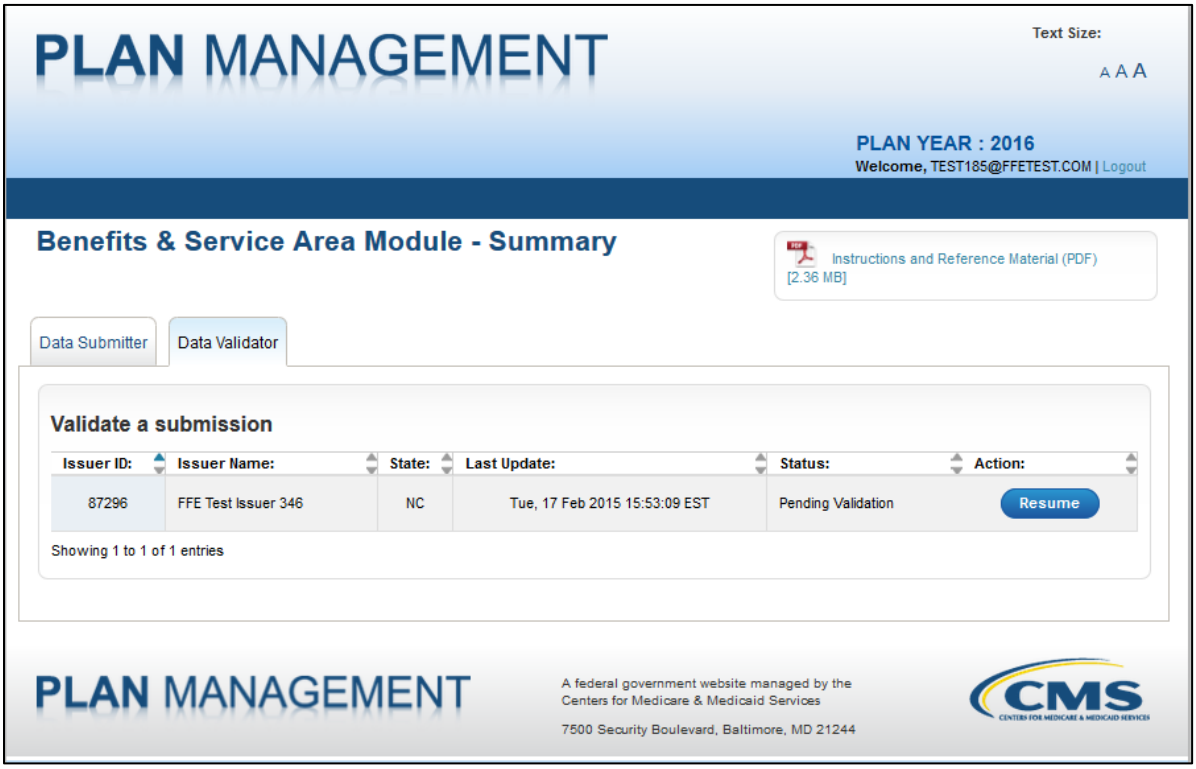


Figure 7: Benefits Validator - Summary Page

Table 3 describes the fields on the Benefits Validator Summary page and provides instructions about how to enter data in these fields.

Table 3: Benefits Validator - Summary Page Fields

Name	User Action	Description
Validate a Submission Table	N/A	Possible Statuses with appropriate action: *Submission Completed - ***Start Validation*** *Pending Validation - ***Resume*** *Validation Completed – ***Edit*** *Cross Validation Completed – ***Edit***
Start Validation	Click button	Navigates you to the Validator Benefits & Service Area page. The ***Start Validation*** button should appear only when a submission has a status of “Submission Completed” or “Pending Validation”.

Name	User Action	Description
Edit	Click button	Navigates you to the Validator Benefits & Service Area page. The ***Edit*** button should appear only when a submission has a status of "Validation Completed".

5.8 Benefits Validator - Benefits & Service Area Page

The Benefits Validator Benefits & Service Area page is where Validators review and validate the data and information provided by the Benefits Submitter. You may download the submitted templates and supplementary documents by clicking the hyperlink in the "File Name" column of the Uploaded Documents table (See Figure 8). Perform a review to ensure all of the provided data and information is valid. Then you must make your determination by selecting the "**Yes**" or "**No**" radio buttons in response to the question, "Do you validate that the information submitted for this section is correct?", and click Submit. If you click Submit without answering the question, the system will return an error message (refer to Figure 9).

Figure 8 shows the Benefits Validator Benefits & Service Area page.

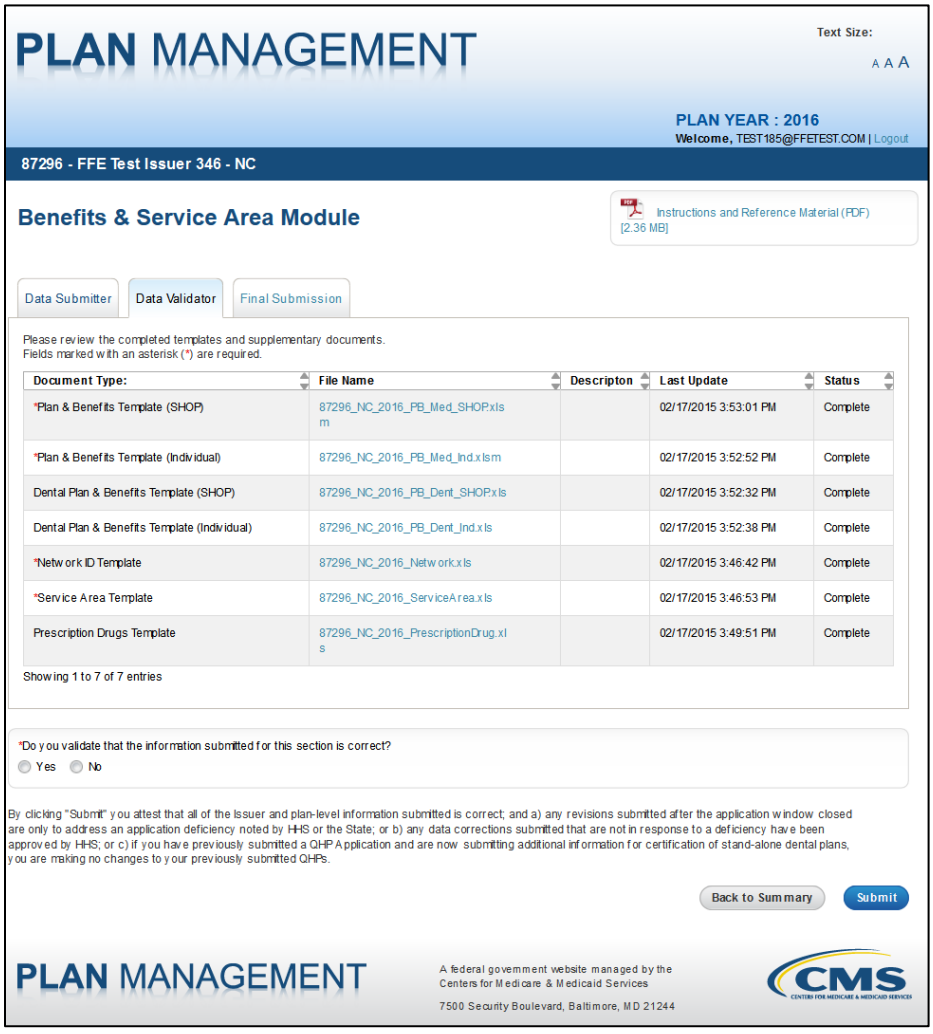


Figure 8: Validator Benefits & Service Area Page

Table 4 describes the fields on the Validator Benefits & Service Area page and provides instructions about how to enter data in these fields.

Table 4: Validator Benefits & Service Area Page Fields

Name	User Action	Description
Yes	Click button	Select Yes to confirm all submitted information is correct.
No	Click button	Select No to confirm the information submitted is not correct. The submission status will change to “Returned for Changes” and the Issuer Submitter will be allowed to resubmit.
Back to Summary	Click button	Navigates you back to the Summary page. If you have not saved your changes, the following popup should appear: “There are unsaved changes. If you continue your changes will be lost. Would you like to continue?”
Submit	Click button	The page refreshes and you will receive a confirmation message. If you do not select “Yes” or “No” and click ***Submit***, the system will return an on-screen error stating the question requires an answer. If Yes, upon clicking Submit, the submission status will change to “Validation Completed.” If No, upon clicking Submit, the submission status will change to “Returned For Changes”.

5.9 Benefits Validator Benefits & Service Area Page - Validation Failed

You must answer the question, "Do you validate that the information submitted for this section is correct?" If you submit the page without answering the "**Yes**" or "**No**" question, the system will return an error message (See Figure 9).

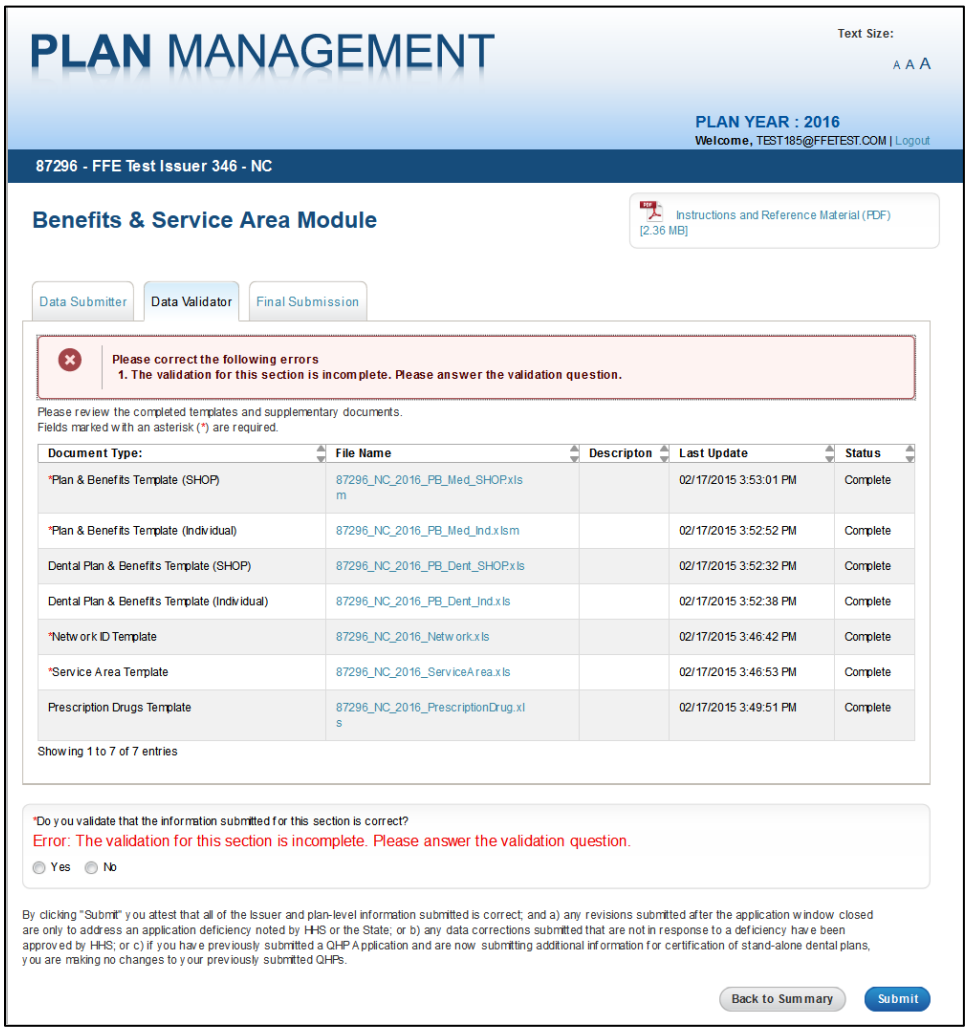


Figure 9: Validator Benefits & Service Area Page - Validation Failed

5.10 Benefits Validator Benefits & Service Area Page - Validation Question = Yes

You must answer the question, "Do you validate that the information submitted for this section is correct?" If you answer "**Yes**" and click Submit, the system will return a confirmation message that you have successfully validated this section (see Figure 10). The submission status will change to "**Validation Completed**".

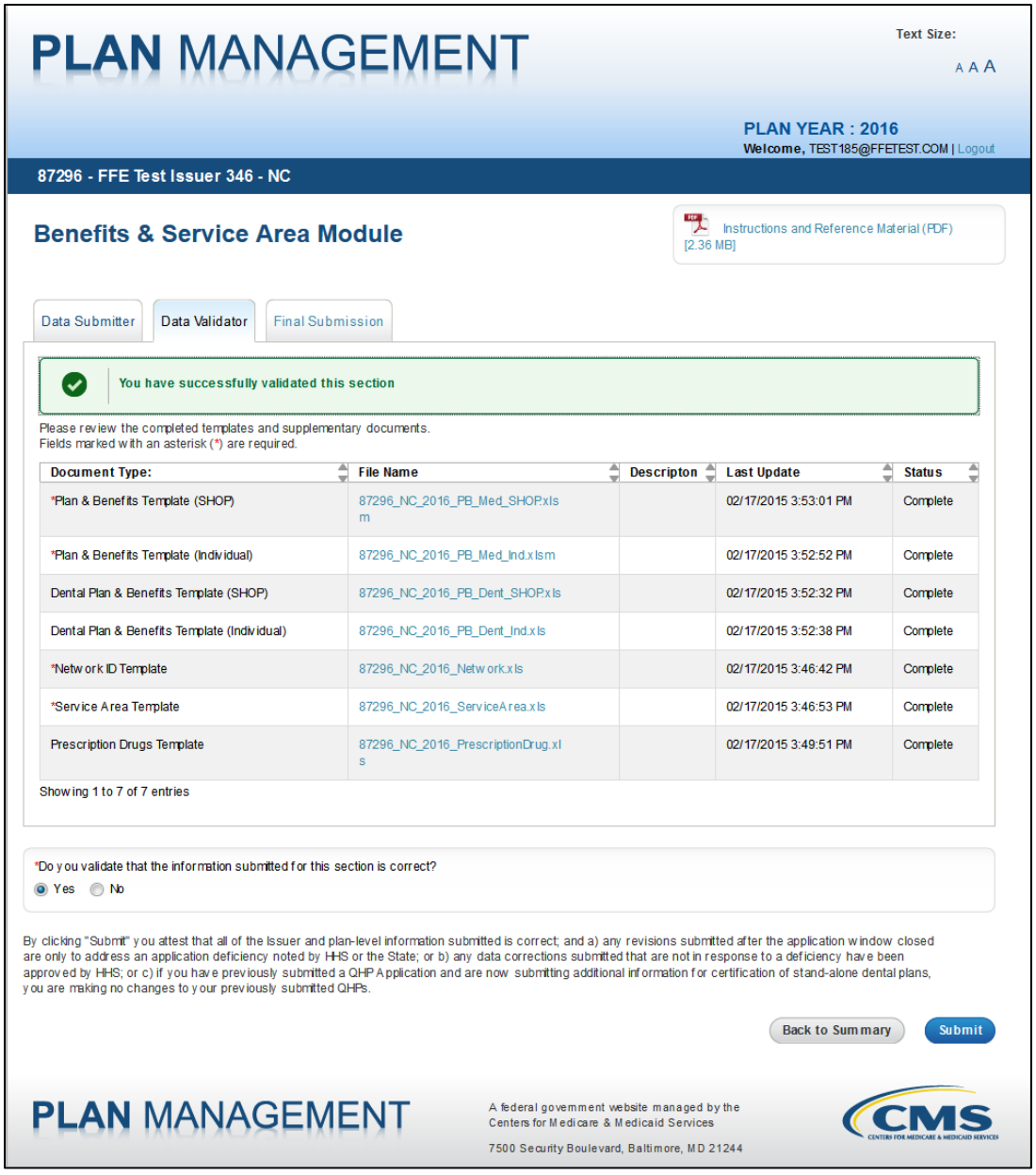


Figure 10: Validator Benefits & Service Area Page - Validation Question = Yes

5.11 Benefits Validator Benefits & Service Area Page - Validation Question = No

You must answer the question, "Do you validate that the information submitted for this section is correct?" If you answer "**No**" and click Submit, the system will return a confirmation message (see Figure 11) that this particular submission *has been returned for changes*. This submission will no longer be available in the Validator Summary page.

Please note that there is no way to send a notification within the system. You must tell your data submitter offline that the submission has been rejected in order for them to correct the submission.

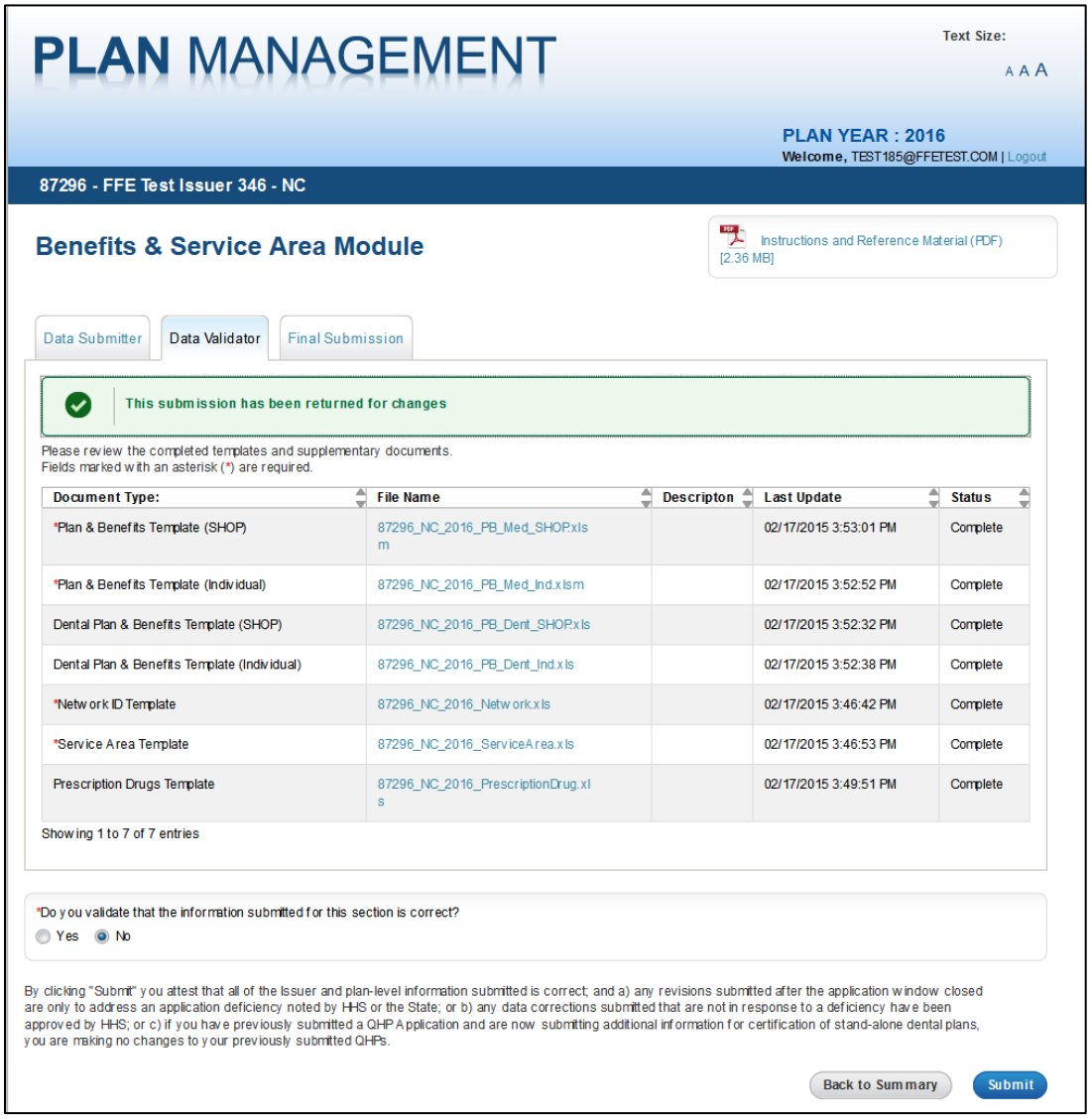


Figure 11: Validator Benefits & Service Area Page - Validation Question = No

5.12 Final Submission

This page allows Benefits Submitters and Benefits Validators to cross validate Final Submission data elements within a submission. **Both** the Submitter and Validator can cross validate the Final Submission data. Only the Validator has the rights to submit an application, which will trigger cross validations and submit an application to be evaluated for QHP certification.

