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FFM Plan Management
Plan Preview 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
9.0	04/22/2016	Accenture / Plan Management	Development for 2016 Plan Management Templates & System Functionality
9.1	05/11/2016	Accenture / Plan Management	Development for 2016 Plan Management Templates & System Functionality
10.0	04/08/2017	Accenture / Plan Management	Development for 2017 Plan Management Templates & System Functionality

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1 Introduction

This user guide provides instructions for Centers for Medicare and Medicaid Services (CMS) users and issuers to use the Plan Preview module in HIOS. Only users with appropriate permissions may access the Plan Preview module.

The Plan Management Plan Preview module allows issuers, states, and the Department of Health and Human Services (HHS) to view issuer and plan data that were submitted to the Centers for Medicare & Medicaid Services (CMS) and validate that this information is accurate.

This User Guide applies to the 2017 Plan Preview module. The 2017 Plan Preview system can be used to view only Plan Year 2017 plans and cannot be used to view Plan Year 2016 plans. To view Plan Year 2016 plans, please use the 2016 version of Plan Preview.

2 Referenced Documents

The Center for Consumer Information and Insurance Oversight (CCIIO) provides additional information detailing policies for submitting and reviewing Qualified Health Plans (QHPs) on the CCIIO webpage. Further instructions and guidance are posted on the CMS zONE portal and CCIIO webpage.

3 Overview

The Plan Management business area consists of processes for collecting Rates, Benefits, Service Areas, Provider Networks, and Prescription Drugs data from issuers planning to offer plans on the Marketplace. The data is collected via:

- User interfaces and services for issuers to submit, review, and modify information.
- Data submission templates (MS Excel-based) that allow issuers to download, populate, validate, and upload data into the Plan Management system.

The Plan Management application design is built on a scalable, n-Tiered environment running on the CMS cloud environment and uses 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 Plan Preview module.

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

NOTE: The term “user” is used throughout this document to refer to a person who requires or has acquired access to the Plan Preview module.

4 Getting Started

This section provides information about 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 11 (latest version available for Windows 7 and Windows 8 as of February, 2016)
   - Firefox 41.0.2

4.2 User Access Considerations

Users of the Plan Preview module are assigned one of the following user roles:

- **Issuer Submitter and Issuer Validator**

  You may use the Plan Preview module if you were assigned the role of **Issuer Submitter** or **Issuer Validator** in any of the three HIOS QHP modules (Issuer, Rating and Benefits and Service Area Modules). You can use the module to view your associated issuers' QHP applications and review plans as they would appear to sample enrollment groups.

- **State Reviewer**

  You may use the Plan Preview module if you were assigned the role of **State Reviewer** in the FFM State Evaluation Module. You can use the module to view issuers' QHP applications and review plans as they would appear to sample enrollment groups.

4.3 Accessing the System

All Federally-Facilitated Marketplace (FFM) users require a CMS Enterprise Portal ID and Health Insurance Oversight System (HIOS) user role to access the system.

4.4 System Organization and Navigation

The Plan Preview Module allows issuers and state reviewers to enter sample rating scenarios and view details and rates for associated Individual Market and Small Group (SHOP) plans.

The web-based application displays plans that were cross-validated in the QHP Application modules or submitted via the System for Electronic Rate and Form Filing (SERFF). You can select the Market Type radio button to either view ***Individual Market*** or ***Small Group (SHOP)*** plans.

If you select the ***Individual*** radio button, you may enter the following demographic information (required fields denoted by asterisk):

- Effective date of coverage*
- Cost-sharing reduction (CSR) variant*
- Return Catastrophic Plans checkbox
- Primary subscriber birthdate*, gender, and tobacco use
- Primary subscriber Zip Code* and county combination*
- If applicable: Dependent birthdate*, gender, tobacco use, relationship*, and residence*

If you select the ***Small Group (SHOP)*** radio button, you may enter the following demographic information (required fields denoted by asterisk):

- Effective date of coverage*
- Primary subscriber birthdate*, gender, and tobacco use
- Employer Zip Code* and county combination*
- If applicable: Dependent birthdate*, gender, tobacco use, and relationship*

After you create a rating scenario, the system will display all available and unavailable plans for your enrollment group. You can preview a list of available and unavailable plans or click to select a specific plan and view its specific rates and benefits.

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

5.1 Plan Preview Module

The Plan Preview module is divided into three main pages: the Summary Page, The Rating Scenario Page and the Plan Details Page for both Individual and Small Group (SHOP) users.

- Summary Page: This is the first page of the Plan Preview module, where you select the issuer whose plans you will view. If you are a State Reviewer with access to issuers in multiple states, you first select the state, and then the issuer whose plans you will view.
- Rating Scenario Page: On this page, you create a sample enrollment group and view available and unavailable plans based on the consumer rating scenario you entered. You can create a scenario for either Individual Market plans or Small Group (SHOP) plans.
- Plan Details Page: You can reach the Plan Details page by clicking on a plan and then clicking ***View Plan***. The Plan Details Page shows further details about each of the plans, including deductibles, out-of-pocket maximums, policies for specific benefits, limits and exclusions, and so on.

5.2 Issuer Summary Page

The Issuer Summary Page is where you can select an issuer ID to review. You will have access to all issuers associated with your user role.

You must be assigned a role of **Submitter** or **Validator** for at least one of the three QHP Application modules (Issuer Module, Benefits and Service Area Module, or Rating Module) or a role of **State Reviewer** in the FFM State Evaluation Module to access this page.

You can download the Plan Preview User Guide by clicking the ***Instructions and Reference Materials (PDF)*** link.

Figure 1 shows the Issuer Summary Page.