5.12.1 Final Submission Access from the Modules

The Final Submission page can be accessed from the Final Submission tab that is integrated within the modules.

Example: From the Benefits and Service Area Module, shown in Figure 12, click the **Final Submission** tab to access the Final Submission page and view the statuses of modules throughout an application.

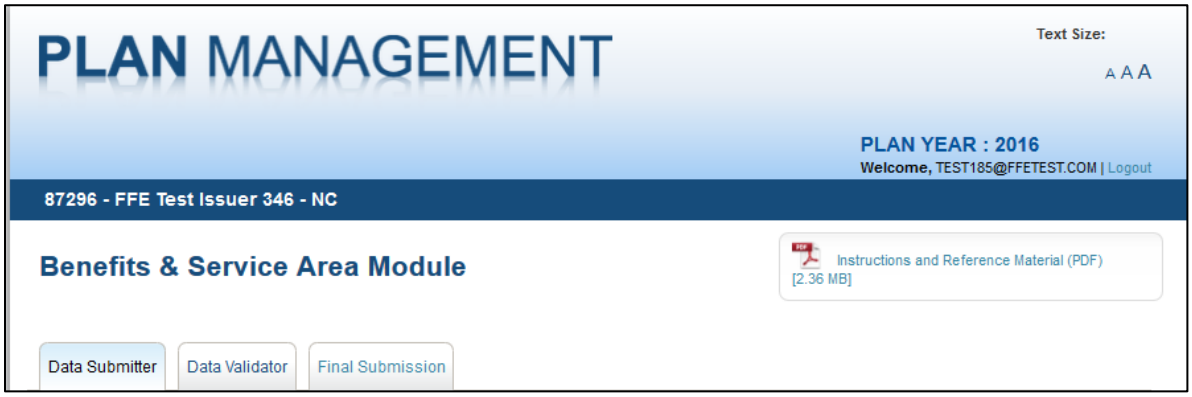


Figure 12: Example: Accessing the Final Submission Page from the Benefits Module

5.12.2 Final Submission Page

Depending on your access level, you can use the Final Submission page (see Figure 13) to perform two distinct functions. Submitters and Validators can cross validate data among modules by clicking the ***Cross Validate*** button. Validators can submit the application by clicking the ***Submit*** button.

The ***Back*** button returns you to the last page accessed prior to navigating to the Final Submission page.

NOTE: Submission of Unified Rate Review is required to complete your QHP application; however, the module status will not be displayed on the page.

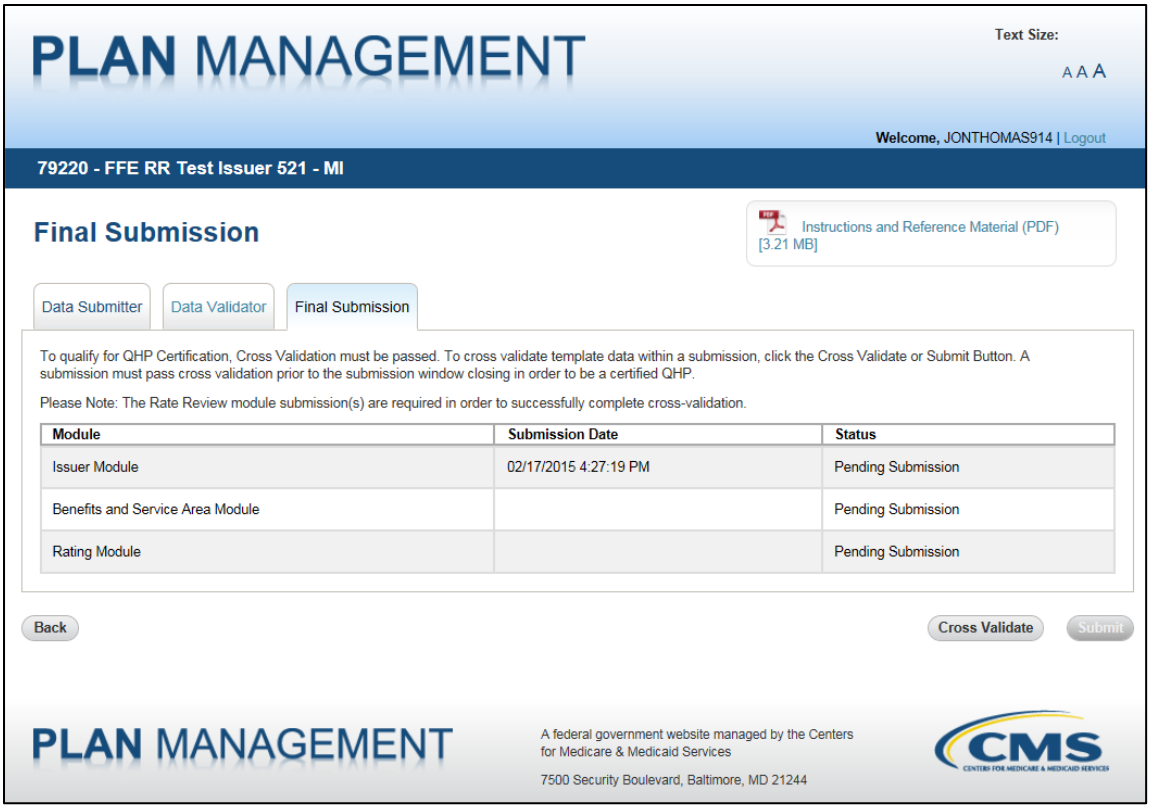


Figure 13: Final Submission Page

5.12.3 Final Submission Page - Errors

When inconsistencies are detected during cross validation, an error report will be generated and an error message will appear on screen (see Figure 14). The error message instructs you to download the Final Submission Error Report to view inconsistent data elements across the modules. You must download the Final Submission Error Report (see Figure 15) by selecting on the ErrorReport.csv link and correct the listed errors.

NOTE: Error report generation will not trigger a status change for any module. You are responsible for coordinating with users from other modules to resolve discrepancies within the application. Once discrepancies are resolved, you must rerun cross validation to verify consistency across the Final Submission data elements.

NOTE: The Error Report is **deleted** once you refresh or leave the page. It is strongly suggested that you download this report.

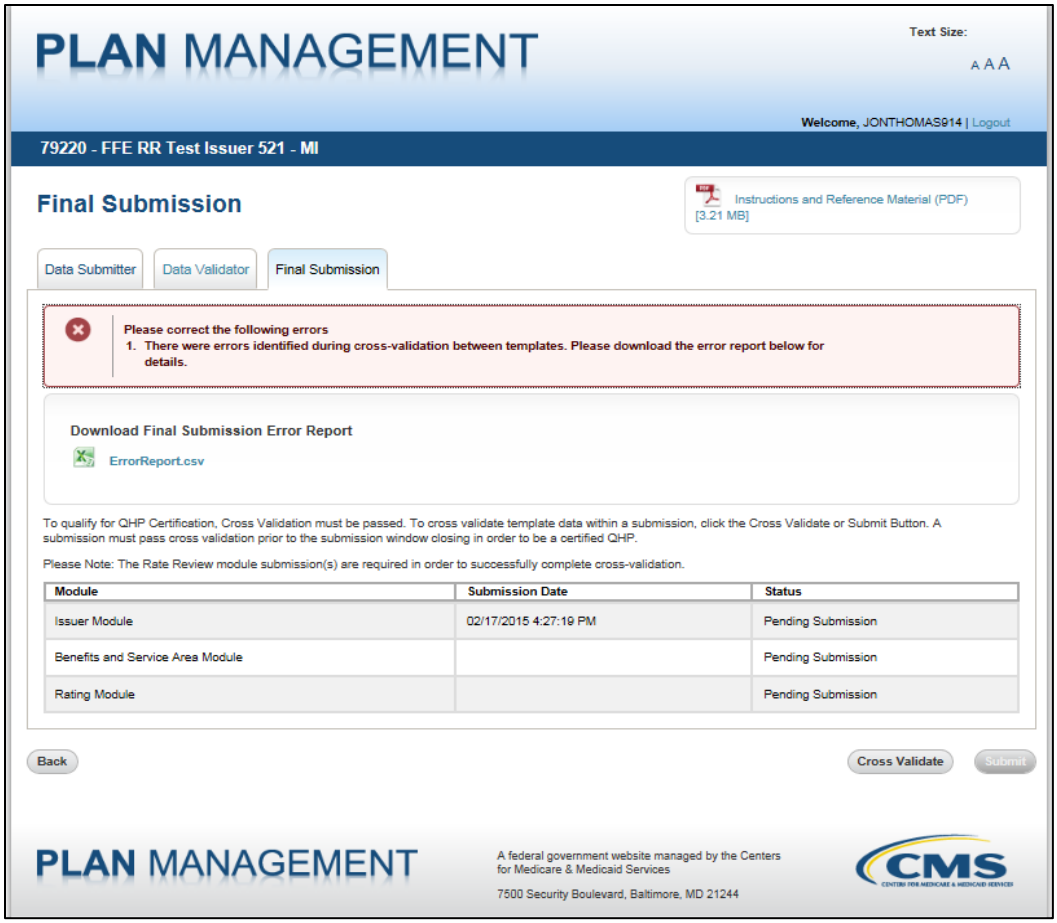


Figure 14: Final Submission Page - Errors

	A	B	C	D	E	F	G
1	URAC template has not been uploaded						
2	NCQA template has not been uploaded						
3	Rate Table template has not been uploaded						
4	Admin template has not been uploaded						
5	Prescription Drug template has not been uploaded						
6	PlanBenefit-Small Group template has not been uploaded						
7	PlanBenefit-Individual template has not been uploaded						
8	ECP template has not been uploaded						
9	Network template has not been uploaded						
10	Service Area template has not been uploaded						
11	Rate Business Rules template has not been uploaded						
12	The following NetworkId's exist in Benefit but not in Network templates []						
13	Not yet checking RateTable dates for PlanBenefit-Individual PlanId's						
14	Not currently checking URR planId's						
15	Issuer Module is not complete and validated						

Figure 15: Final Submission Error Report

5.12.4 Final Submission Page - Cross Validations Successful

After cross validations have passed, you will receive a confirmation message stating the chosen Issuer ID application has been successfully Cross Validated (see Figure 16). The Validator must still click ***Submit*** for the application to be flagged for Evaluation (Refer to 5.13.5 Final Submission Page - Submitted).

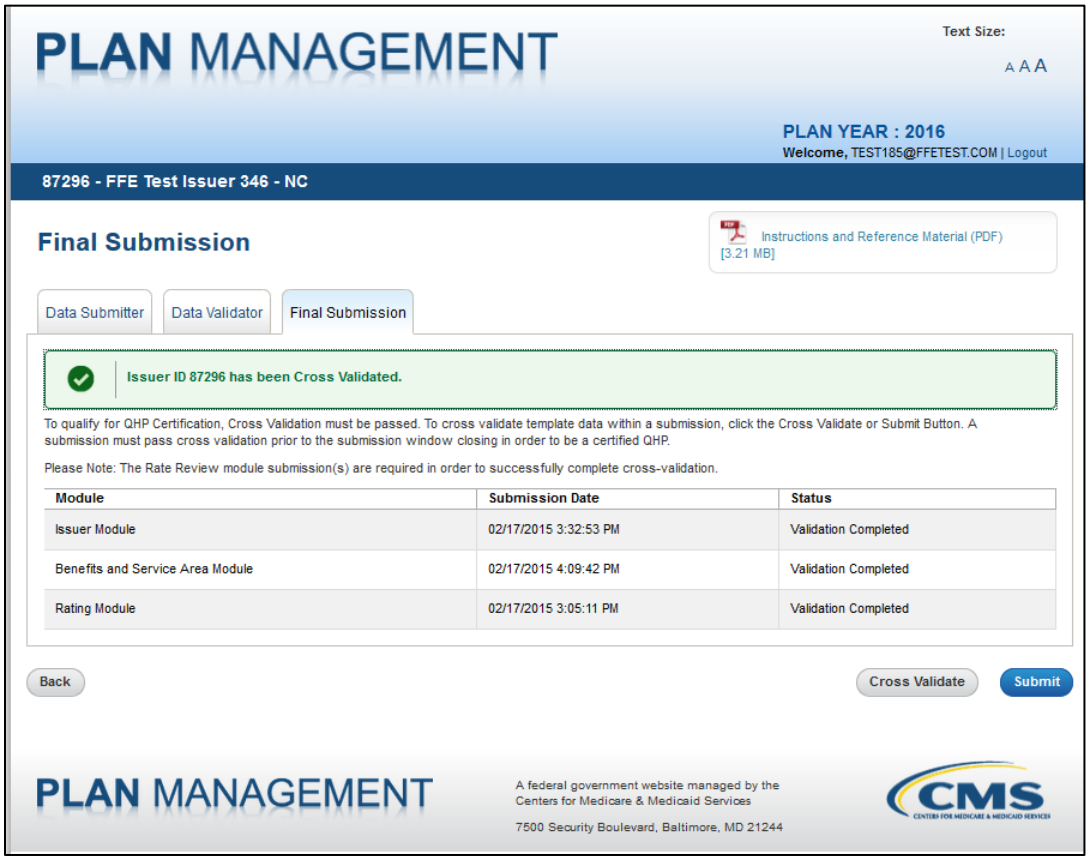


Figure 16: Final Submission Page - Cross Validations Successful

5.12.5 Final Submission Page - Submitted

Once all module statuses show as "**Validation Completed**," a **Validator** can submit the application by clicking the ***Submit*** button.

After you successfully submit the application, the Module statuses read "**Cross Validation Completed**" (see Figure 17), and the ***Submit*** button becomes disabled. If there are modifications to any Module, you must repeat the Final Submission Cross Validation process. If changes are made, the Module statuses will no longer read "Cross Validation Completed."

NOTE: You must complete the Final Submission prior to the close of the submission window for an application to qualify for QHP certification.

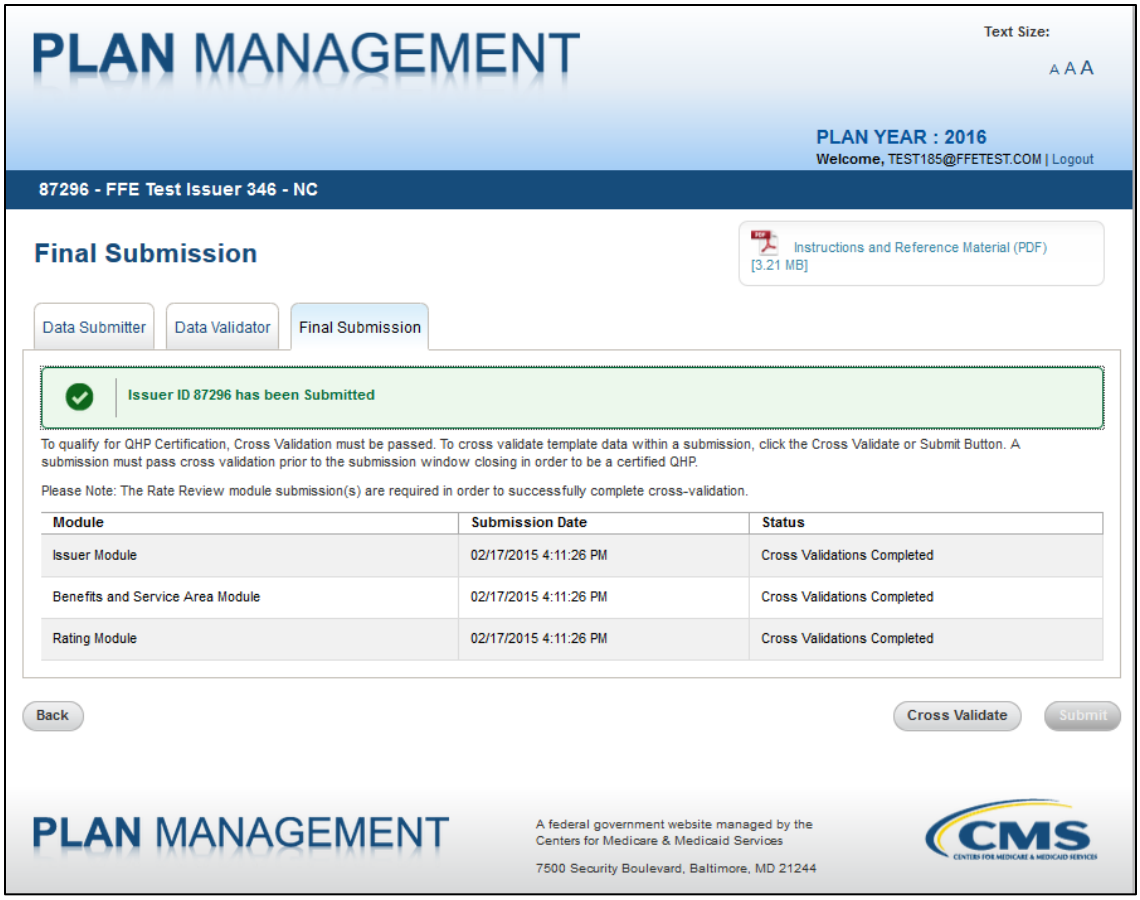


Figure 17: Final Submission Page - Submitted

5.13 Resubmission

The Resubmission (see Figure 19) functionality allows Validators to initiate the resubmission of the application to address a deficiency noted by HHS or the State and to submit a data correction during the plan preview period.