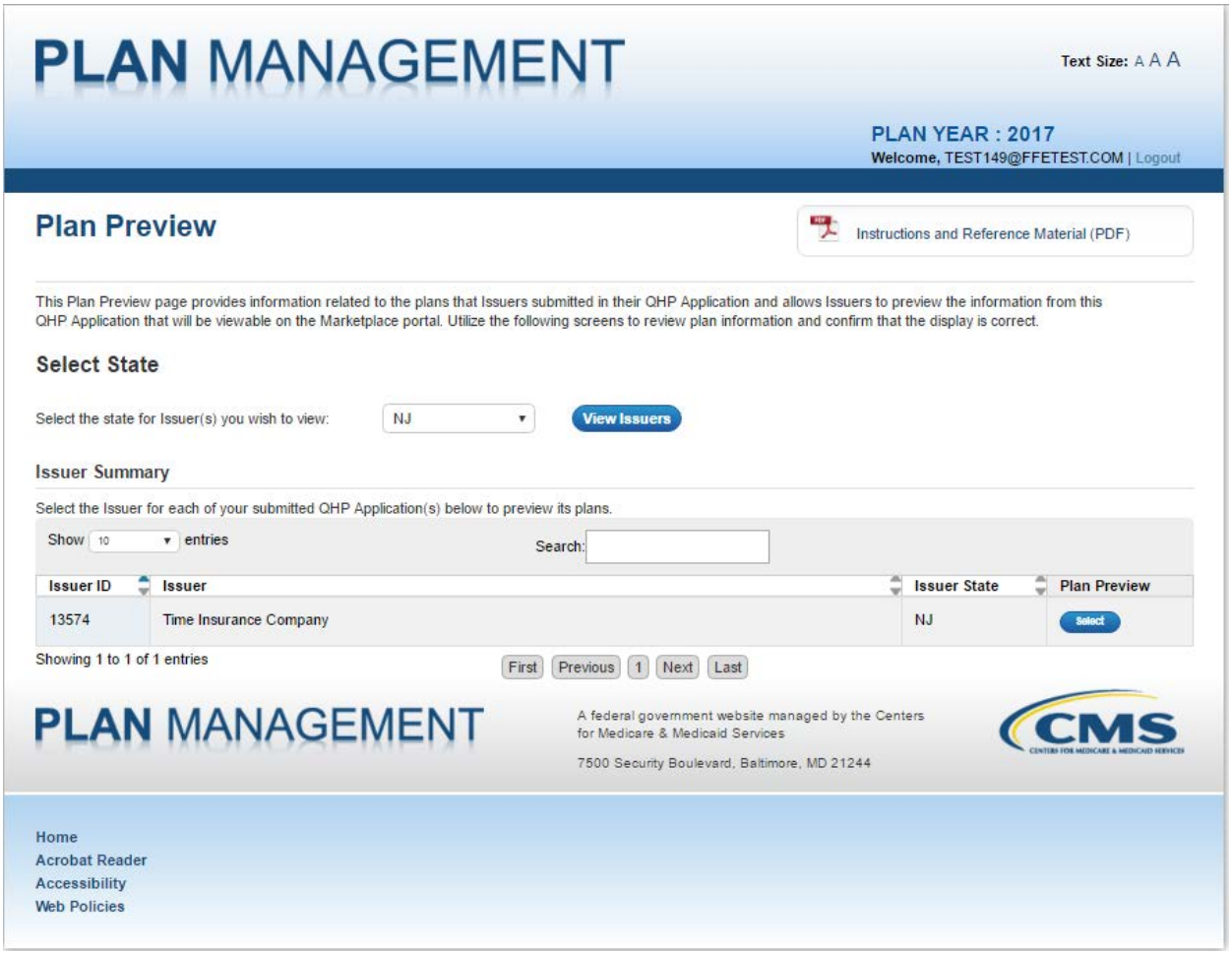

Figure 1: Issuer Summary Page

If you are a State Reviewer and have access to issuers from multiple states, you will see a drop-down menu in the "Select-State" section of the Issuer Summary Page. To select a state, click on the drop-down list and select a state, and then click the ***View Issuers*** button. Otherwise, if you are not a State Reviewer with access to issuers from multiple states, you will directly proceed to the Issuer Summary section.

You can use the buttons in the Issuer Summary Table to change the order or search the list of issuer IDs. Click the ***Show Entries*** dropdown list to select the number of entries you would like to view per page, and navigate through the table of issuers available using the ***First***, ***Previous***, ***Next*** and ***Last*** toggles. Use the ***Search*** bar to search for specific issuer IDs or names. Click the ***Select*** button in the Plan Preview column to view an issuer.

Table 1 describes the fields on the Issuer Summary Page.

Table 1: Issuer Summary Page Fields

Field Name	Description	Value
Issuer ID (pre-populated)	The 5-digit HIOS issuer ID.	Numeric
Issuer (pre-populated)	The HIOS Legal Name for this issuer.	Text

Field Name	Description	Value
State (pre-populated)	The 2-letter abbreviation of the issuer's state.	Text
Plan Preview (pre-populated)	The actions available for the user for this issuer.	Select Button

5.3 Rating Scenario Page

The Rating Scenario page is where you enter an enrollment scenario and generate a list of plans that are available and unavailable to your enrollment group. You can also select any available plan to preview on the Plan Details Page. Use the Market Type radio buttons (shown in Figure 2) to choose to view ***Individual*** or ***Small Group (SHOP)*** plans for your enrollment groups.

5.3.1 Rating Scenario – Individual Market

Select the ***Individual*** Market Type radio button at the top of the Rating Scenario page (see Figure 2 to view available and unavailable Individual Market plans. Then enter your enrollment group information and click the ***Update Plan Results*** button. The system generates a list of available and unavailable Individual Market plans, mimicking the logic that Individual Market Plan Compare uses to return a list of plans available to an enrollment group. (For information on unavailable plans appearing on the Rating Scenario page, see Section 5.3.4.)

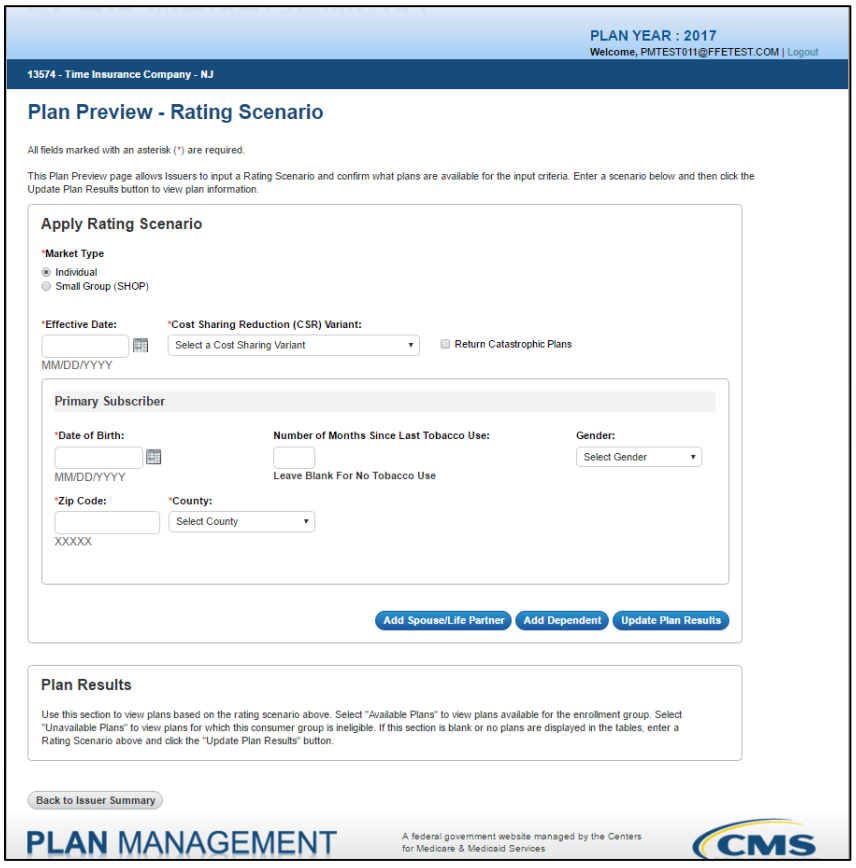

Figure 2: Rating Scenario – Apply Rating Scenario (Individual)

Enter your general plan criteria in the "Apply Rating Scenario" box and information about the primary subscriber in the "Primary Subscriber" box. Table 2 describes the fields in the Apply

Rating Scenario box on the Rating Scenario page for Individual Market scenarios and provides instructions about how to enter data in these fields. (Note: The "Effective Date" field determines plan eligibility based on the Rate Effective Date from the Rates template.)

Table 2: Rating Scenario – Apply Rating Scenario Fields (Individual)

Field Name	Description	Value
Market Type	Allows the user to select the Market Type to view.	Radio buttons • Individual • Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY 2017 plans can be viewed in 2017 Plan Preview.	Date (MM/DD/YYYY)
Cost Sharing Reduction (CSR) Variant	Allows the user to select a CSR variation type to view.	Dropdown • Exchange variant (no CSR) • 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
Return Catastrophic Plans Checkbox	Checking this box returns catastrophic plans as available. If the box is unchecked, catastrophic plans will return as unavailable.	Checkbox

Table 3 describes the fields in the primary subscriber section of the Apply Rating Scenario box for Individual Market scenarios and provides instructions about how to enter data in these fields.

Table 3: Rating Scenario – Primary Subscriber Fields (Individual)

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the primary subscriber.	Date (MM/DD/YYYY)
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown • Male • Female
Number of Months since Last Tobacco Use	Allows the user to enter a 3 digit number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Zip Code	Allows the user to enter a 5 digit zip code.	Numeric
County	Allows the user to enter a county associated with the provided zip code.	Populated by system (Based on zip code entry)

5.3.2 Rating Scenario – Small Group (SHOP)

Select the ***Small Group (SHOP)*** Market Type radio button at the top of the Rating Scenario page (see Figure 3) to view available and unavailable SHOP plans. Then enter your rating scenario and click the ***Update Plan Results*** button. The system generates a list of available and unavailable SHOP plans.