NOTE: Entering the resubmission process will invalidate the previously submitted QHP application to allow information to be modified and resubmitted.

You can initiating the resubmission process from any QHP application module. Resubmission may impact data entries and validation previously completed in other QHP Application modules. Once you begin the resubmission process, the module status will change to "Return for Changes" and all other modules to "Validation Completed." To modify a module with the status of "Validation Completed," follow the instructions provided in section 5.12.

Once the resubmission process has been successfully processed, you must follow the original submission process (Submission, Validation, Cross Validation) previously outlined within this guide.

5.13.1 Resubmission Benefits Validator: Summary Page

The Benefits Validator Summary (see Figure 18) is where you can select an application to initiate the resubmission. You can also select **Edit** for any submissions with the status of "Cross Validation Completed." You must be assigned the role of **Benefits Validator** to access this page.

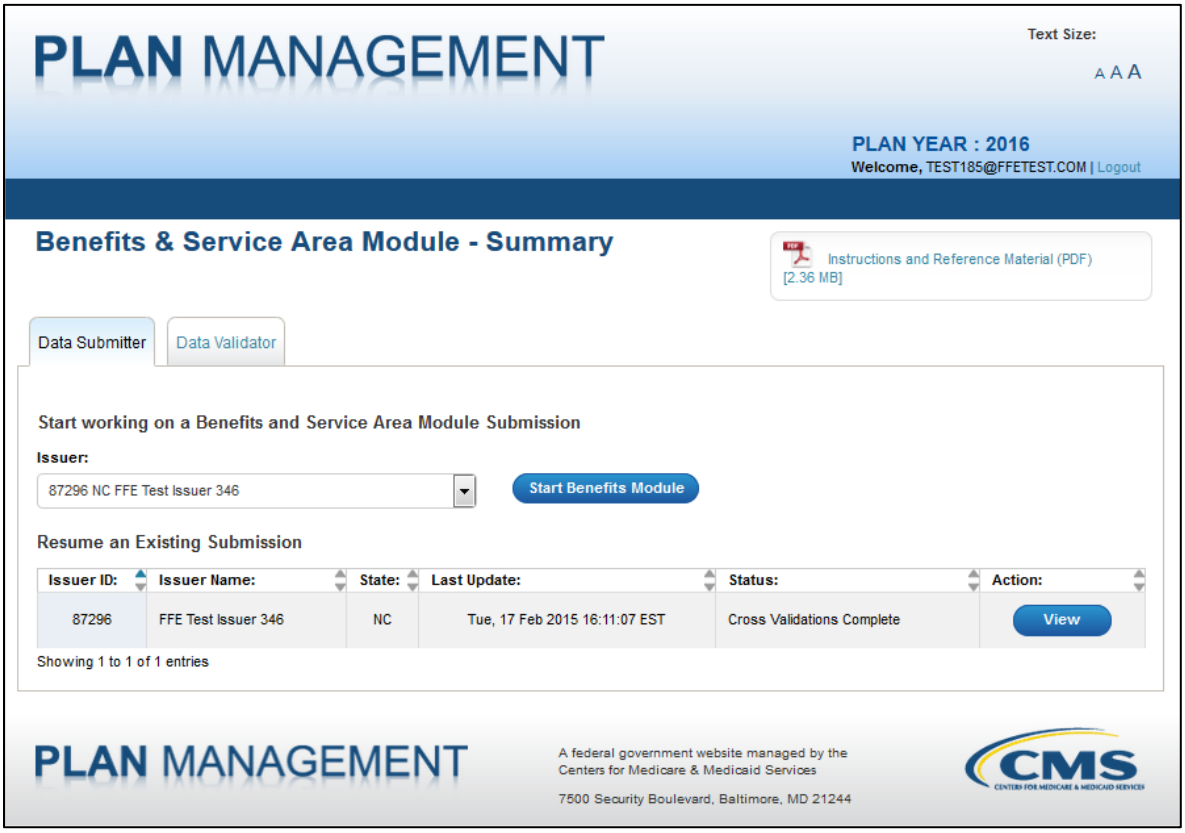


Figure 18: Benefits Validator - Summary Page

5.13.2 Resubmission Benefits Validator: Benefits & Service Area Page

The Benefits Validator page of the Benefits & Service Area module allows you to review the validated data and information provided by the Benefits Submitter.

You must select the ***Resubmission*** button from the alert box (see Figure 19). A confirmation pop-up will appear to ensure the resubmission is process is triggered to only address justifications outlined by CMS (see Figure 20). Selecting "**No**" will simply close the pop-up screen with no changes made to the module/application. If you select "**Yes,**" the pop-up screen will close and a confirmation message will display stating that the module status has changed to "Return to Submitter" and that the module is now routed back to the submitter (see Figure 21).

Figure 19: Resubmission Alert Box

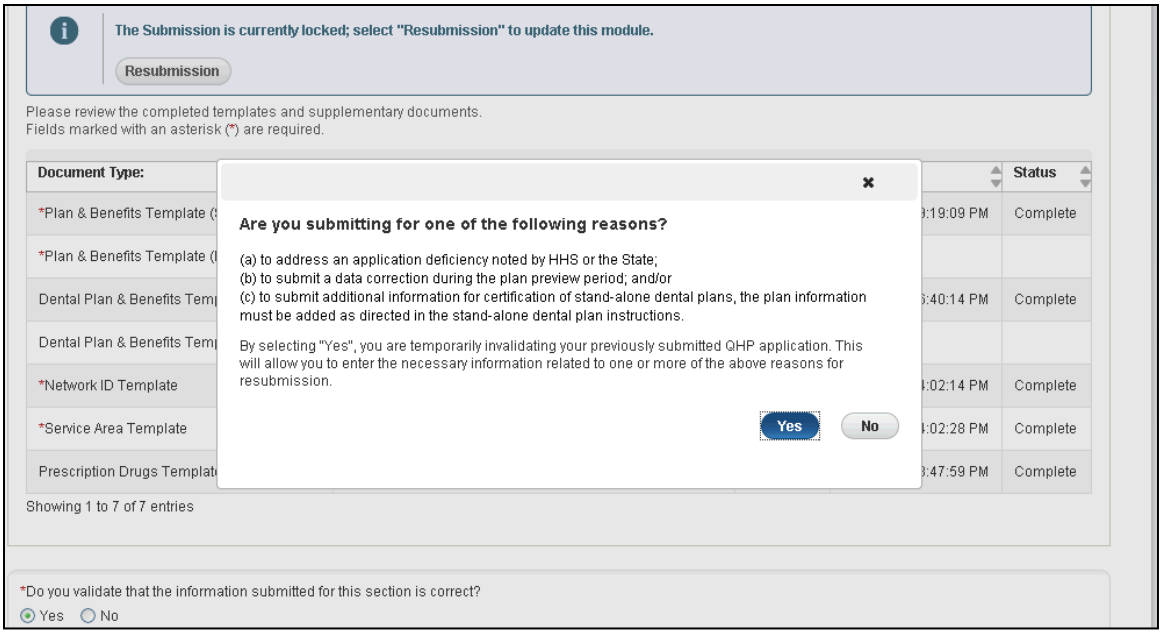


Figure 20: Confirmation Pop-Up

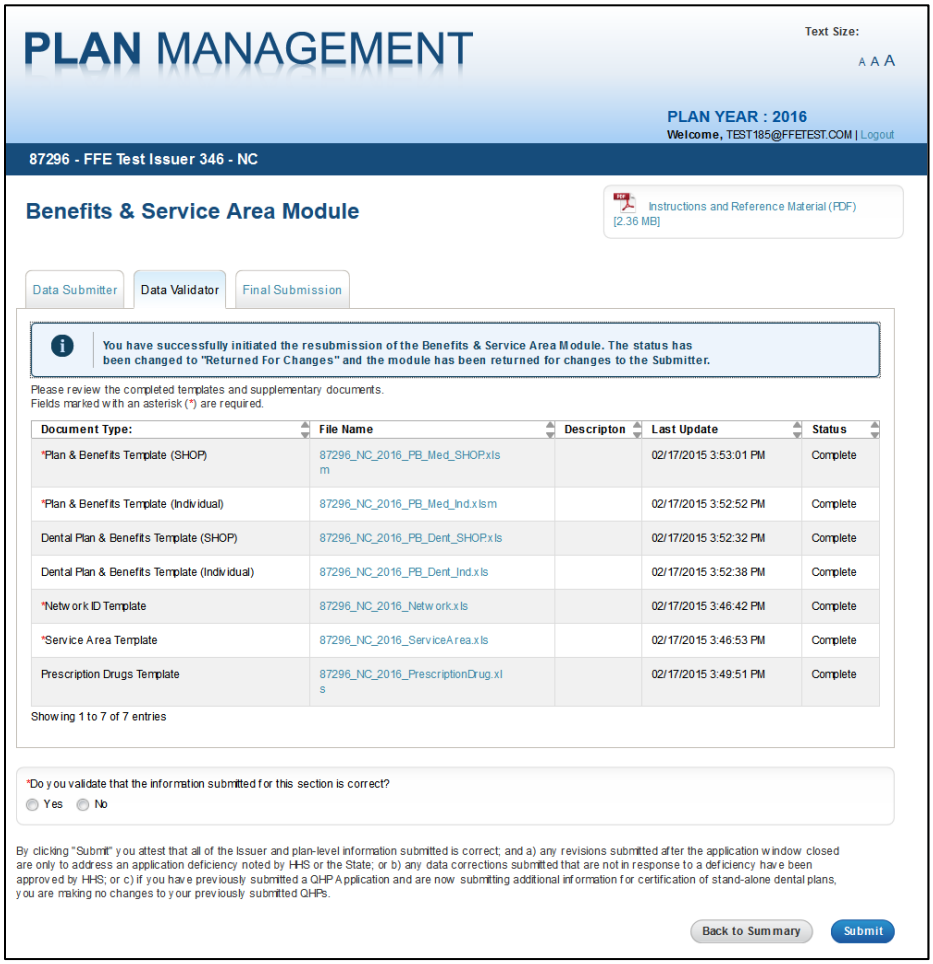


Figure 21: Resubmission Confirmation Message

6 Templates

The Benefits & Service Area module is where you can complete the following templates and upload the template-generated .xml files:

- Network Template
- Service Area Template
- Prescription Drug Template
- Plans & Benefits Template

This section provides background information and descriptions of the data elements contained within these templates.

NOTE: For Plan Year 2016, ALL templates should have a version of 5.12. If the versions are not current, you will not be able to complete the template upload and receive errors.

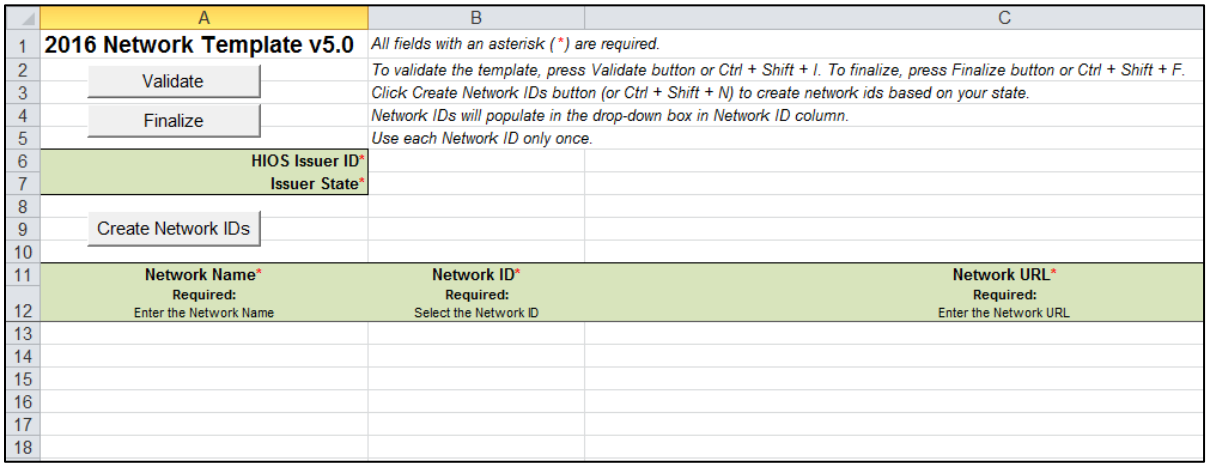
6.1 Network Template

You must cross reference your networks with network IDs and provide the Network URL that will be displayed on Eligibility and Enrollment pages. This is similar to provider directories.

The Network Template links to the Plans & Benefits template. Each plan in the Plans & Benefits template must list the Network ID with which it is associated.

Before using this template, you must first enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

Figure 22 shows a blank Network template.



	A	B	C
1	**2016 Network Template v5.0**	*All fields with an asterisk (*) are required.*	
2	Validate	*To validate the template, press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*	
3		*Click Create Network IDs button (or Ctrl + Shift + N) to create network ids based on your state.*	
4	Finalize	*Network IDs will populate in the drop-down box in Network ID column.*	
5		*Use each Network ID only once.*	
6	**HIOS Issuer ID***		
7	**Issuer State***		
8			
9	Create Network IDs		
10			
11	**Network Name***	**Network ID***	**Network URL***
12	**Required:** Enter the Network Name	**Required:** Select the Network ID	**Required:** Enter the Network URL
13			
14			
15			
16			
17			
18			

Figure 22: Network Template

Table 5 describes the fields on the Network template.

Table 5: Network Template Fields

Field Name	Description	Field Values
Issuer HIOS Issuer ID	Five digit number that uniquely identifies the Issuer.	Numeric
Issuer State	Select which State this template applies to.	Dropdown: State Abbreviations + Territories
Network Name	Enter the name of the specific network	Alphanumeric (including special characters)
Network ID	An ID generated by the template to identify each network provider directory.	Alphanumeric (including special characters)
Network URL	URL associated with the specific Network.	Alphanumeric (including special characters)

6.2 Service Area Template

Plan coverage is defined by service area. Each service area is linked to a plan or multiple plans in the Plans & Benefits template.

Issuers define service areas by state name, county name or Zip code. If a service area covers part, but not all, of a state, the issuer must define it by the covered counties. If a service area covers part, but not all, of a county, the issuer must define it by the covered Zip codes.

The Service Area template links to the Plans & Benefits template. Each plan in the Plans & Benefits template must list the Service Area ID with which it is associated.

NOTE: Zip Codes are subject to change and should be verified for validity.

Before using this template, you must enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

The Service Area template is shown in Figure 23.

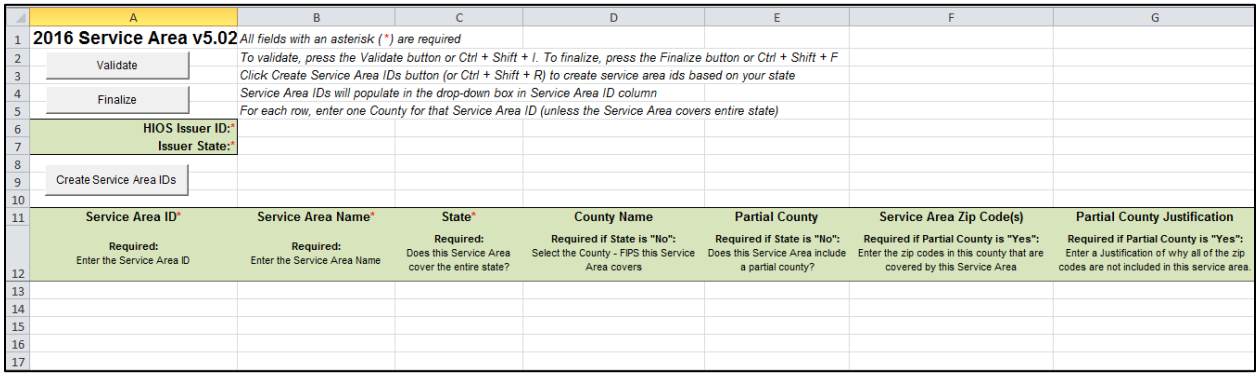


Figure 23: Service Area Template

Table 6 describes the fields in the Service Area template.

Table 6: Service Area Template Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five digit number that identifies the Issuer.	Numeric
Issuer State	Select which State this template applies to.	Dropdown: State Abbreviations + Territories
Service Area ID	An ID generated by the template to identify each geographic service area.	Service Area IDs - this will vary based upon creation of IDs
Service Area Name	The name associated with a specific Service Area.	Alphanumeric (including special characters)
State	Flag to denote that the service area covers the entire state.	Dropdown: Yes No
County Name	The name of a county or counties that are included in a service area.	Dropdown: Counties - will vary depending on State Alphanumeric (including special characters)
Partial County	An indicator of whether a service area contains any partial counties.	Dropdown: Yes No
Service Area Zip Code(s)	For any partial counties included in a service area, list each ZIP code from that county included in this service area.	Numeric separated by comma
Partial County Justification	Space to provide justification for why all the zip codes are not included in this service area.	Alphanumeric (including special characters)

6.3 Prescription Drug Template

Use the Prescription Drug template to provide formularies and drug lists.

The formulary is defined by the number of tiers and their cost sharing information. Each formulary links to one drug list, which includes the list of RxCUIs and the cost sharing tier they fall into.

The Prescription Drug Template links to the Plans & Benefits template using the formulary ID. Each plan in the Plans & Benefits template must list the formulary ID with which it is associated.

Before using this template, you must enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

Figure 24 shows the Formulary Tiers tab of the Prescription Drug template.

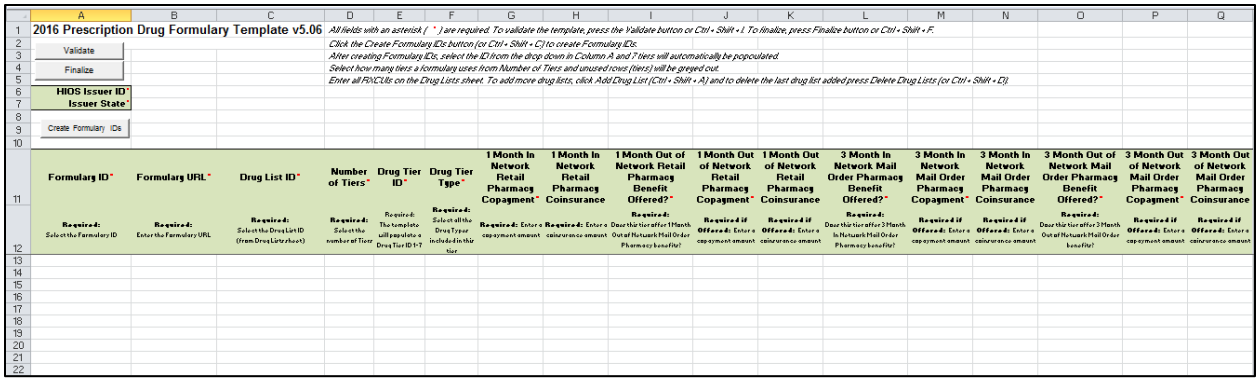


Figure 24: Prescription Drug Template - Formulary Tiers Tab

Table 7 describes the fields in the Formulary Tiers tab of the Prescription Drug template. Note that if you select "$X" as a value for any of the fields, a pop-up window will appear for you to enter a dollar value to the second decimal point ($X.XX). Also note that if you select "X%" as a value for any of the fields, a pop-up window will appear for you to enter a percentage value to the second decimal point (X.XX %).

Table 7: Prescription Drug Template - Formulary Tiers Tab Fields

Field Name	Description	Field Values
Issuer ID	Five digit number that identifies the Issuer.	Numeric
Issuer State	Select which State this template applies to.	Dropdown: State Abbreviations + Territories
Formulary ID	An ID generated by the template to identify each formulary.	Dropdown: Varies based on State and Number of Formularies entered
Formulary URL	URL for your formulary document.	Alphanumeric (including special characters)
Drug List ID	Template generated identifier for Drug List in template.	Dropdown: Varies based on number of Drug Lists
Number of Tiers	The number of cost share tiers included in the formulary.	1-7
Drug Tier ID	Template populated field according to the selection in *Number of tiers*.	Numeric

Field Name	Description	Field Values
Drug Tier Type	List of Drug Types included in this tier.	Popup Window: • Generic • Preferred Generic • Non-Preferred Generic • Brand Preferred Brand • Non-Preferred Brand • Specialty Drugs • Zero Cost Share Preventative Drugs • Medical Service Drugs
1 Month in Network Retail Pharmacy Copayment	Indicate copayment for Up to 1 Month In-Network Retail Pharmacy.	Dropdown: • No Charge • No Charge after deductible • $X • $X Copay after deductible • $X Copay before deductible • Not Applicable
1 Month in Network Retail Pharmacy Coinsurance	Indicate coinsurance for Up to 1 Month In-Network Retail Pharmacy.	Dropdown: • No Charge • No Charge after deductible • X% • X% Coinsurance after deductible • Not Applicable
1 Month Out of Network Retail Pharmacy Benefit Offered?	Indicate whether 1 Month Out-of-Network Retail Pharmacy is offered.	Dropdown: • Yes • No
1 Month Out of Network Retail Pharmacy Copayment	Indicate copayment for Up to 1 Month Out-of-Network Retail Pharmacy.	Dropdown: • No Charge • No Charge after deductible • $X • $X Copay after deductible • $X Copay before deductible • Not Applicable
1 Month Out of Network Retail Pharmacy Coinsurance	Indicate coinsurance for Up to 1 Month Out-of-Network Retail Pharmacy.	Dropdown: • No Charge • No Charge after deductible • X% • X% Coinsurance after deductible • Not Applicable

Field Name	Description	Field Values
3 Month In Network Mail Order Pharmacy Benefit Offered?	Indicate whether 3 Month In-Network Mail Order Pharmacy Benefit is offered.	Dropdown: • Yes • No
3 Month In Network Mail Order Pharmacy Copayment	Indicates copayment amount for mail order pharmacy 3-month supply In-Network.	Dropdown: • No Charge • No Charge after deductible • $X • $X Copay after deductible • $X Copay before deductible • Not Applicable
3 Month In Network Mail Order Pharmacy Coinsurance	Indicate cost-sharing type for 3 Month out-of-network Mail Order Pharmacy.	Dropdown: • No Charge • No Charge after deductible • X% • X% Coinsurance after deductible • Not Applicable
3 Month Out-of-Network Mail Order Pharmacy Benefit Offered?	Indicate whether 3 Month Out-of-Network Mail Order Pharmacy Benefit is offered.	Dropdown: • Yes • No
3 Month Out-of-Network Mail Order Pharmacy Copayment	Indicate copayment amount for mail order pharmacy 3-month supply Out-of-Network.	Dropdown: • No Charge • No Charge after deductible • $X • $X Copay after deductible • $X Copay before deductible • Not Applicable
3 Month Out-of-Network Mail Order Pharmacy Coinsurance	Indicate coinsurance amount for mail order pharmacy 3-month supply Out-of-Network.	Dropdown: • No Charge • No Charge after deductible • X% • X% Coinsurance after deductible • Not Applicable

Figure 25 shows the Drug Lists tab of the Prescription Drug template.

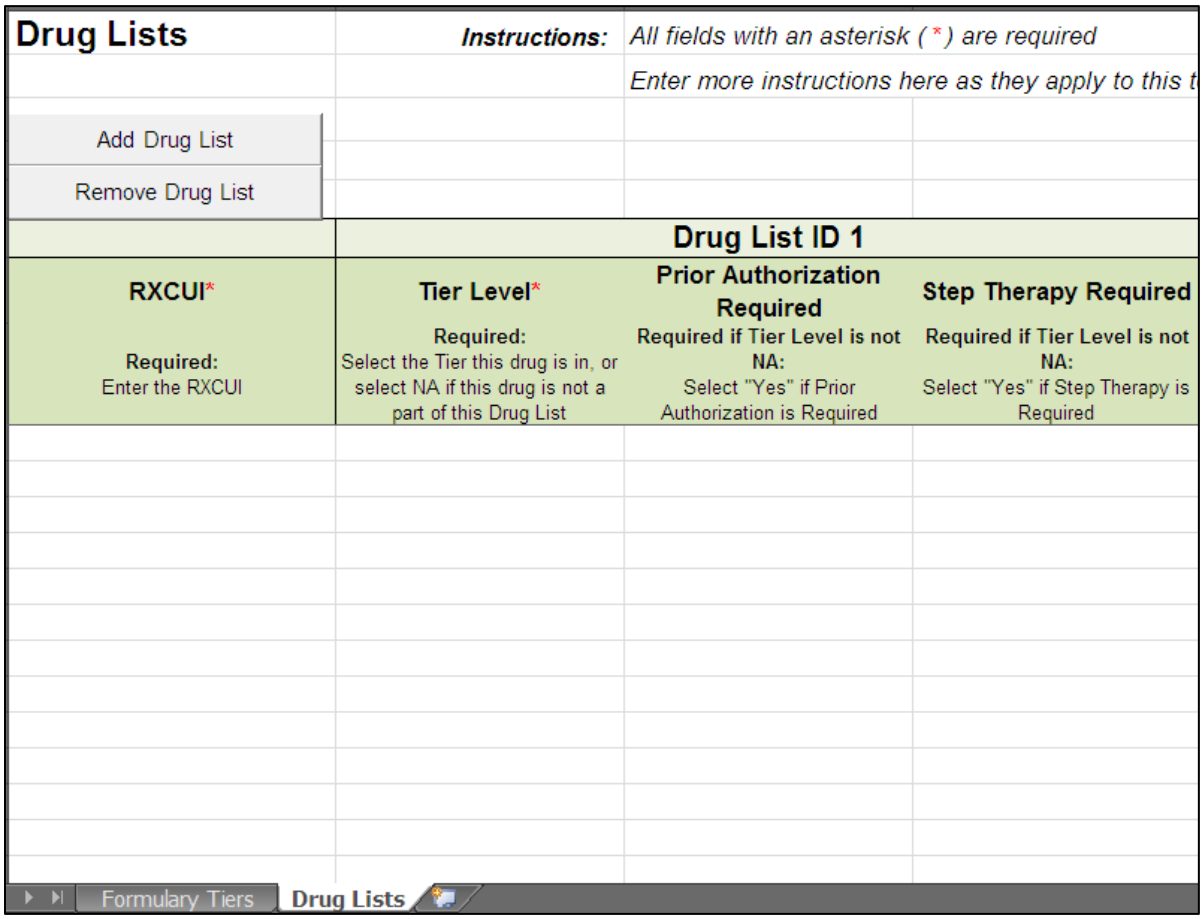


Figure 25: Prescription Drug Template – Drug Lists Tab Field

Table 8 describes the fields in the Drug Lists tab of the Prescription Drug template.

Table 8: Prescription Drug Template - Drug Lists Tab Fields

Field Name	Description	Field Values
RxCUI	1-8 digit RxNorm Count Unique Identifier	Numeric
Tier Level	Cost-sharing tier level.	Dropdown: • N/A • 1-7
Prior Authorization Required	Indicate whether prior authorization is required.	Dropdown: • Yes • No
Step Therapy Required	Indicate whether step therapy is required.	Dropdown: • Yes • No

6.4 Plan & Benefits Template Add-in File

The add-in file is the key for proper functionality of the Plans & Benefits template. This file contains all the macros, code, and logic required to calculate cost share variances and populate EHB data within the Plans & Benefits template. The add-in file also creates a new tab called "Plans & Benefits" on the Excel ribbon within the template, with different buttons available to assist you in creating your plans.

For certain circumstances for working with multi-year templates, please refer to Appendix C.

To complete the Plans & Benefits template, you must do the following, or the template will not function properly:

- Delete all prior versions of the add-in file from your computer, unless explicitly following Appendix C guidelines for working with multi-year template versions.
- Download the most current add-in file and **save it in the same folder as the Plans & Benefits template.**

Once you open the Plan & Benefits Template, macros from the add-in file will be automatically integrated.

If you encounter any problems creating Plans & Benefits due to the Add-In file, refer to Appendix B and Appendix C for further guidance.

6.5 Plans & Benefits Template

This template captures the following four levels of data:

- General plan information
- Plan cost sharing information
- General benefit information
- Benefit cost sharing information

The Plans & Benefits template contains two sections (tabs). The first section is the "**Benefits Package**," which includes high level information regarding the plans, as well as a list of benefits with any quantitative limits or exclusions (refer to Tables 9-19 for Health and Tables 30-38 for Stand-Alone Dental Plan (SADP). All plans defined within a Benefits Package will share the same set of benefits and limits but differ in cost sharing variations.

The second section is the "**Cost Share Variances**" (CSR). The CSR tab is where you provide Deductibles and Maximum Out of Pocket (MOOP) information for In/Out/Combined Networks, for both Individual and Family, as well as In/Out/Combined Network Copays and Coinsurances (refer to Tables 20-28 for Health and Tables 38-42 for SADP). You must provide this information for each plan variance.

Before using this template, you must enable macros in Microsoft Excel. Refer to Appendix A for directions to enable macros.

NOTE: There must be one Cost Share Variances tab for each Benefits Package tab. Corresponding tabs will be labeled with the same number.

Figure 26 shows the Benefits Package tab of the Plans & Benefits Template.

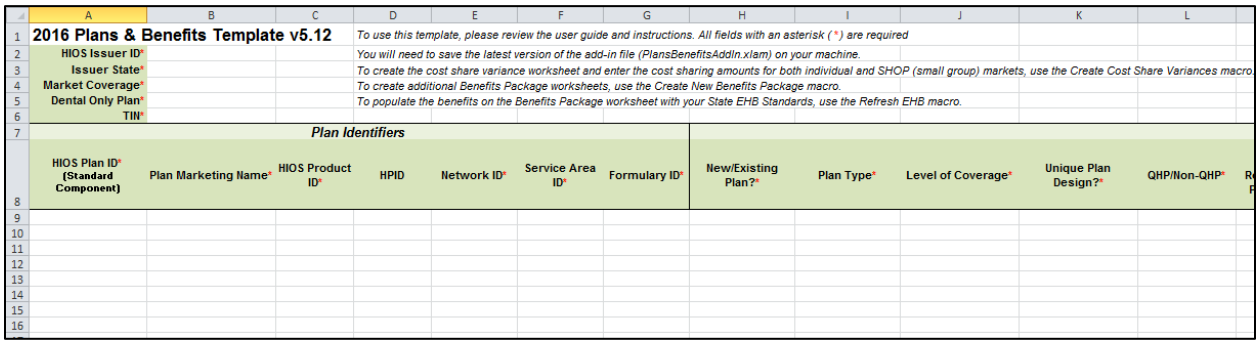


Figure 26: Plans & Benefits Template – Health Benefits Package Tab

Table 9 describes the fields in the Benefits Package tab of the Plans & Benefits template.

Table 9: Plans & Benefits Template – Health Benefits Package Tab Fields

Field Name	Description	Field Values
HIOS Issuer ID	Five digit number that identifies the Issuer.	Numeric
Issuer State	Select which State this template applies to.	Dropdown: State Abbreviations + Territories
Market Coverage Type	Market coverage, individual or SHOP, for the entire benefit package/template.	Dropdown: SHOP (Small Group) Individual
Dental Only Plan Indicator	Indicator if the plans offered in this benefit package are for stand-alone dental only (not medical).	Dropdown: Yes No
TIN	Tax Identification Number	Numeric

Table 10 describes the fields in the Plan Identifiers section of the Benefits Package tab.

Table 10: Health Benefits Package Tab - Plan Identifiers Section Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component)	HIOS generated unique Standard Component ID that makes up the plan ID.	Alphanumeric
Plan Marketing Name	Name of each plan.	Alphanumeric (including special characters)
HIOS Product ID	The HIOS Product ID associated with each proposed Exchange plan.	Alphanumeric
HPID	Associated 10-digit Health Plan Identifier.	Numeric
Network ID	The Network ID for this plan which identifies the Network Provider Directory this plan uses.	Dropdown: List of values will be imported in from the Network Template by user

Field Name	Description	Field Values
Service Area ID	The Service Area ID for this plan which identifies the Service Area the plan covers.	Dropdown: List of values will be imported in from the Service Area Template by user
Formulary ID	The Formulary ID for this plan which identifies which prescription drug formulary this plan uses.	Dropdown: List of values will be imported in from the Prescription Drug Template by user

Table 11 describes the fields in the Plan Attributes section of the Benefits Package tab.

Table 11: Health Benefits Package Tab - Plan Attributes Section Fields

Field Name	Description	Field Values
New/Existing Plan	Indicate if the plan is new or existing.	Dropdown: New Plan Existing Plan
Plan Type	Identifies the type of provider network.	Dropdown: Indemnity PPO HMO POS EPO
Level of Coverage	Coverage level for a specific proposed plan.	Dropdown: Platinum Gold Silver Bronze Catastrophic
Unique Plan Design	Indicates if this is a unique plan design for AV Calculator purposes. These are health plans that are not compatible with the AV Calculator.	Dropdown: Yes No
QHP/Non QHP	Indicator if the plan is offered on exchange, off exchange or on both.	Dropdown: On Exchange Off Exchange Both
Notice Required for Pregnancy	Indicator if notice is required for pregnancy.	Dropdown: Yes No
Is a Referral Required for Specialist?	Indicator if a referral is required for specialist visit.	Dropdown: Yes No
Specialist Requiring a Referral	Specialist types for which referrals are required for this plan.	Alphanumeric (including special characters)
Plan Level Exclusions	All plan level exclusions.	Alphanumeric (including special characters)

Field Name	Description	Field Values
Limited Cost Sharing Plan Variation - Est Advance Payment	Estimate of the per-member per- month dollar value of the cost-sharing reductions to be provided over the benefit year under limited cost sharing plan variation.	Whole Dollar Amount
Does this plan offer Composite Rating?	Indicates whether plans will be available based on the average enrollee premium amounts of enrollees at the time of enrollment.	Dropdown: Yes No
Child-Only Offering	Indicator of whether a specific plan will also be offered at a child-only rate or have a corresponding child-only plan.	Dropdown: Allows Adult and Child-Only Allows Adult-Only Allows Child-Only
Child Only Plan ID	Identifies the associated child-only equivalent Plan ID.	Alphanumeric
Wellness Program Offered	Indicates whether the plan offers wellness programs according to Section 2705 of the Public Health Service Act.	Dropdown: Yes No
Disease Management Programs Offered	Indicates whether disease management programs are offered with this plan.	Dropdown: Asthma Heart disease Depression Diabetes High blood pressure & high cholesterol Low back pain Pain management Pregnancy Weight Loss Programs
EHB Percent of Total Premium	Indicates the percentage of the total plan premium that is comprised of EHBs.	Percentage between 0 and up to and including 100%

Table 12 describes the fields in the Stand-Alone Dental Only section of the Benefits Package tab.

Table 12: Health Benefits Package Tab - Stand-Alone Dental Only Section Fields

Field Name	Description	Field Values
EHB Apportionment for Pediatric Dental	Identifies the dollar amount of the expected monthly premium allocated for the Pediatric Dental EHB.	Whole Dollar Amount
Guaranteed vs. Estimated Rate	Indicates if the rate for this stand-alone dental plan is a guaranteed rate or an estimated rate.	Dropdown: Guaranteed Rate Estimated Rate

Table 13 describes the fields in the AV Calculator section of the Benefits Package tab.

Table 13: Health Benefits Package Tab - AV Calculator Section Fields

Field Name	Description	Field Values
Maximum Coinsurance for Specialty Drugs	Indicates if there is a limit on the amount of coinsurance on specialty prescription drugs by capping the maximum coinsurance payment on specialty drugs at a set amount.	Whole Dollar Amount
Maximum Number of Days for Charging Inpatient Copay?	Indicates if there is a limit on the number of days on which a patient can be charged copay for an inpatient stay, if inpatient copays are charged per day.	Whole Number
Begin Primary Care Cost-Sharing After a Set Number of Visits?	Indicates if primary care cost sharing begins after a certain number of (fully covered) visits have occurred.	Whole Number
Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?	Indicates when to begin subjecting primary care visits to the deductible or coinsurance rates only after a certain number of primary care visits with copay have occurred.	Whole Number

Table 14 describes the fields in the Plan Dates section of the Benefits Package tab.