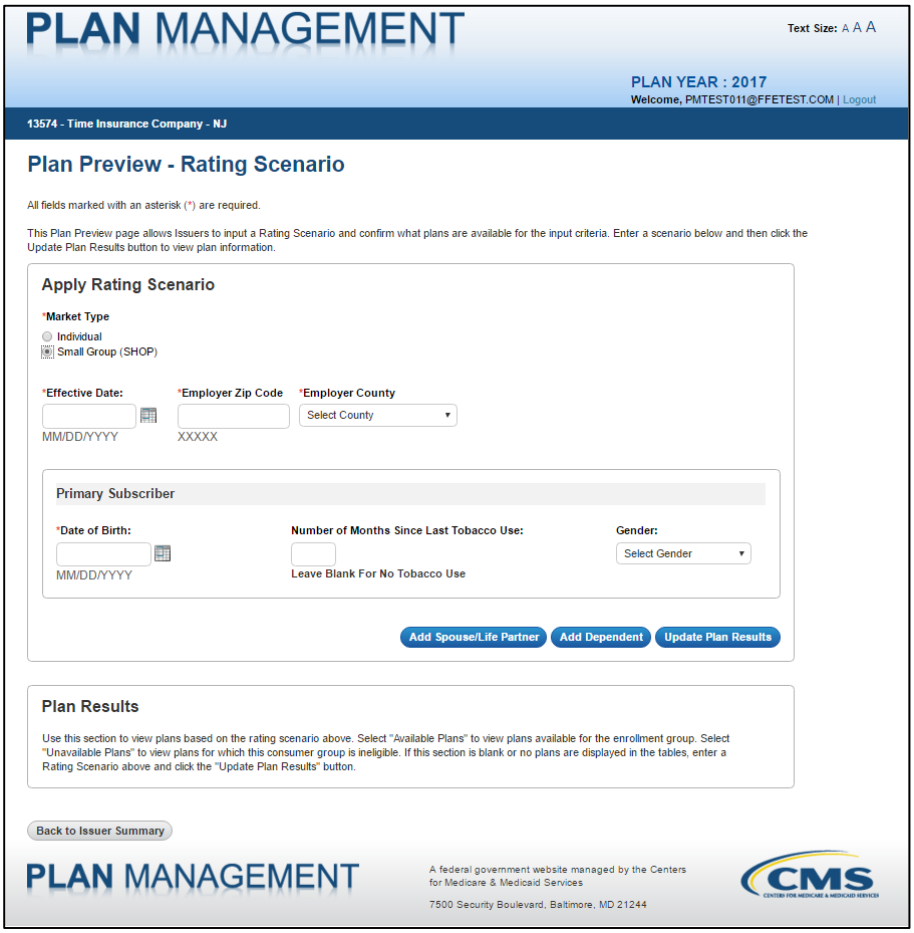

Figure 3: Rating Scenario – Apply Rating Scenario (SHOP)

When you enter a Small Group (SHOP) rating scenario, you will not see a place to input CSR information or subscriber residence information; they are not relevant to SHOP plans, so the system will hide these fields. Fields for “Employer Zip Code” and “Employer County” will appear as SHOP rating scenario fields.

Enter your general plan criteria in the Apply Rating Scenario box and information about the primary subscriber in the Primary Subscriber box. Table 4 describes the fields in the Apply Rating Scenario box on the Rating Scenario page for SHOP scenarios and provides instructions about how to enter data in these fields.

Table 4: Rating Scenario – Apply Rating Scenario Fields (SHOP)

Field Name	Description	Value
Market Type	Allows the user to select the Market Type to view.	Radio button • Individual • Small Group (SHOP)
Effective Date	Allows the user to select an effective date of coverage for the rating scenario. Only PY 2017 plans can be viewed in 2017 Plan Preview.	Date (MM/DD/YYYY)
Employer Zip Code	Allows the user to enter a 5 digit zip code.	Numeric
Employer County	Allows the user to enter the county associated with the provided zip code.	Populated by system (Based on zip code entry)

Table 5 describes the fields in the primary subscriber section of the Apply Rating Scenario box for SHOP scenarios and provides instructions about how to enter data in these fields.

Table 5: Rating Scenario – Primary Subscriber Fields (SHOP)

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the primary subscriber.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3 digit number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the primary subscriber (not required).	Dropdown • Male • Female

5.3.3 Rating Scenario – Add Dependents

Along with your primary subscriber, you may add up to five dependents to your sample enrollment group. Your dependents may be identified as either a Spouse, Life Partner, Child, Brother or Sister, or Ward. Your enrollment group may contain at most one spouse or one life partner. If you add a spouse or life partner to your enrollment group, you may add up to four additional dependents, for a total of five dependents; if you do not add a spouse or life partner, you may add up to five dependents. (**NOTE**: The restriction on dependents only exists within Plan Preview and does not exist within Individual Market or FF-SHOP Plan Compare.)

To add a spouse or life partner to your enrollment group, click the ***Add Spouse/Life Partner*** button beneath the Primary Subscriber box (see Figure 3 above), and you will see a new section for the Spouse/Life Partner. You may enter a gender for the scenario's spouse/life partner but this field is not required as gender does not impact eligibility or rate calculations. You can remove any dependent by clicking the ***Remove Spouse/Life Partner*** or ***Remove Dependent*** button.

Figure 4 shows the Spouse/Life Partner box on the Rating Scenario page.

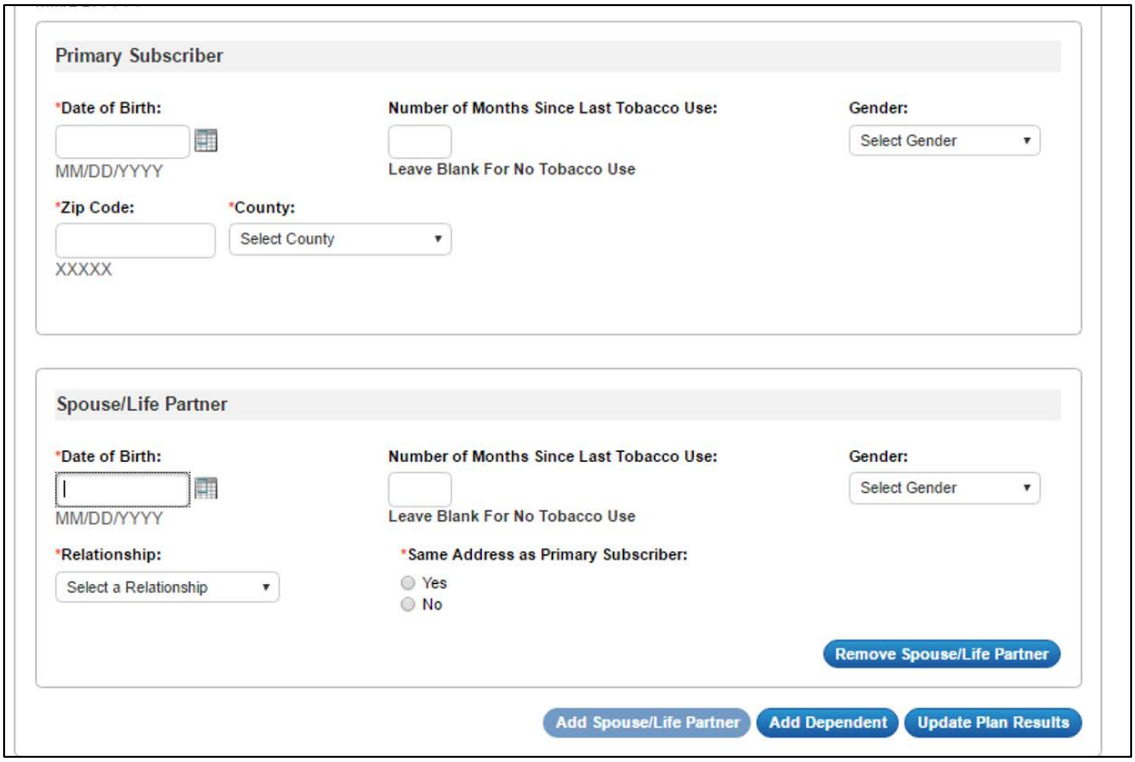

Figure 4: Rating Scenario – Add Spouse / Life Partner

Table 6 describes the fields in the Spouse/Life Partner box on the Rating Scenario Page and provides instructions about how to enter data in these fields.

Table 6: Rating Scenario – Spouse/Life Partner Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the spouse/life partner.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3 digit number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Gender	Allows the user to select the gender of the spouse/life partner (not required).	Dropdown • Male • Female
Relationship	Allows the user to identify the relationship type.	Dropdown • Spouse • Life Partner
Same address as Primary Subscriber	Allows the user to indicate that the spouse/life partner's address is the same as the primary subscriber's address. (Note: Does not appear for SHOP.)	Radio button • Yes • No

To add a 'child,' 'brother or sister,' or 'ward' dependent to your enrollment group, click the ***Add Dependent*** button beneath the Primary Subscriber box (see Figure 4 above).

A section will expand for you to input scenario information for dependents. The first dependent in the list will be called "Dependent 1," and additional dependents will be numbered in order from "Dependent 2" through "Dependent 5." The ***Add Dependent*** button will remain active until you reach the maximum of five dependents. You can remove any dependent by clicking the ***Remove Dependent*** button.

Figure 5 shows an enrollment group with a child, ward and brother or sister as dependents on the Rating Scenario page.