Table 14: Health Benefits Package Tab - Plan Dates Section Fields

Field Name	Description	Field Values
Plan Effective Date	Effective date of the plan.	Date
Plan Expiration Date	Date that a plan becomes closed and no longer accepts new enrollments.	Date

Table 15 describes the fields in the Geographic Coverage section of the Benefits Package tab.

Table 15: Health Benefits Package Tab - Geographic Coverage Section Fields

Field Name	Description	Field Values
Out of Country Coverage	Indicates whether care obtained outside the country is covered under the plan.	Dropdown: Yes No
Out of Country Coverage Description	A short description of whether care obtained outside the country is covered under the plan.	Alphanumeric (including special characters)
Out of Service Area Coverage	Indicates whether care obtained outside the service area is covered under the plan.	Dropdown: Yes No
Out of Service Area Coverage Description	A short description of whether care obtained outside the service area is covered under the plan.	Alphanumeric (including special characters)
National Network	Indicates whether a national network is available.	Dropdown: Yes No

Table 16 describes the fields in the URLs section of the Benefits Package tab.

Table 16: Health Benefits Package Tab - URLs Section Fields

Field Name	Description	Field Values
Enrollment URL	URL for the location on the plan website where the enrollee will effectuate payment.	Alphanumeric (including special characters)

Table 17 describes the fields in the Benefit Information section of the Benefits Package tab.

Table 17: Health Benefits Package Tab - Benefit Information Section Fields

Field Name	Description	Field Values
Benefits	Name of the benefit.	N/A
EHB	Indicates if this benefit is an EHB benefit.	N/A
State Required Benefit	Indicates if this benefit is a state required benefit.	N/A

Table 18 describes the fields in the General Information section of the Benefits Package tab.

Table 18: Health Benefits Package Tab - General Information Section Fields

Field Name	Description	Field Values
Is this Benefit Covered?	Indicates if this benefit is covered or not covered.	Dropdown: Covered Not Covered (or blank)
Quantitative Limit on Service	Indicates if there are quantitative limits on this benefit.	Dropdown: Yes No (or blank)
Limit Quantity	Indicates any quantitative limits on this benefit (e.g., number of days or visit limits).	Whole Number

Field Name	Description	Field Values
Limit Unit	Indicates unit of those limits.	Popup: First Category Visit(s) Dollars Exam(s) Days Item(s) Months Treatment(s) Procedure(s) Hours Admission(s) Second Category Year Benefit Period Lifetime Month Episode Stay Transplant 6 Months 2 Years 3 Years Procedure Week Admission
Minimum Stay	Identifies the minimum stay, in hours, for this benefit.	Whole Number
Exclusions	List of exclusions if particular services or diagnoses are excluded from this plan.	Alphanumeric (including special characters)
Benefit Explanation (text Field)	Free text field to list any notes on the Benefit	Alphanumeric (including special characters)
EHB Variance Reason	Reason that this benefit varies from EHB.	Dropdown: Above EHB Substituted Substantially Equal Using Alternate Benchmark Other Law/Regulation Additional EHB Benefit Dental Only Plan Available

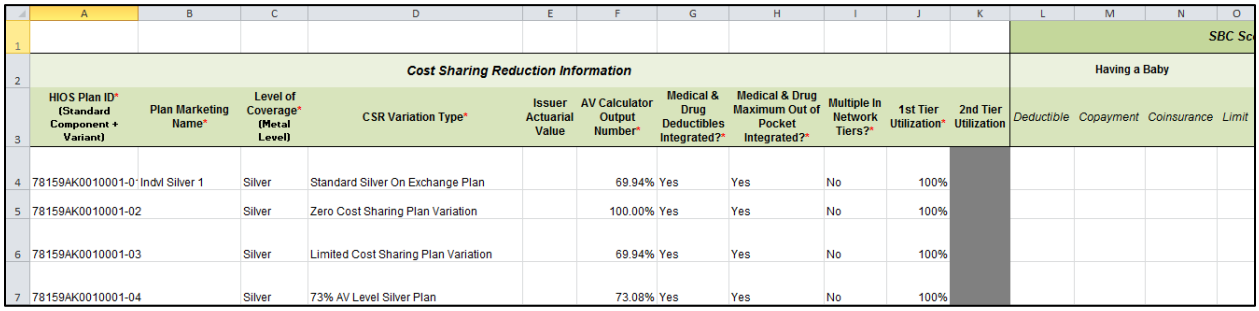
Table 19 describes the fields in the Deductibles and Out of Pocket Exceptions section of the Benefits Package tab.

Table 19: Health Benefits Package Tab - Deductibles and Out of Pocket Exceptions Section Fields

Field Name	Description	Field Values
Excluded from In Network MOOP	Indicates if this benefit is excluded from the in network maximum out of pocket.	Dropdown: Yes No

Field Name	Description	Field Values
Excluded from Out of Network MOOP	Indicates if this benefit is excluded from the out of network maximum out of pocket?	Dropdown: Yes No

Figure 27 shows the Cost Share Variances tab of the Plans & Benefits Template.



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1															SBC Sc
2	Cost Sharing Reduction Information											Having a Baby			
3	HIOS Plan ID* (Standard Component + Variant)	Plan Marketing Name*	Level of Coverage* (Metal Level)	CSR Variation Type*	Issuer Actuarial Value	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*	Medical & Drug Maximum Out of Pocket Integrated?*	Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization	Deductible	Copayment	Coinsurance	Limit
4	78159AK0010001-0	Indvl Silver 1	Silver	Standard Silver On Exchange Plan		69.94%	Yes	Yes	No	100%					
5	78159AK0010001-02		Silver	Zero Cost Sharing Plan Variation		100.00%	Yes	Yes	No	100%					
6	78159AK0010001-03		Silver	Limited Cost Sharing Plan Variation		69.94%	Yes	Yes	No	100%					
7	78159AK0010001-04		Silver	73% AV Level Silver Plan		73.08%	Yes	Yes	No	100%					

Figure 27: Health Plans & Benefits Template - Cost Share Variances Tab

Table 20 describes the fields in the Cost Share Variances tab of the Plans & Benefits template.

Table 20: Health Plans & Benefits Template - Cost Share Variances Tab Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component + Variant)	HIOS generated unique Standard Component ID with suffixes automatically added depending on the plan variation.	Copied over from the Benefits Package sheet, with suffixes added.
Plan Marketing Name	Name of each plan.	Copied over from the Benefits Package sheet.
Level of Coverage (Metal Level)	Pre-populated with metal level from designated plan.	Copied over from the Benefits Package sheet.
CSR Variation Type	The Cost Share Reduction Variance level of the plan.	Auto-Populated (varies by proposed metal level): Zero Cost Sharing Plan Variation Limited Cost Sharing Plan Variation 73% AV Level Silver Plan CSR 87% AV Level Silver Plan CSR 94% AV Level Silver Plan CSR Standard Bronze On Exchange Standard Bronze Off Exchange Standard Silver On Exchange Standard Silver Off Exchange Standard Gold On Exchange Standard Gold Off Exchange Standard Platinum On Exchange Standard Platinum Off Exchange
Issuer Actuarial Value	Issuer calculated Actuarial Value.	Percentage
AV Calculator Output Number	The Actuarial Value of this plan as calculated by the AV Calculator.	Percentage

Field Name	Description	Field Values
Medical & Drug Deductibles Integrated?	Indicates if this plan design has an integrated medical and drug deductible. Based on your selection, certain fields will be disabled.	Dropdown: Yes No
Medical & Drug Maximum Out of Pocket Integrated?	Indicates if this plan design has an integrated medical and drug out of pocket maximum. Based on your selection, certain fields will be disabled.	Dropdown: Yes No
Multiple In Network Tiers?	Indicates if this plan uses multiple in-network provider tiers.	Dropdown: Yes No
1st Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 1 for plans with multiple in network tiers.	Percentage
2nd Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 2 for plans with multiple in network tiers.	Percentage

Table 21 describes the fields in the SBC Scenario section of the Cost Share Variances tab.

Table 21: Health Cost Share Variances Tab - SBC Scenario Section Fields

Field Name	Description	Field Values
Having a Baby - Deductible	Estimated deductible for the SBC scenario “Having a baby.”	Whole Dollar Amount
Having a Baby - Copayment	Estimated copayment for the SBC scenario “Having a baby.”	Whole Dollar Amount
Having a Baby - Coinsurance	Estimated coinsurance for the SBC scenario “Having a baby.”	Whole Dollar Amount
Having a Baby - Limit	Estimated Limit dollar amount for the SBC scenario “Having a baby.”	Whole Dollar Amount
Having Diabetes - Deductible	Estimated deductible for the SBC scenario “Having Diabetes.”	Whole Dollar Amount
Having Diabetes - Copayment	Estimated copayment for the SBC scenario “Having Diabetes.”	Whole Dollar Amount
Having Diabetes - Coinsurance	Estimated coinsurance for the SBC scenario “Having Diabetes.”	Whole Dollar Amount
Having Diabetes - Limit	Estimated Limit dollar amount for the SBC scenario “Having Diabetes.”	Whole Dollar Amount

Table 22 describes the fields in the Maximum Out of Pocket for Medical EHB Benefits section of the Cost Share Variances tab.

Table 22: Health Cost Share Variances Tab - Maximum Out of Pocket for Medical EHB Benefits Section Fields

Field Name	Description	Field Values

Field Name	Description	Field Values
In Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Maximum Out of Pocket for Medical EHB Benefits In Network Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Individual	The Maximum Out of Pocket for Medical EHB Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Maximum Out of Pocket for Medical EHB Benefits In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Maximum Out of Pocket for Medical EHB Benefits Out of Network Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Maximum Out of Pocket for Medical EHB Benefits Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 23 describes the fields in the Maximum Out of Pocket for Drug EHB section of the Cost Share Variances tab.

Table 23: Health Cost Share Variances Tab - Maximum Out of Pocket for Drug EHB Section Fields

Field Name	Description	Field Values
In Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Maximum Out of Pocket for Drug EHB Benefits In Network Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Individual	The Maximum Out of Pocket for Drug EHB Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Maximum Out of Pocket for Drug EHB Benefits In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
Out of Network - Family	The Maximum Out of Pocket for Drug EHB Benefits Out of Network Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Maximum Out of Pocket for Drug EHB Benefits Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 24 describes the fields in the Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) section of the Cost Share Variances tab.

Table 24: Health Cost Share Variances Tab - Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Section Fields

Field Name	Description	Field Values
In Network - Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network - Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Out of Network Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 25 describes the fields in the Medical EHB Deductible section of the Cost Share Variances tab.

Table 25: Health Cost Share Variances Tab - Medical EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Medical EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Medical EHB Deductible - In Network - Family dollar amount.	Dropdown: $X Not Applicable
Medical EHB Default Coinsurance In Network (Tier 1)	The Medical EHB default Coinsurance for In Network Tier 1.	Percentage
In Network Tier 2 - Individual	The Medical EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Medical EHB Deductible - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Medical EHB Default Coinsurance In Network (Tier 2)	The Medical EHB Default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Medical EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Medical EHB Deductible - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Medical EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Medical EHB Deductible - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 26 describes the fields in the Drug EHB Deductible section of the Cost Share Variances tab.

Table 26: Health Cost Share Variances Tab - Drug EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Drug EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Drug EHB Deductible - In Network - Family dollar amount.	Dropdown: $X Not Applicable
Drug EHB Default Coinsurance In Network (Tier 1)	The Drug EHB default Coinsurance for In Network Tier 1.	Percentage

Field Name	Description	Field Values
In Network Tier 2 - Individual	The Drug EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Drug EHB Deductible - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Drug EHB Default Coinsurance In Network (Tier 2)	The Drug EHB default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Drug EHB Deductible - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 27 describes the fields in the Combined Medical and Drug EHB Deductible section of the Cost Share Variances tab.

Table 27: Health Cost Share Variances Tab - Combined Medical and Drug EHB Deductible Section Fields

Field Name	Description	Field Values
In Network - Individual	The Combined Medical and Drug EHB Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Combined Medical and Drug EHB Deductible - In Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined Medical and Drug EHB Default Coinsurance In Network (Tier 1)	The Combined Medical and Drug EHB default Coinsurance for In Network.	Percentage
In Network Tier 2 - Individual	The Combined Medical and Drug EHB Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Combined Medical and Drug EHB Deductible - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
Combined Medical and Drug EHB Default Coinsurance In Network (Tier 2)	The Combined Medical Drug EHB Default Coinsurance for In Network Tier 2.	Percentage
Out of Network - Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Combined Medical Drug EHB Deductible - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Combined Medical Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 28 describes the fields in the URL's section of the Benefits Package tab.

Table 28: Health Cost Share Variances Tab - URLs Section Fields

Field Name	Description	Field Values
URL for Summary of Benefits & Coverage	URL that provides a link to the Summary of Benefits and Coverage document that is required to be posted on the plan's website.	Alphanumeric (including special characters)
Plan Brochure	Plan Brochure URL.	Alphanumeric (including special characters)

Table 29 describes the fields in the HSA/HRA Detail section of the Cost Share Variances tab.

Table 29: Health Cost Share Variances Tab - HSA/HRA Details

Field Name	Description	Field Values
HSA - Eligible	Indicates if this plan meets all the requirements to be a Health Savings Account (HSA)-qualified high deductible health plan.	Dropdown: Yes No (default)
HSA/HRA Employer Contribution	Indicates if this plan has a HSA/HRA employer contribution. Applies to small group (SHOP) only.	Dropdown: Yes No
HSA/HRA Employer Contribution Amount	Dollar amount of HSA/HRA employer contribution. Applies to small group (SHOP) only.	Whole Dollar Amount

Table 30 describes the fields in the Other Deductible (User Defined) section of the Cost Share Variances tab.

Table 30: Health Cost Share Variances Tab - Other Deductible (User Defined) Section Fields

Field Name	Description	Field Values
In Network - Individual	Other Deductible (user defined) - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	Other Deductible (user defined) - In Network - Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Individual	Other Deductible (user defined) - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	Other Deductible (user defined) - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network - Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	Other Deductible (user defined) - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	Other Deductible (user defined) - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	Other Deductible (user defined) - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 31 describes the fields in the Each Covered Benefit section of the Cost Share Variances tab.

Table 31: Health Cost Share Variances Tab - Each Covered Benefit Section Fields

Field Name	Description	Field Values
Copay - In Network (Tier 1)	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay before deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Day $X Copay per Stay $X Copay Per Stay $X Copay Per Stay before deductible $X Copay Per Stay after deductible $X Copay Per Stay per day $X Copay Per Stay per day before deductible $X Copay Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Field Name	Description	Field Values
Copay - In Network (Tier 2)	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay before deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Stay $X Copay Per Stay before deductible $X Copay Per Stay after deductible $X Copay Per Stay per day $X Copay Per Stay per day before deductible $X Copay Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Field Name	Description	Field Values
Copay - Out of Network	Type of copayment and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible $X $X Copay after deductible $X Copay before deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Copay per Stay $X Copay Per Stay before deductible $X Copay Per Stay after deductible $X Copay Per Stay per day $X Copay Per Stay per day before deductible $X Copay Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Field Name	Description	Field Values
Coinsurance - In Network (Tier 1)	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% Coinsurance after deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Coinsurance per Stay $X Coinsurance Per Stay before deductible $X Coinsurance Per Stay after deductible $X Coinsurance Per Stay per day $X Coinsurance Per Stay per day before deductible $X Coinsurance Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Field Name	Description	Field Values
Coinsurance - In Network (Tier 2)	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% Coinsurance after deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Coinsurance per Stay $X Coinsurance Per Stay before deductible $X Coinsurance Per Stay after deductible $X Coinsurance Per Stay per day $X Coinsurance Per Stay per day before deductible $X Coinsurance Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Field Name	Description	Field Values
Coinsurance - Out of Network	Type of coinsurance and/or whether the benefit is subject to deductible.	Dropdown: No Charge No Charge after deductible X% Coinsurance after deductible Not Applicable NOTE: If the benefit is Skilled Nursing Facility or Inpatient Hospital, then the values below replace the default copayment options: $X Coinsurance per Stay $X Coinsurance Per Stay before deductible $X Coinsurance Per Stay after deductible $X Coinsurance Per Stay per day $X Coinsurance Per Stay per day before deductible $X Coinsurance Per Stay per day after deductible No Charge No Charge after deductible Not Applicable NOTE: For Mental/Behavioral Health Inpatient Services and Substance Abuse Disorder Inpatient Services, **all** of the options in both lists above will be available.

Figure 28 shows the SADP Benefits Package tab of the Plans & Benefits Template.

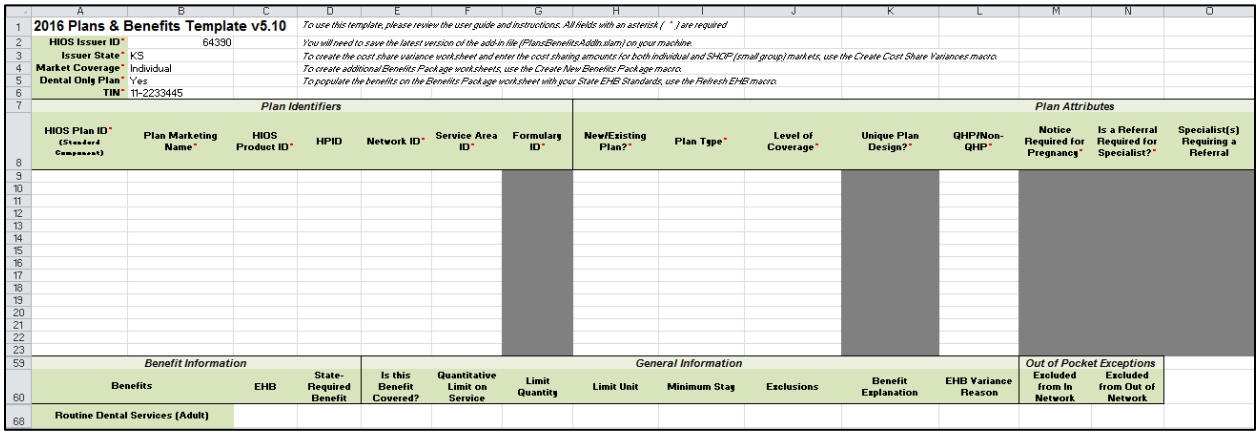


Figure 28: Plans & Benefits Template – SADP Benefits Package Tab

Table 32 describes the fields in the SADP Benefits Package tab of the Plans & Benefits template.

Table 32: Plans & Benefits Template – SADP Benefits Package Tab Fields

Field Name	Description	Field Values
HIOS Issuer ID	HIOS Issuer ID	Numeric
Issuer State	State Abbreviation	Dropdown: State Abbreviations + Territories
Market Coverage Type	Market coverage, individual or SHOP, for the entire benefit package/template.	Dropdown: SHOP (Small Group) Individual
Dental Only Plan	Indicator if the plans offered in this benefit package are for stand-alone dental only (not medical).	Dropdown: Yes No
TIN	Tax Identification Number	Numeric

Table 33 describes the fields in the Plan Identifiers section of the SADP Benefits Package tab.

Table 33: SADP Benefits Package Tab - Plan Identifiers Section Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component)	HIOS generated number assigned to a specific proposed QHP.	Alphanumeric
Plan Marketing Name	Name of each plan.	Alphanumeric (including special characters)
HIOS Product ID	The HIOS Product ID associated with each proposed Exchange plan.	Alphanumeric
HPID	Associated Health Plan Identifier.	Numeric
Network ID	The Network ID for this plan from the Network ID template.	Dropdown: List of values will be imported in from the Network Template by user
Service Area ID	The Service Area ID for this plan from the Service Area template.	Dropdown: List of values will be imported in from the Service Area Template by user

Table 34 describes the fields in the Plan Attributes section of the SADP Benefits Package tab.

Table 34: SADP Benefits Package Tab - Plan Attributes Section Fields

Field Name	Description	Field Values
New/Existing Plan	Indicates whether the plan is new or existing.	Dropdown: New Plan Existing Plan
Plan Type	Network design for the product: indemnity, preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO).	Dropdown: Indemnity PPO HMO POS EPO
Level of Coverage	Coverage level for a specific proposed plan (High, Low)	Dropdown: High Low
QHP/Non QHP	Indicator if the plan is offered on exchange, off exchange or on both.	Dropdown: On Exchange Off Exchange Both
Plan Level Exclusions	List all plan level exclusions.	Alphanumeric (including special characters)
Child-Only Offering	Indicates whether the plan is child-only.	Dropdown: Allows Adult and Child-Only Allows Child-Only
EHB Apportionment for Pediatric Dental	Dollar amount of monthly premium that is for EHB benefits only.	Whole Dollar Amount
Guaranteed vs. Estimated Rate	Indicates whether rate for this stand-alone dental plan is guaranteed or estimated.	Dropdown: Guaranteed Rate Estimated Rate

Table 35 describes the fields in the Plan Dates section of the SADP Benefits Package tab.

Table 35: SADP Benefits Package Tab - Plan Dates Section Fields

Field Name	Description	Field Values
Plan Effective Date	Effective date of the plan.	Date
Plan Expiration Date	Date that a plan becomes closed and no longer accepts new enrollments.	Date

Table 36 describes the fields in the Geographic Coverage section of the SADP Benefits Package tab.

Table 36: SADP Benefits Package Tab - Geographic Coverage Section Fields

Field Name	Description	Field Values
Out of Country Coverage	Indicates whether care obtained outside the country is covered under the plan.	Dropdown: Yes No
Out of Country Coverage Description	A short description of whether care obtained outside the country is covered under the plan.	Alphanumeric (including special characters)
Out of Service Area Coverage	Indicates whether care obtained outside the service area is covered under the plan.	Dropdown: Yes No
Out of Service Area Coverage Description	A short description of whether care obtained outside the service area is covered under the plan.	Alphanumeric (including special characters)
National Network	Indicates whether a national network is available.	Dropdown: Yes No

Table 37 describes the fields in the URL's section of the Benefits Package tab.

Table 37: SADP Benefits Package Tab - URLs Section Fields

Field Name	Description	Field Values
Enrollment URL	URL for the location on the plan website where the enrollee will effectuate payment.	Alphanumeric (including special characters)

Table 38 describes the fields in the Benefit Information section of the Benefits Package tab.

Table 38: SADP Benefits Package Tab - Benefit Information Section Fields

Field Name	Description	Field Values
Benefits	Name of the benefit.	N/A
EHB	Indicates if this benefit is an EHB benefit.	N/A
State Required Benefit	Indicates if this benefit is a state required benefit.	N/A

Table 39 describes the fields in the General Information section of the Benefits Package tab.

Table 39: SADP Benefits Package Tab - General Information Section Fields

Field Name	Description	Field Values
Is this Benefit Covered?	Indicates if this benefit is covered or not covered.	Dropdown: Covered Not Covered (or blank)
Quantitative Limit on Service	Indicates if there are quantitative limits on this benefit.	Dropdown: Yes No (or blank)

Field Name	Description	Field Values
Limit Quantity	Indicates any quantitative limits on the benefit (e.g., number of days or visit limits).	Whole Number
Limit Unit	Indicates unit of those limits.	Popup: First Category Visit(s) Dollars Exam(s) Days Item(s) Months Treatment(s) Procedure(s) Hours Admission(s) Second Category Year Benefit Period Lifetime Month Episode Stay Transplant 6 Months 2 Years 3 Years Procedure Week Admission
Minimum Stay	Identifies the minimum stay, in hours, for this benefit.	Whole Number
Exclusions	Lists the exclusions if particular services or diagnoses are excluded from this plan.	Alphanumeric (including special characters)
Benefit Explanation (text Field)	Free text field to list any notes explaining this.	Alphanumeric (including special characters)
EHB Variance Reason	Reason that this benefit varies from EHB.	Dropdown: Above EHB Substituted Substantially Equal Using Alternate Benchmark Other Law/Regulation Additional EHB Benefit Dental Only Plan Available

Table 40 describes the fields in the Deductibles and Out of Pocket Exceptions section of the Benefits Package tab.

Table 40: SADP Benefits Package Tab - Deductibles and Out of Pocket Exceptions Section Fields

Field Name	Description	Field Values
Subject to Deductible (Tier 1)	Indicates if this benefit is subject to deductible for Tier 1.	Dropdown: Yes No
Subject to Deductible (Tier 2)	Indicates if this benefit is subject to deductible for Tier 2.	Dropdown: Yes No
Excluded from In Network MOOP	Indicates if this benefit is excluded from the in network maximum out of pocket.	Dropdown: Yes No
Excluded from Out of Network MOOP	Indicates if this benefit is excluded from the out of network maximum out of pocket?	Dropdown: Yes No

Figure 29 shows the Cost Share Variance tab of the SADP Plans & Benefits Template.

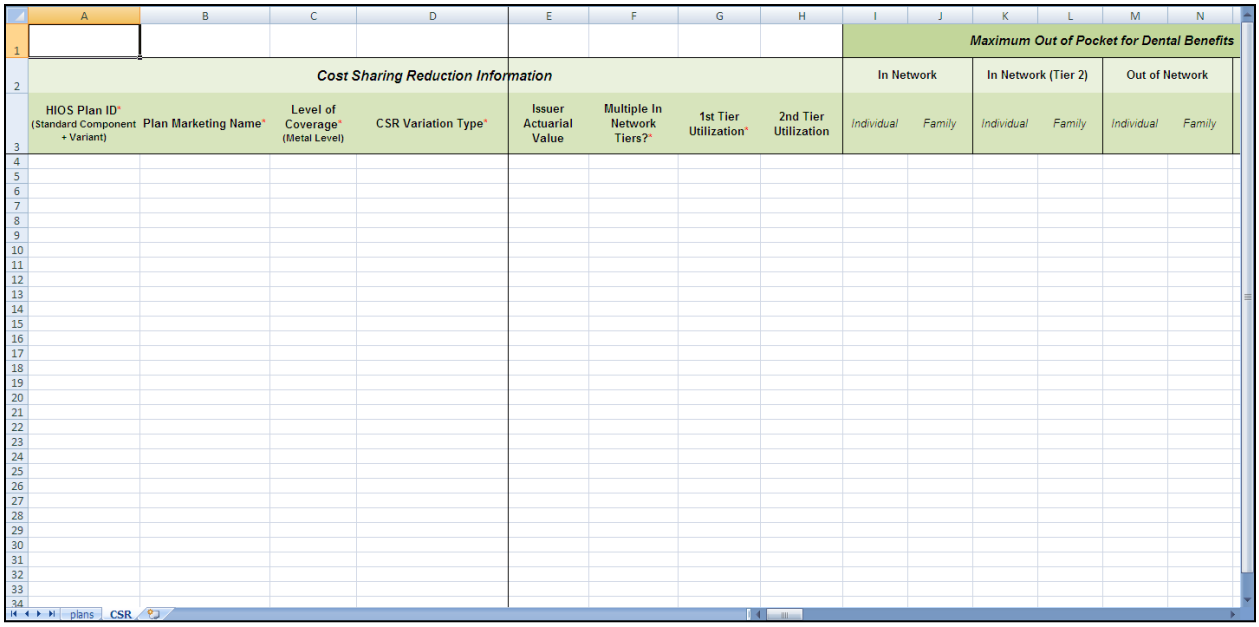


Figure 29: SADP Plan & Benefits Template – Cost Share Variance Tab

Table 41 describes the fields in the Cost Share Variances tab of the Plans & Benefits template.

Table 41: SADP Plans & Benefits Template - Cost Share Variances Tab Fields

Field Name	Description	Field Values
HIOS Plan ID (Standard Component + Variant)	HIOS generated unique Standard Component ID with suffixes automatically added depending on the plan variation.	Copied over from the Benefits Package sheet, with suffixes added.
Plan Marketing Name	Name of each plan.	Copied over from the Benefits Package sheet.
Level of Coverage (Metal Level)	Pre-populated with metal level from designated plan.	Copied over from the Benefits Package sheet.
CSR Variation Type	The Cost Share Reduction Variance level of the plan.	Auto-Populated (varies by proposed metal level): Standard On Exchange Standard Off Exchange
Issuer Actuarial Value	Issuer calculated Actuarial Value.	Percentage
Multiple In Network Tiers?	Indicates if this plan uses multiple in-network provider tiers.	Dropdown: Yes No
1st Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 1 for plans with multiple in network tiers.	Percentage
2nd Tier Utilization	Indicates the proportion of claims costs anticipated to be utilized in Tier 2 for plans with multiple in network tiers.	Percentage

Table 42 describes the fields in the Maximum Out of Pocket for Maximum Out of Pocket for Dental Benefits section of the Cost Share Variances tab.

Table 42: SADP Cost Share Variances Tab - Maximum Out of Pocket for Dental Benefits Section Fields

Field Name	Description	Field Values
In Network - Individual	The Maximum Out of Pocket for Maximum Out of Pocket for Dental Benefits In Network Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Maximum Out of Pocket for Dental Benefits In Network Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Individual	The Maximum Out of Pocket for Dental Benefits In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 - Family	The Maximum Out of Pocket for Dental Benefits In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable

Field Name	Description	Field Values
Out of Network - Individual	The Maximum Out of Pocket for Dental Benefits Out of Network Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network - Family	The Maximum Out of Pocket for Dental Benefits Out of Network Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Maximum Out of Pocket for Dental Benefits Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Maximum Out of Pocket for Dental Benefits Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 43: SADP Cost Share Variances Tab – Dental Benefit Deductible Section Fields

Field Name	Description	Field Values
In Network – Individual	The Dental Benefit Deductible - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	The Dental Benefit Deductible - In Network - Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 – Individual	The Dental Benefit Deductible - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 – Family	The Dental Benefit Deductible - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network – Individual	The Dental Benefit - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network – Family	The Combined Medical Drug EHB Deductible - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	The Combined Medical Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

Table 44: SADP Cost Share Variances Tab - URLs Section Fields

Field Name	Description	Field Values
URL for Summary of Benefits & Coverage	URL that provides a link to the Summary of Benefits and Coverage document that is required to be posted on the plan's website.	Alphanumeric (including special characters)
Plan Brochure	Plan Brochure URL.	Alphanumeric (including special characters)

Table 45: SADP Cost Share Variances Tab - Other Deductible (User Defined) Section Fields

Field Name	Description	Field Values
In Network – Individual	Other Deductible (user defined) - In Network - Individual dollar amount.	Dropdown: $X Not Applicable
In Network - Family	Other Deductible (user defined) - In Network - Family dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 – Individual	Other Deductible (user defined) - In Network Tier 2 - Individual dollar amount.	Dropdown: $X Not Applicable
In Network Tier 2 – Family	Other Deductible (user defined) - In Network Tier 2 - Family dollar amount.	Dropdown: $X Not Applicable
Out of Network – Individual	The Combined Medical Drug EHB Deductible - Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Out of Network – Family	Other Deductible (user defined) - Out of Network - Family dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Individual	Other Deductible (user defined) - Combined In/Out of Network - Individual dollar amount.	Dropdown: $X Not Applicable
Combined In/Out of Network - Family	Other Deductible (user defined) - Combined In/Out of Network - Family dollar amount.	Dropdown: $X Not Applicable

7 Template Error Reports

The Benefits & Service Area module may produce "Failed" reports for any of the four templates, if the templates do not pass back-end validation. You must download the report(s) and correct the errors listed in the report(s) before you can successfully re-submit the template.

NOTE: The error reports displayed below are samples. They are not comprehensive lists of all the possible errors you may receive.

7.1 Network Template Failed Report

Figure 30 shows a sample Network Template Failed Report.

	A
1	HIOS Issuer ID 1234 - Invalid HIOS Issuer ID (Networks - B6)
2	Issuer State MD - Invalid Issuer State (Networks - B7)
3	Network Name - Invalid Network Name value (Networks - A13)
4	Network ID NDD001 - Invalid Network ID (Networks - B13)
5	Network URL ww.networkID1 - Invalid Network URL (Networks - C13)

Figure 30: Network Template Failed Report

7.2 Service Area Template Failed Report

Figure 31 shows a sample Service Area Template Failed Report.

	A
1	HIOS Issuer ID 12345 - Invalid HIOS Issuer ID (Service Areas - B6)
2	Issuer State MD - Invalid Issuer State (Service Areas - B7)
3	County Name Fairfax - Invalid County Name (Service Areas - D13)
4	Service Area Zip Codes 21021 - Invalid Service Area Zip (Service Areas - F13)
5	Service Area ID MDS001 - Invalid Service Area ID (Service Areas - A13)
6	Service Area Name - Invalid value for Service Area Name (Service Areas - B13)
7	State YA - Invalid value for State (Service Areas - C13)
8	Partial County Yes. - Invalid value for Partial County Coverage (Service Areas - E13)
9	Partial County Justification - Invalid value for Partial County Justification (Service Areas - G13)

Figure 31: Service Area Template Failed Report

7.3 Prescription Drug Template Failed Report

Figure 32 shows a sample Prescription Drug Template Failed Report.

	B
1	Issuer ID 1234 - Invalid Issuer ID (Formulary Tiers - B6)
2	Issuer State VA - Invalid State (Formulary Tiers - B7)
3	Formulary ID AKF009 - Invalid Formulary ID (Formulary Tiers - A13)
4	Drug List ID - Invalid value for Drug List ID (Formulary Tiers - C13)
5	Number of Tiers 8 - Invalid value for Number of Tiers (Formulary Tiers - D13)
6	Drug Tier ID 8 - Invalid, Drug Tier ID must be 1,2,3,4,5,6, or 7 in sequential order (Formulary Tiers - E13)
7	Drug Tier Type - Invalid Drug Tier Type (Formulary Tiers - F13)
8	Copayment 20.99 - Invalid value for Copayment (Formulary Tiers - H13)
9	Coinsurance 10.5% - Invalid value for Coinsurance (Formulary Tiers - I13)
10	Copayment 9.99 - Invalid value for Copayment (Formulary Tiers L13)
11	Coinsurance 15.50% - Invalid value for Coinsurance (Formulary Tiers - M13)
12	Copayment 9.99 - Invalid value for Copayment (Formulary Tiers P13)
13	Coinsurance 20% - Invalid value for Coinsurance (Formulary Tiers - Q13)
14	Copayment 9.99 - Invalid value for Copayment (Formulary Tiers - T13)
15	Coinsurance 15.50% - Invalid value for Coinsurance (Formulary Tiers - U13)
16	RxCUI 123456789 - Invalid value for RxCUI (Drugs Lists - A9)
17	Tier Level - Invalid value for Tier Level (Drug Lists - B9)
18	Prior Authorization Required - Invalid value for Prior Authorization Drug Lists - C9)
19	Step Therapy Required - Invalid value for Step Therapy (Drug Lists - D9)

Figure 32: Prescription Drug Template Failed Report

7.4 Plans & Benefits Template Failed Report

Figure 33 shows a sample Plans & Benefits Template Failed Report.

	A
1	HIOS Issuer ID A123X5 - Invalid HIOS Issuer ID (Benefits Package - B2)
2	Issuer State VX - Invalid state (Benefits Package - B3)
3	Market Coverage Type Shop - Invalid Market Coverage Type (Benefits Package - B4)
4	Dental Only Plan Indicator - Invalid value for Dental Only Plan Indicator (Benefits Package - B5)
5	TIN A1239T78 - Invalid TIN (Benefits Package - B6)
6	Plan Marketing Name - Invalid Plan Marketing Name (Benefits Package - B9)
7	HPID AX123654789 - Invalid HPID (Benefits Package - D9)
8	Network ID VAN000 - Invalid Network ID (Benefits Package - E9)
9	Service Area ID VAS000 - Invalid Service Area ID (Benefits Package - F9)
10	Formulary ID VAF000 - Invalid Formulary ID (Benefits Package - G9)
11	New/Existing Plan - Invalid value for New/Existing Plan (Benefits Package - H9)
12	Plan Type PPS - Invalid Plan Type (Benefits Package - I9)
13	Metal Level Gold - Invalid Metal Level (Benefits Package - J9)
14	HSA/HRA Employer Contribution Yes - Invalid value for HSA/HRA Employer Contribution (Benefits Package - S9)
15	Child Only Plan ID 12345VA0019999 - Invalid value for Child Only Plan ID (Benefits Package - V9)
16	EHB Apportionment for Pediatric Dental 10% - Invalid value for EHB Apportionment for Pediatric Dental (Benefits Package - Y9)
17	Guaranteed vs. Estimated Rate YES - Invalid value for Guaranteed vs. Estimated Rate (Benefits Package - Z9)
18	Maximum Coinsurance for Specialty Drugs o - Invalid value for Maximum Coinsurance for Specialty Drugs (Benefits Package - AA9)
19	Plan Effective Date 3/1/2013 - Invalid Plan Effective Date (Benefits Package - AE9)
20	Plan Expiration Date 11/22/2013- Invalid Plan Expiration Date (Benefits Package - AF9)
21	Limit Quantity 9.5- Invalid value for Limit Quantity (Benefits Package - G26)
22	Limit Unit - Invalid value for Limit Unit (Benefits Package - H26)
23	Minimum Stay 2.5 - Invalid value for Minimum Stay (Benefits Package - I26)
24	Metal Level Gold - Invalid Metal Level (Cost Share Variances - C4)

Figure 33: Plans & Benefits Template Failed Report

8 Troubleshooting and Support

8.1 Error Messages

Table 46 provides a list of error messages in the Benefits Module of the Plan Management system.