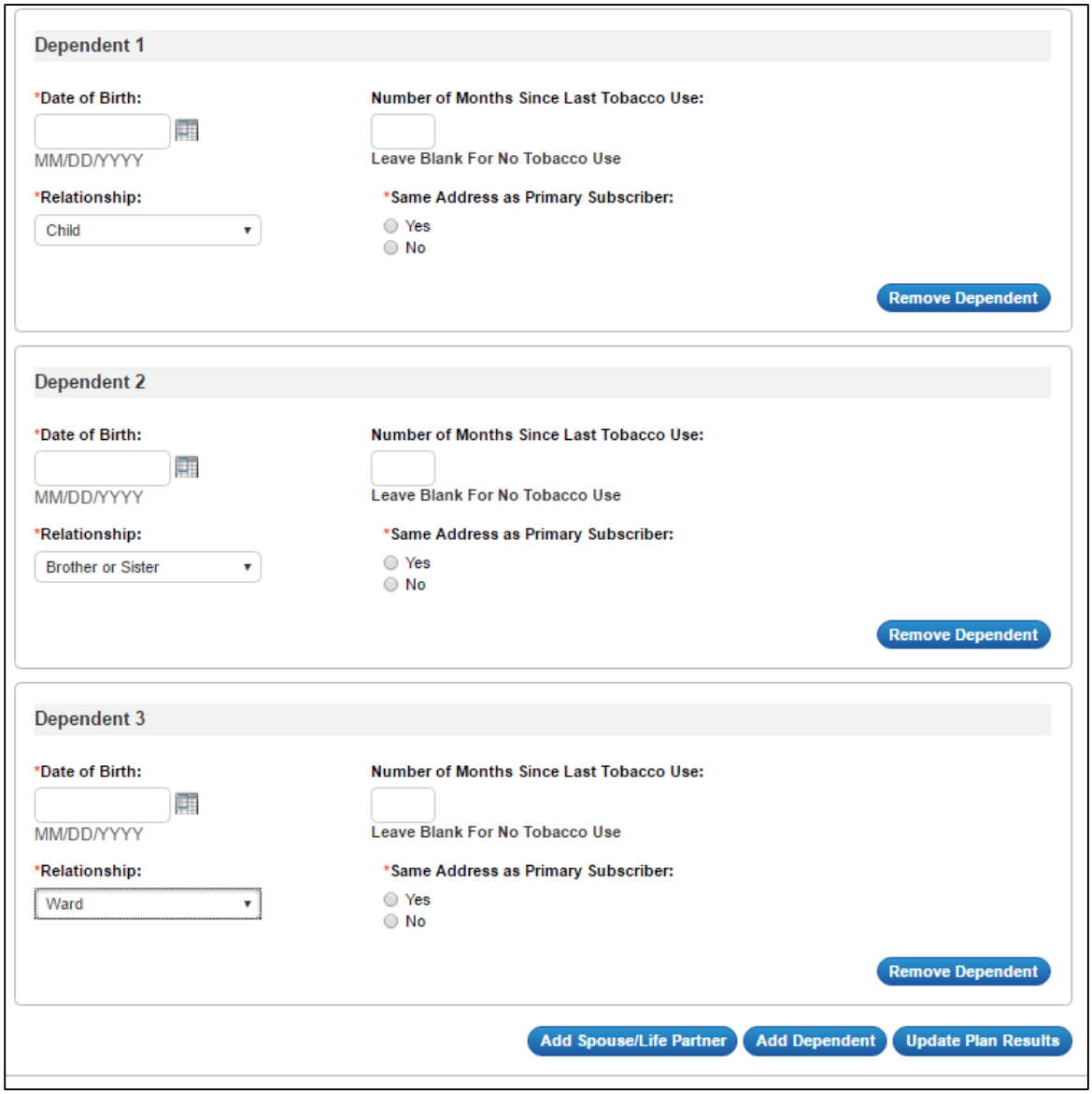

Figure 5: Rating Scenario – Add Dependent

Table 7 describes the fields in the dependent box on the Rating Scenario page and provides instructions about how to enter data in these fields.

Table 7: Rating Scenario – Dependent Fields

Field Name	Description	Value
Date of Birth	Allows the user to select a Date of Birth for the spouse/life partner.	Date (MM/DD/YYYY)
Number of Months since Last Tobacco Use	Allows the user to enter a 3 digit number of months since last tobacco use or leave blank for no tobacco use.	Numeric • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Relationship	Allows the user to identify the relationship type.	Dropdown • Child • Brother or Sister • Ward
Same address as Primary Subscriber	Allows the user to indicate that the spouse/life partner's address is the same as the primary subscriber's address. (Note: Does not appear for SHOP.)	Radio button • Yes • No

5.3.4 Rating Scenario – Plan Results

After you enter your rating scenario, click ***Update Plan Results*** to view a list of available and unavailable plans for your enrollment group. The plans will appear in the Plan Results table with the plans' IDs, names, metal levels, market, plan types, product types, and links for additional information. Use the ***Available*** and ***Unavailable*** radio buttons to switch between available or unavailable plans. Click the ***Available*** radio button to view all of the plans that will be available to your sample enrollment group. The plan results page defaults to displaying the Available Plans table.

Figure 6 shows the Plan Results table with a list of available plans for the rating scenario.

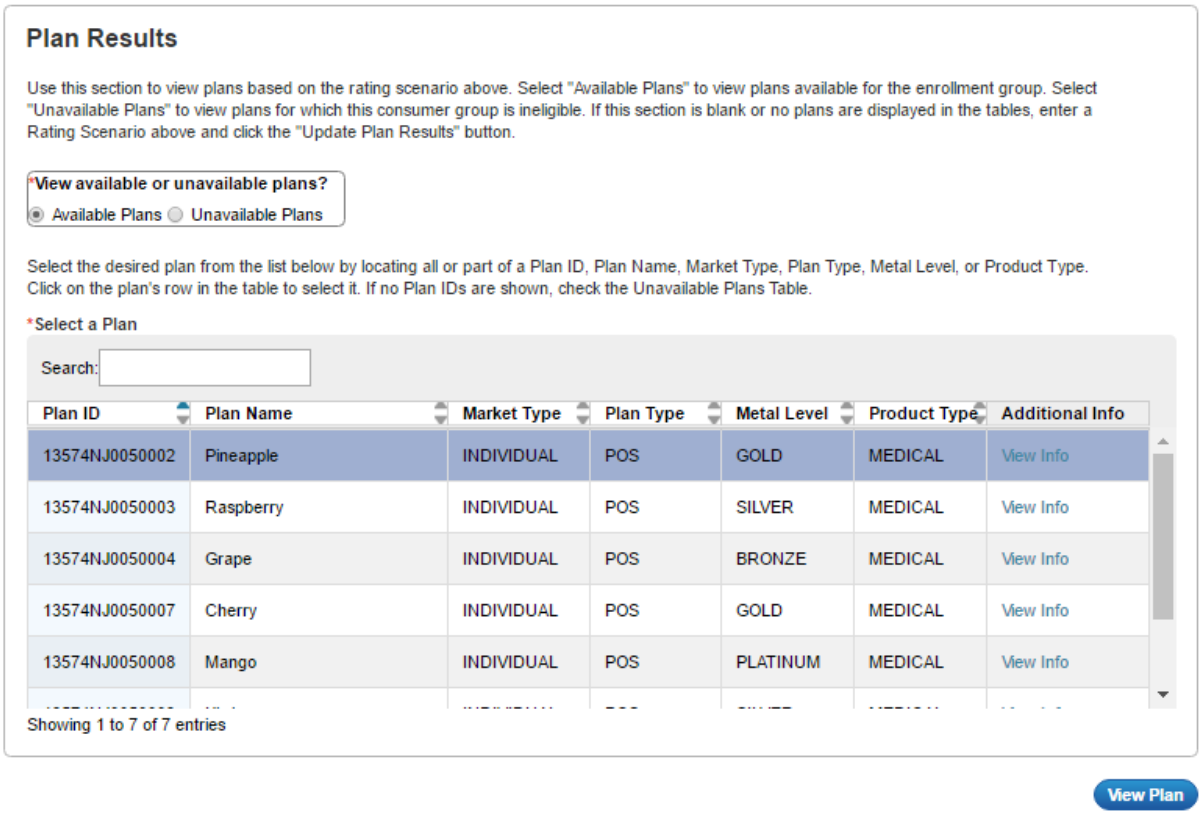

Figure 6: Plan Results – Available Plans

To view additional information on a plan, click the ***View Info*** button in the Additional Info column. You will see a pop-up box with the Plan ID, Payment URL, Customer Service Phone Number, Customer Service URL, and Billing Address fields. Payment URL is populated via the submitted Plans and Benefits template. Customer Service Phone Number, Customer Service URL, and Billing Address fields are populated via data entered in HIOS in the "Marketplace" tab.

NOTE: You will see the Payment URL in Plan Preview for SHOP plans, but consumers will not see the payment URL, Customer Service Phone Number or Billing Address on FF-SHOP Plan Compare because SHOP payments are made within the FF-SHOP Portal.

Figure 7 shows the Additional Info pop-up.

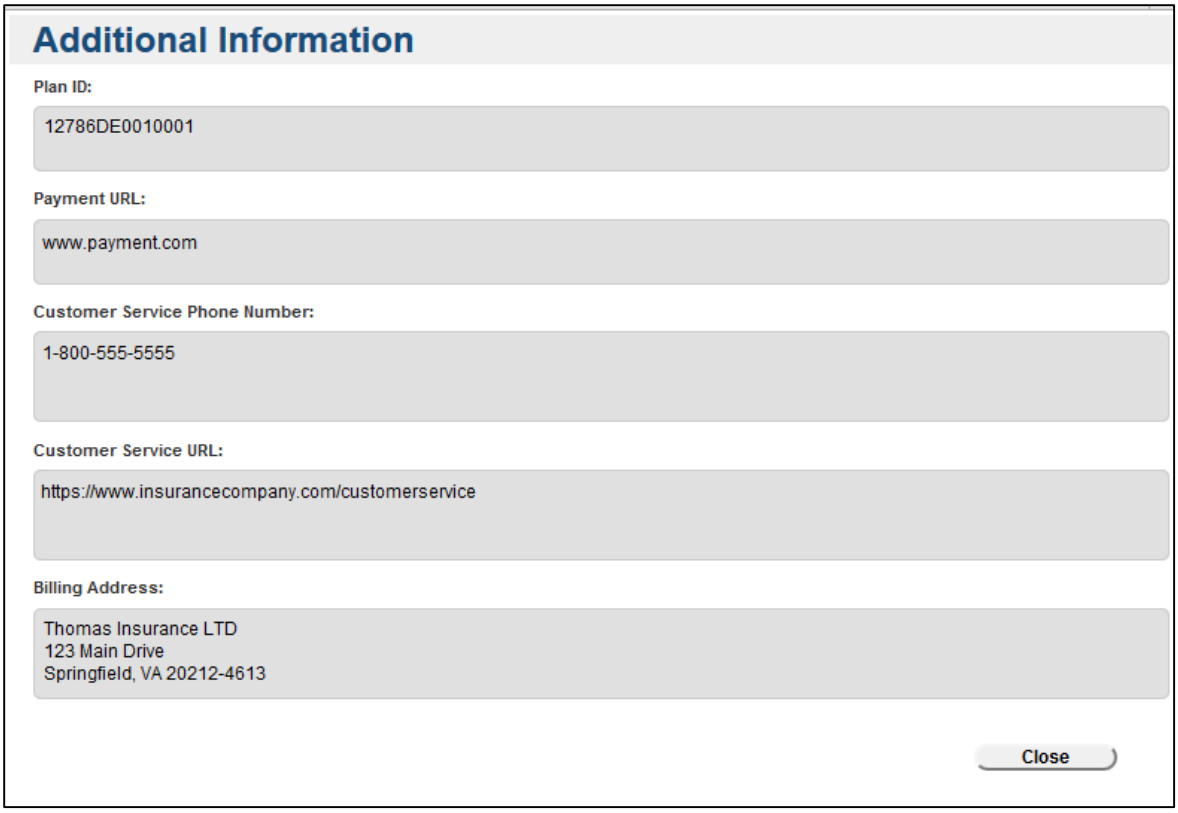

Figure 7: Available Plans – Additional Information

If you click the ***Unavailable*** radio button, the system displays plans that are unavailable to your enrollment group.

Note that Individual Market plans will not appear as available or unavailable for the Small Group (SHOP) rating scenario groups, and vice-versa.

Only cross-validated plans will display on the Available or Unavailable Plans Table. For your reference a complete list of unavailable reasons and codes is provided in Table 8 below.

Table 8: Plan Results - Unavailable Plan Reason Codes

Reason Code	Unavailable Reason Text	Description	Click "View Info" to Display Reason
316	"Out of Service Area"	This reason code displays if the user-input Zip-Code/County is not in the plan's service area	Yes
318	"Dependent X over max age" where X is the dependent number	This reason code displays if an included Child dependent is over the maximum age allowed by the plan's business rules	No