Table 46: Plan Management System Error Messages

Error Message	Corrective Action
The username or password is incorrect.	Input the correct login credentials and click Sign In.
This username has been locked-out. Contact your HIOS Admin to unlock your account.	Contact HIOS to have the account unlocked.
Error: An application currently exists for this Issuer.	Select the Issuer from the Resume Existing Submission table on the Submitter Summary page.
Please correct the following errors.	Upload the required templates listed out in the error message on the Submitter Benefits & Service Area page.
The validation for this section is incomplete. Please answer the validation question.	Answer the validation question by selecting Yes or No and then clicking Submit, on the Validator Benefits & Service Area page.
There were errors identified during cross-validation between the templates. Please download the error report below for details.	Validators are responsible for coordinating with users from other modules to resolve discrepancies within the application.
Invalid Template version uploaded. Please upload the current template version. Check with the CMS helpdesk for directions on how to access the correct versions of the templates.	The user will receive this error message when uploading an invalid template year version.

8.2 Support

Table 47 provides a list of contacts.

Table 47: Points of Contact

Contact	Organization	Phone	Email	Role	Responsibility
Exchange Operation Support Desk (XOSC)	CMS	855-CMS-1515 (855-267-1515)	CMS_FEPS@cms.hhs.gov	Help desk support	1st level user support & problem reporting

9 Glossary

Term/Phrase	Definition
Issuer	A participating insurance organization that provides insurance for an individual or family.
User	An individual who accesses the application. A user of the Benefits & Service Area module will be a Submitter or Validator. A user's access is controlled by assigned roles and entitlements (responsibilities).

10 Acronyms and Abbreviations

Acronym / Abbreviation	Definition
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare & Medicaid Services
CSR	Cost Sharing Reduction Variance
EHB	Essential Health Benefit
FFM	Federally-Facilitated Marketplace
HSA	Health Savings Account
HHS	Health and Human Services
HIOS	Health Insurance Oversight System
HMO	Health Maintenance Organization
HPID	Health Plan Identifier
HRA	Health Reimbursement Account
NIH	National Institute of Health
POS	Point-of-Service Plan
PPO	Preferred Provider Organization
MOOP	Maximum Out Of Pocket
QHP	Qualified Health Plan
RxCUI	RxNorm Concept Unique Identifier (US NIH; drug standardization)
RSA	Retirement Savings Account
SADP	Stand-Alone Dental Plan
SHOP	Small Business Health Options Program
URL	Uniform Resource Locator

Appendix A: Enabling Macros in Microsoft Excel 2007-2010

In order to properly view and use the Excel templates for the QHP Application, macros need to be enabled. It is recommended that the user enable macros before downloading any templates.

1. From the Office button in the top left corner (refer to Figure 34), choose ***Excel Options***.

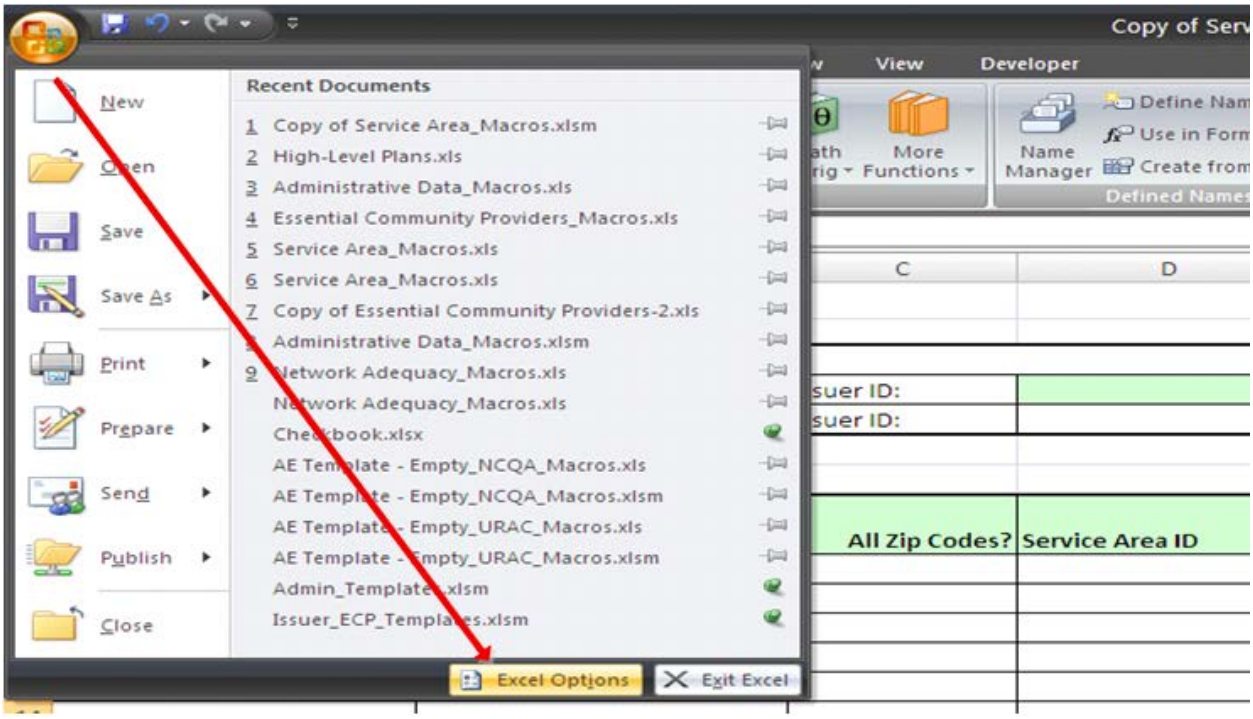


Figure 34: Choosing Excel Options

2. From Excel Options (refer to Figure 35), Choose “Trust Center”

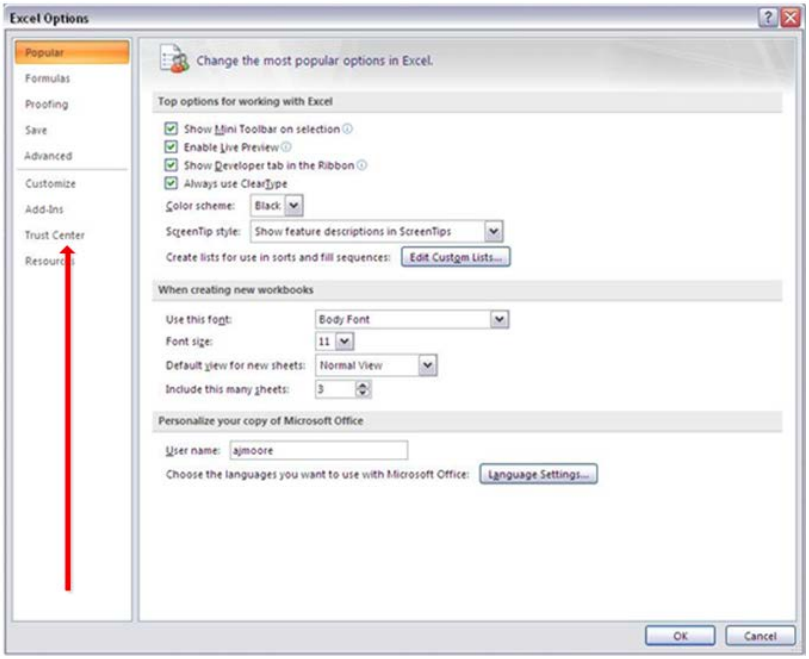


Figure 35: Choosing Trust Center

3. Choose “Trust Center Settings” (refer to Figure 36),

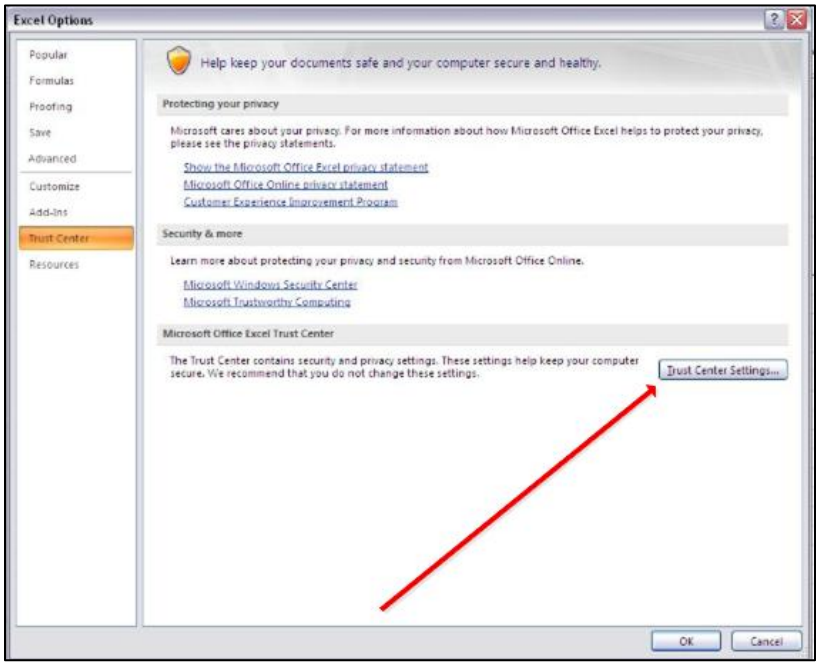


Figure 36: Choosing Trust Center Settings

4. Choose “Macro Settings” (refer to Figure 37),

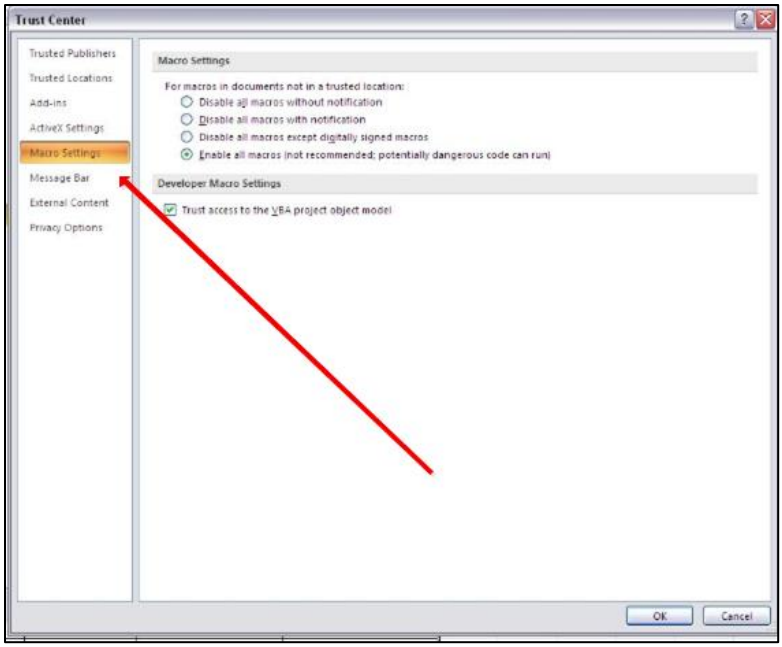


Figure 37: Choosing Macro Settings

5. Choose “Disable all macros with notification” (refer to Figure 38),

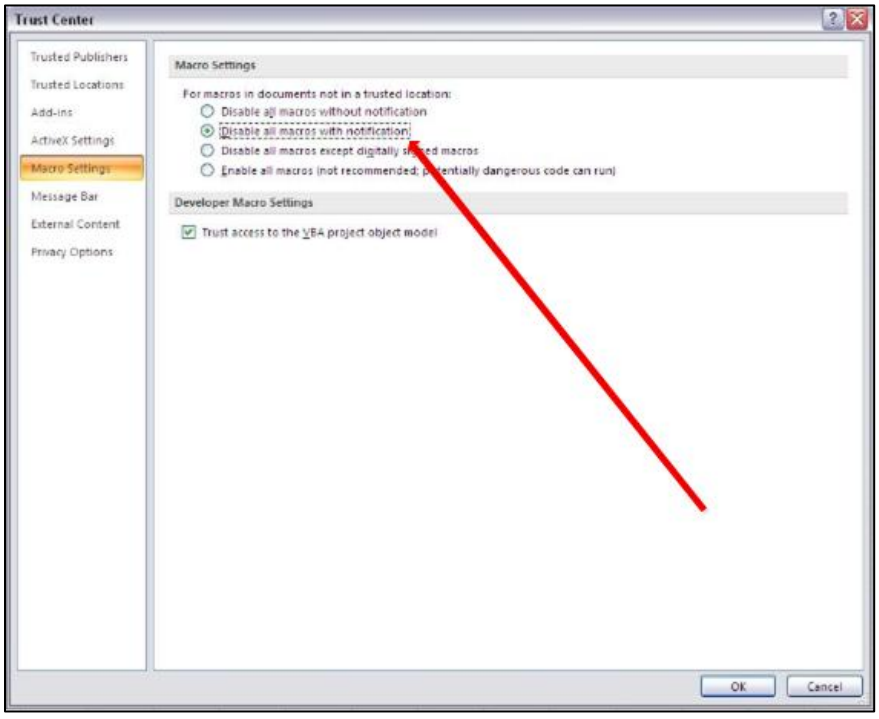


Figure 38: Choosing Disable all macros with notification

6. When opening any of the templates downloaded from the site, you see the following prompt at the top of the spreadsheet (refer to Figure 39). Click “Options…”

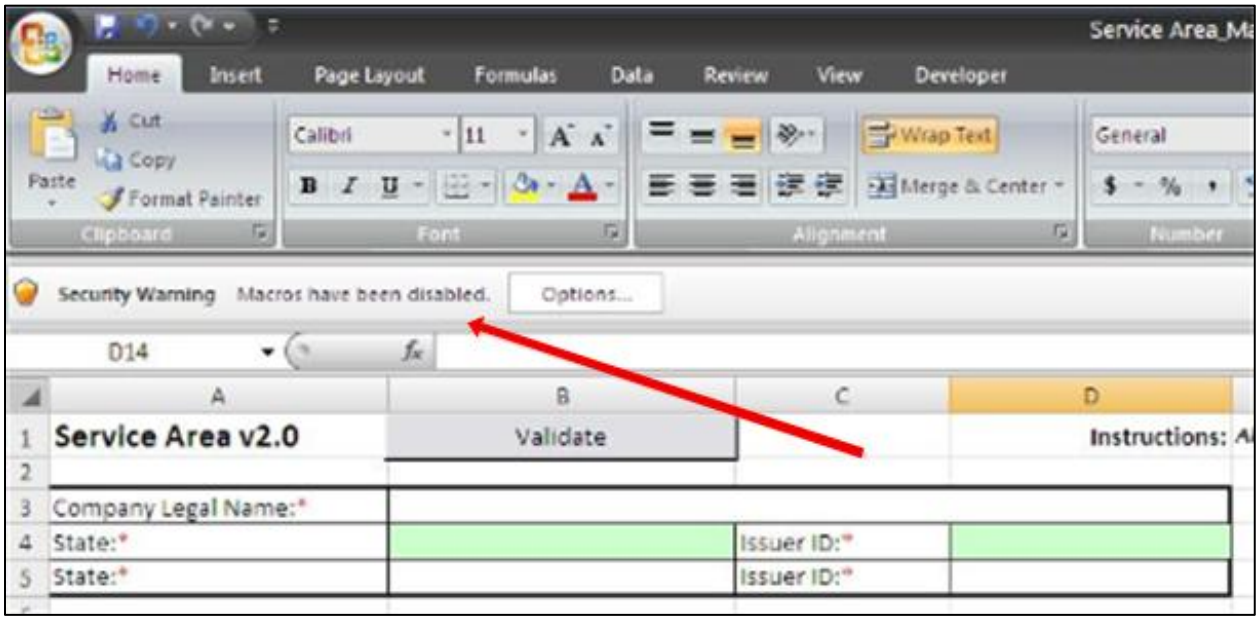


Figure 39: Security Warning on Downloaded Template

7. Choose “Enable this content” (refer to Figure 40),

Figure 40: Choosing Enable this content

8. Macros are now enabled for the open workbook. Repeat steps 6 & 7 every time a new template is downloaded.

Appendix B: Enabling the Plans & Benefits Add-in file in Excel 2007-2010

In order to properly view and use the Plans & Benefits template for the Benefits & Service Area Module, the Plans & Benefits Add-in file needs to be enabled. It is critical that the user delete any previous versions of the add-in file from their computer (unless explicitly following the guidelines in Appendix C for multi-year template versions), and download and save the most recent version of the add-in file in the same folder as the Plans & Benefits template.

Once all prior versions of the add-in file have been deleted from your computer and the most current version of the add-in file has been saved, open the Plans & Benefits template.

1. From the File menu shown in Figure 41, click ***Options***.

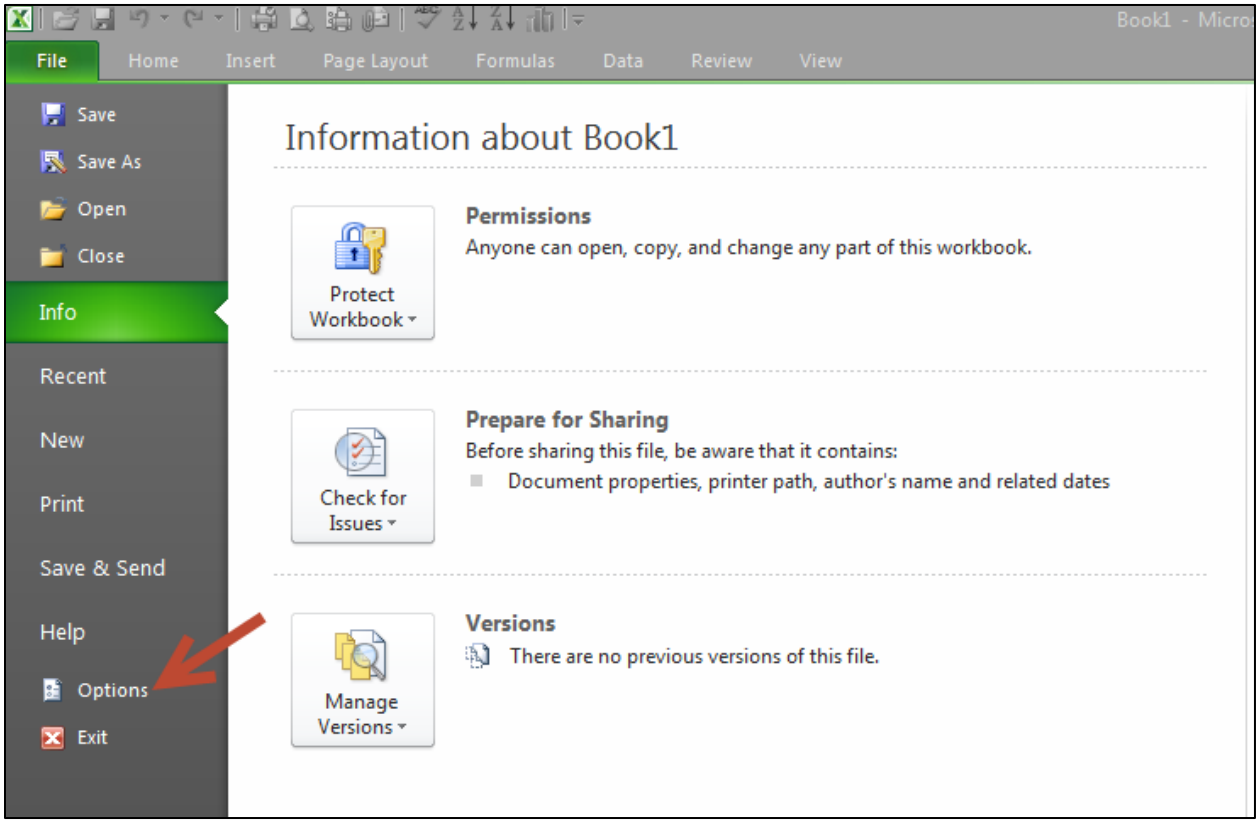


Figure 41: Selecting Excel Options

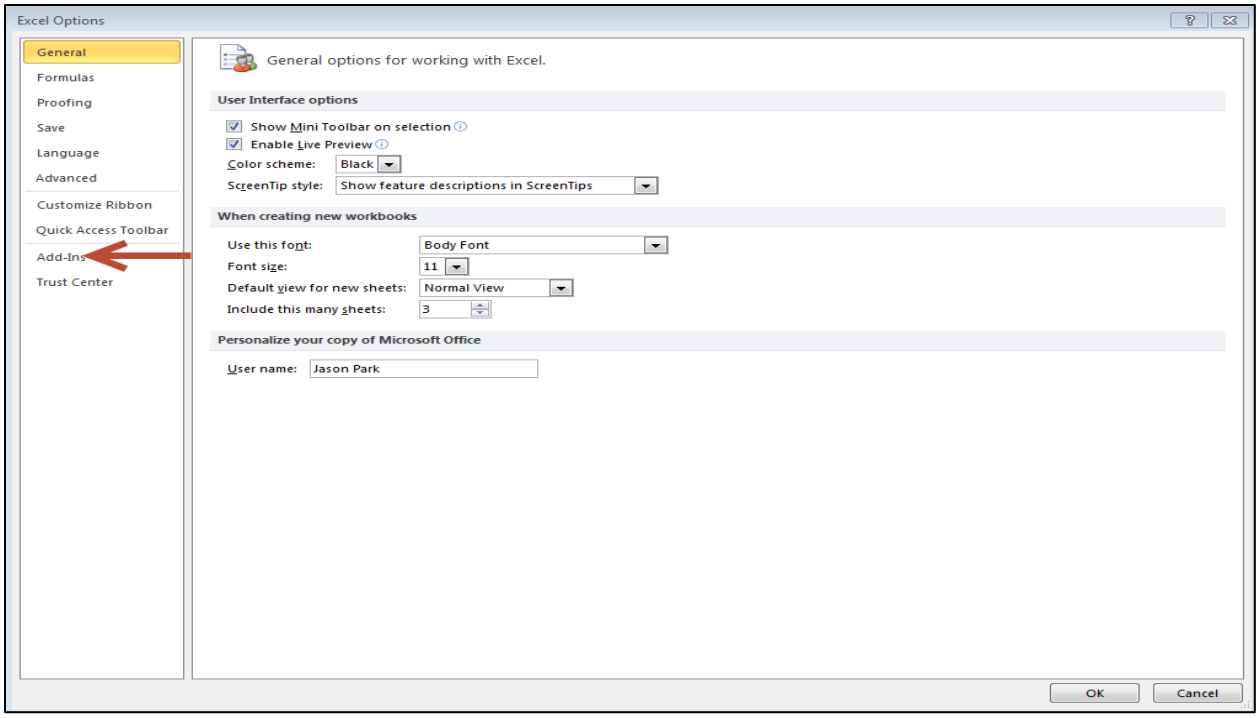


Figure 42: Selecting Add-Ins

2. Select Excel Add-ins and click ***Go*** (refer to Figure 43).

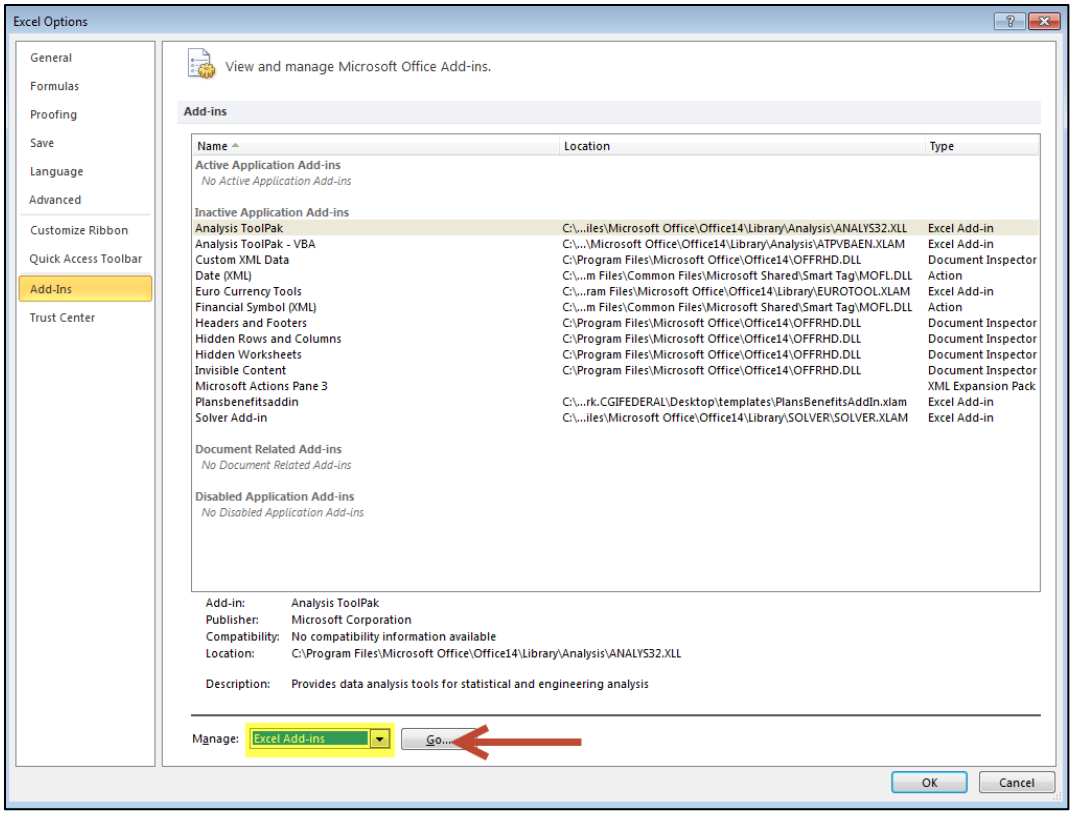


Figure 43: Manage Excel Add-Ins

3. From the Add-Ins popup, click ***Browse*** (refer to Figure 44).

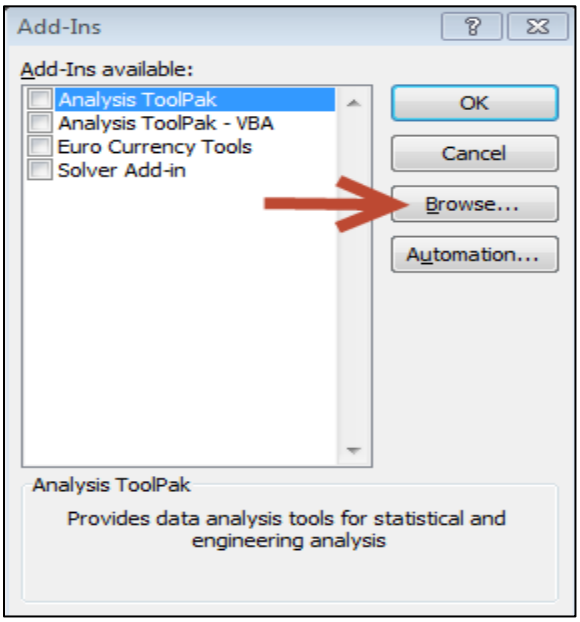


Figure 44: Browse for Add-In File

4. From the file dialog box, find the add-in file on your machine and click ***OK*** (refer to Figure 45).

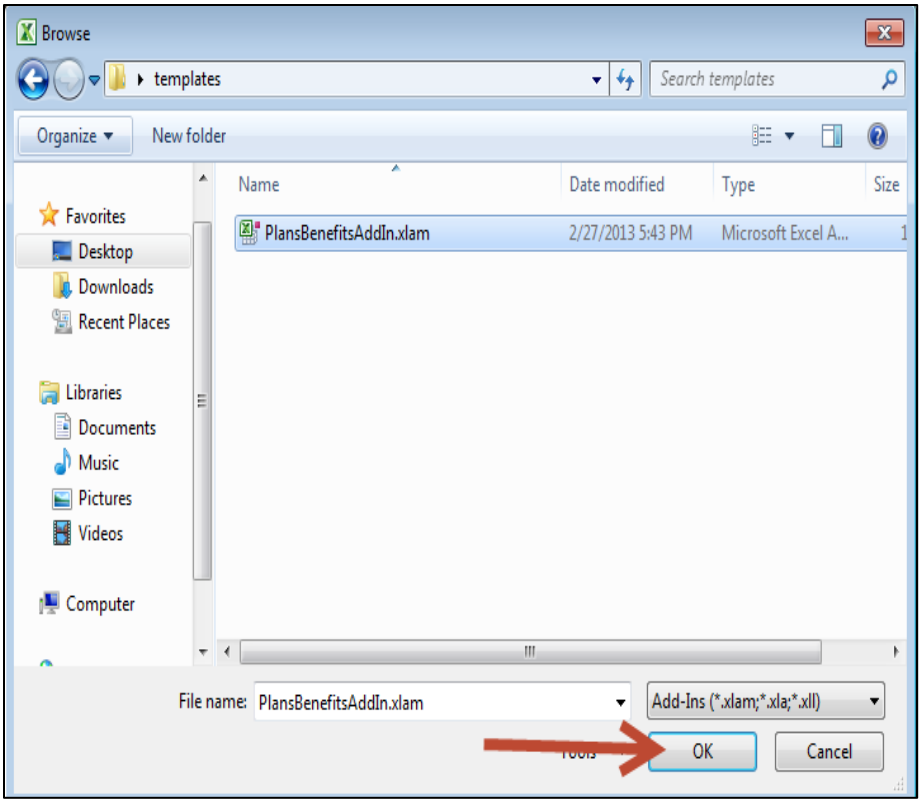


Figure 45: Select Add-In File

5. The add-in file is now available. Select ***OK*** (refer to Figure 46).

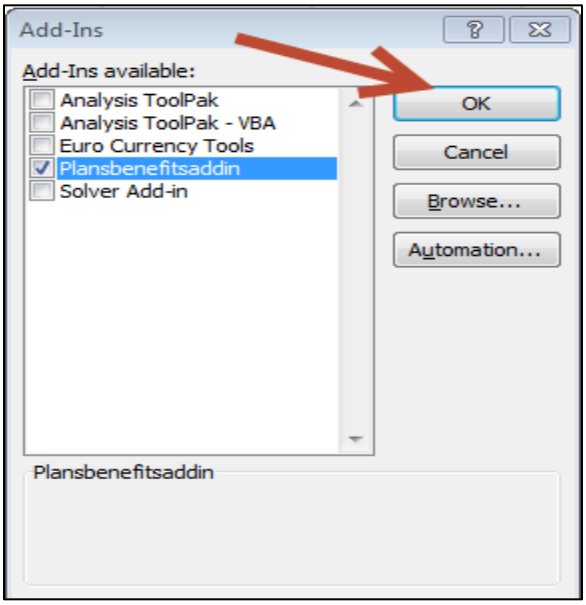


Figure 46: Add-In File Now Available

Appendix C: Working With Dual Template Versions

Issuers may need to work with multiple Plans & Benefits template versions to complete filing requirements. For example:

- Issuers submitting Off-Exchange insurance plans must submit Plans and Benefits data through RBIS.
  - RBIS will only accept the Plans and Benefits V1.32 template, which is only compatible with the V1.34 Plans and Benefits Add In.
- Issuers submitting On-Exchange insurance plans must be submitted through the FFM. The FFM will only accept the Plans and Benefits V5.12 template which is only compatible with the V512 Plans and Benefits Add In.

The steps here describe submission of both data sets with minimal complications for Issuers.

General Guidelines:

- **Add-in File:** It is vitally important to **NOT** rename the PlansBenefitsAddIn File. The Add-in File will not work if it is renamed.
- **Location:** Save the PlansBenefitsAddIn file in the same folder as the Plans & Benefits template in order for the macros to run properly. To ensure proper functionality, please download the latest Plans & Benefits Add-In file and AV Calculator into a **separate** folder than any other versions of these tools.
- When working with the Plans & Benefits Template and associated Add-in File, it is very important to close ALL open excel documents. If ANY excel documents are left open, the last used PlansBenefitsAddIn will be incorrectly loaded.
- Furthermore, Excel caches the last add-in file you selected, so the correct add-in file needs to be re-loaded whenever you switch back and forth between the two templates, instructions found in Appendix B.

Detailed Steps:

1. Create two folders on local machine:
   - Plan Year 2015
   - Plan Year 2016
2. Move all downloaded tools related to older Plan Years into the appropriate folder.
   - Plans & Benefits Template V1.32
   - PlansBenefitsAddIn File V1.32
   - Once validated, these versions can be uploaded to RBIS.
3. Download all Plan Year 2016 tools into the appropriate folder.
   - Plans & Benefits Template V5.12
   - PlansBenefitsAddIn File V5.12
   - Once validated, these versions can be uploaded to HIOS.

Once appropriately linked, the corresponding Add-In File version will display on the associated template. See screenshots below.

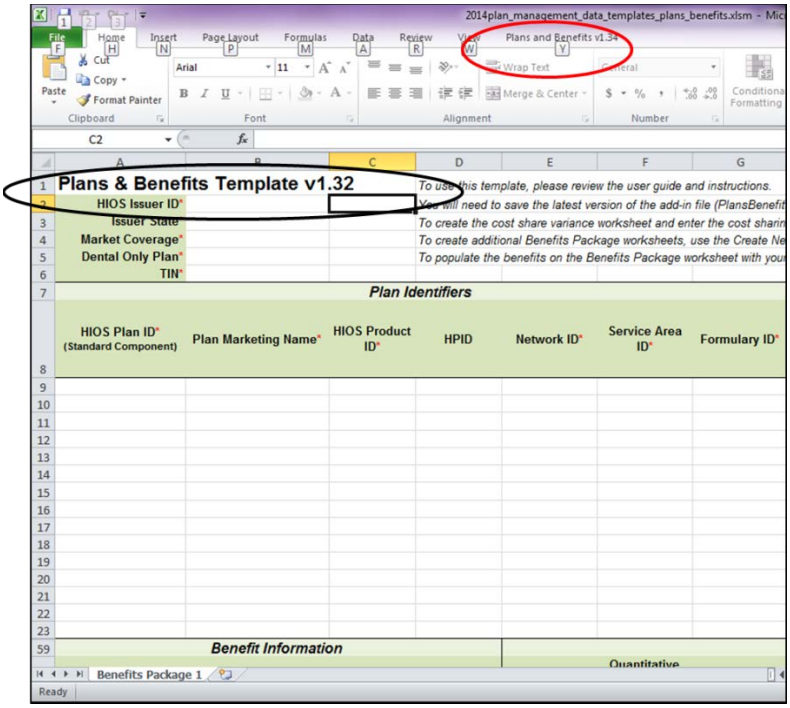


Figure 47: Plans & Benefits 2014 v1.32 Template & Add-In correctly associated

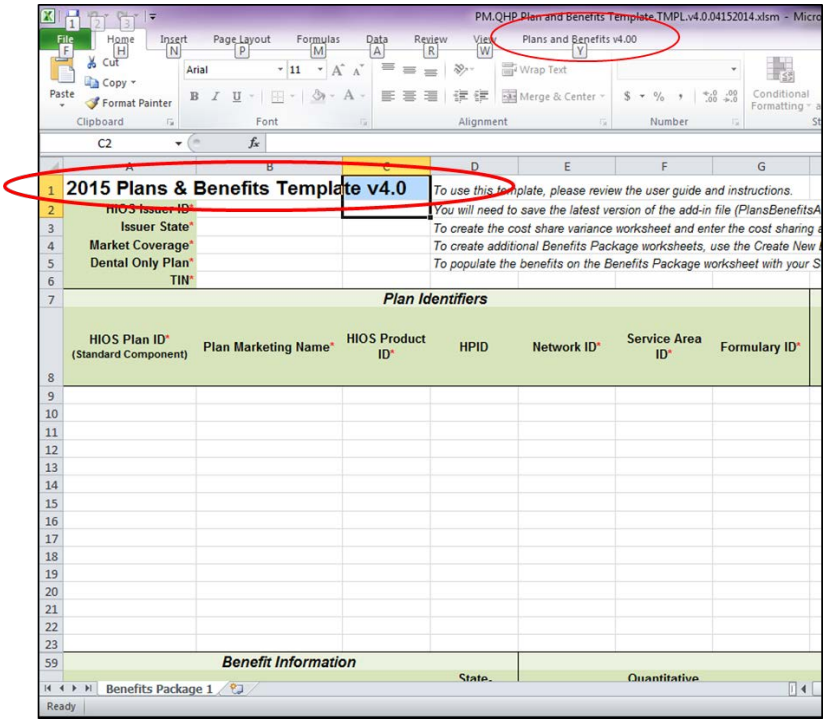


Figure 48: Plans & Benefits 2015 v4.0 Template & Add-In correctly associated