Reason Code	Unavailable Reason Text	Description	Click "View Info" to Display Reason
321	"X Relationship not allowed" where X is the dependent's relationship type, e.g. "Spouse Relationship not allowed"	This reason code displays if an included dependent relationship is not included in the allowed relationships, or if an included dependent is required to reside with the primary subscriber but does not.	No
322	"No rate for X" where X is the subscriber, e.g. "No rate for Dependent 1"	This reason code displays if a rate is not found for a subscriber, e.g. if the user-input county is included in a plan's Service Area but not in the plan's Rating Area.	No
600	"CSR Variant Mismatch"	This reason code displays if the user-input CSR Variant is not found for a plan, e.g. a user-input CSR Variant of 87% AV Level Silver Plan would not be found for a Gold plan.	No
602	"Ineligible for Child-only"	This reason code displays if the enrollment group is not eligible for child-only plans but the plan is child-only. • All enrollees must be under 21 years of age, and any dependents must have the 'brother or sister' relationship type • The group cannot include child, ward, spouse, or life partner relationship types	Yes
603	"Ineligible for Adult-only"	This reason code displays if the enrollment group is not eligible for adult-only plans but the plan is adult-only.	Yes
604	"Ineligible for Catastrophic"	This reason code displays if the enrollment group is not eligible for catastrophic plans but the plan has a metal level of catastrophic.	No
605	"Child-only plans are not available in the Small Group On Exchange Market"	This reason code displays if the enrollment scenario Market Type is Small Group (SHOP) but the plan is child-only.	Yes
606	"Catastrophic plans are not available in the Small Group On Exchange Market"	This reason code displays if the enrollment scenario Market Type is Small Group (SHOP) but the plan is catastrophic.	No
607	"Plan enrollment is closed"	Plan has a suppression status of closed	No
608	"Plan status invalid; plan will not display"	Plan needs updated suppression status	No

In the Unavailable Plans Table, the columns “Reason” and “Code,” list the reason why the plan is unavailable for your rating scenario and the associated ‘Reason Code.’ If Reason Codes **318, 321, 322, 600, 606, 607, or 608** apply to a plan, then the ***View Info*** button will be inactive since an unavailable reason is already displayed. If the plan is unavailable for another reason, the ***View Info*** button will be activated. Reason Codes **316, 602, 603, and 605** require Issuers to click the ***View Info*** button to view the reason or reasons why a plan is unavailable.

Figure 8 shows the Plan Results table with a list of unavailable plans. Figure 9 shows the same table after clicking the ***View Info*** button for the plans shown.

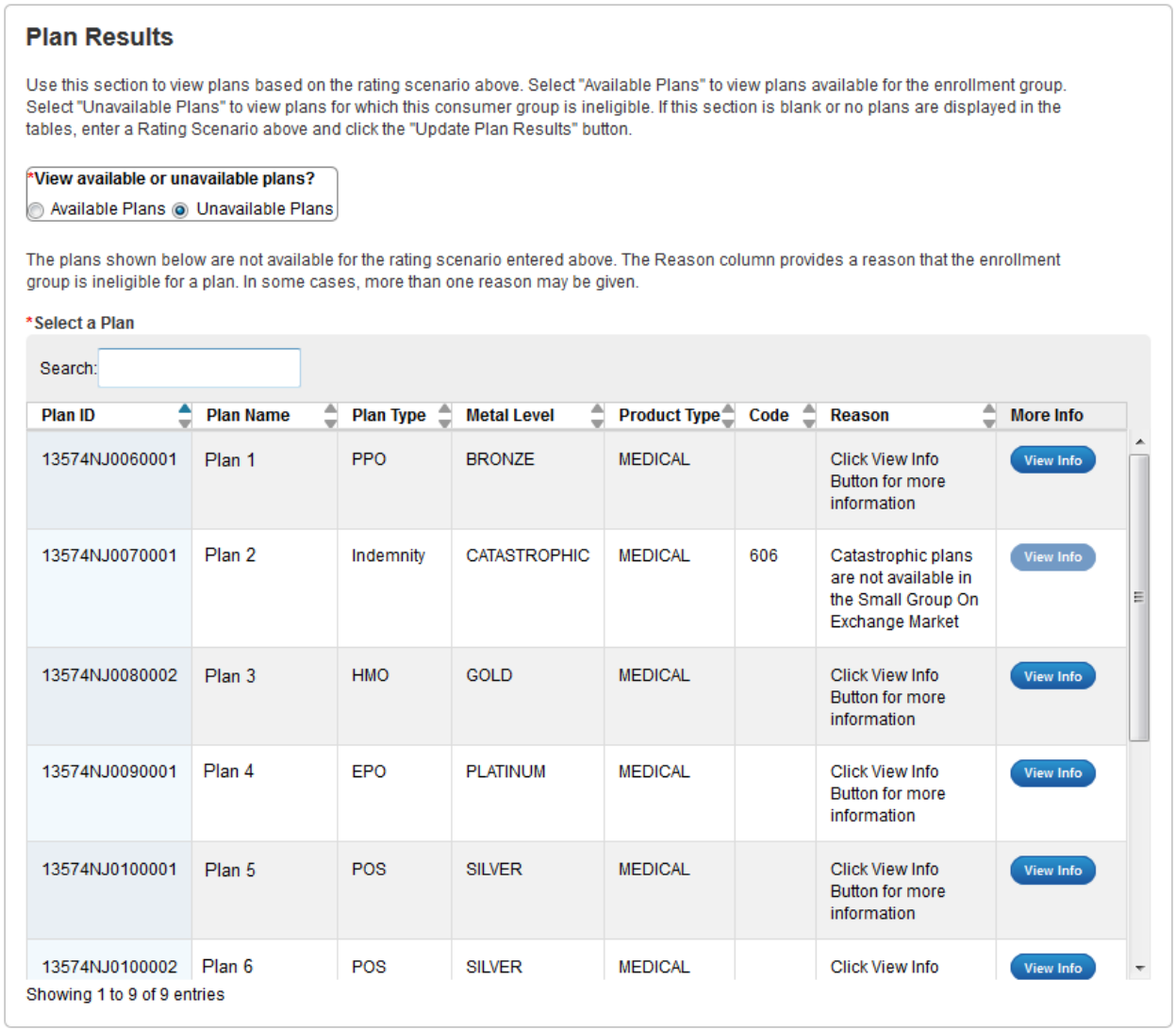

Figure 8: Plan Results – Unavailable Plans

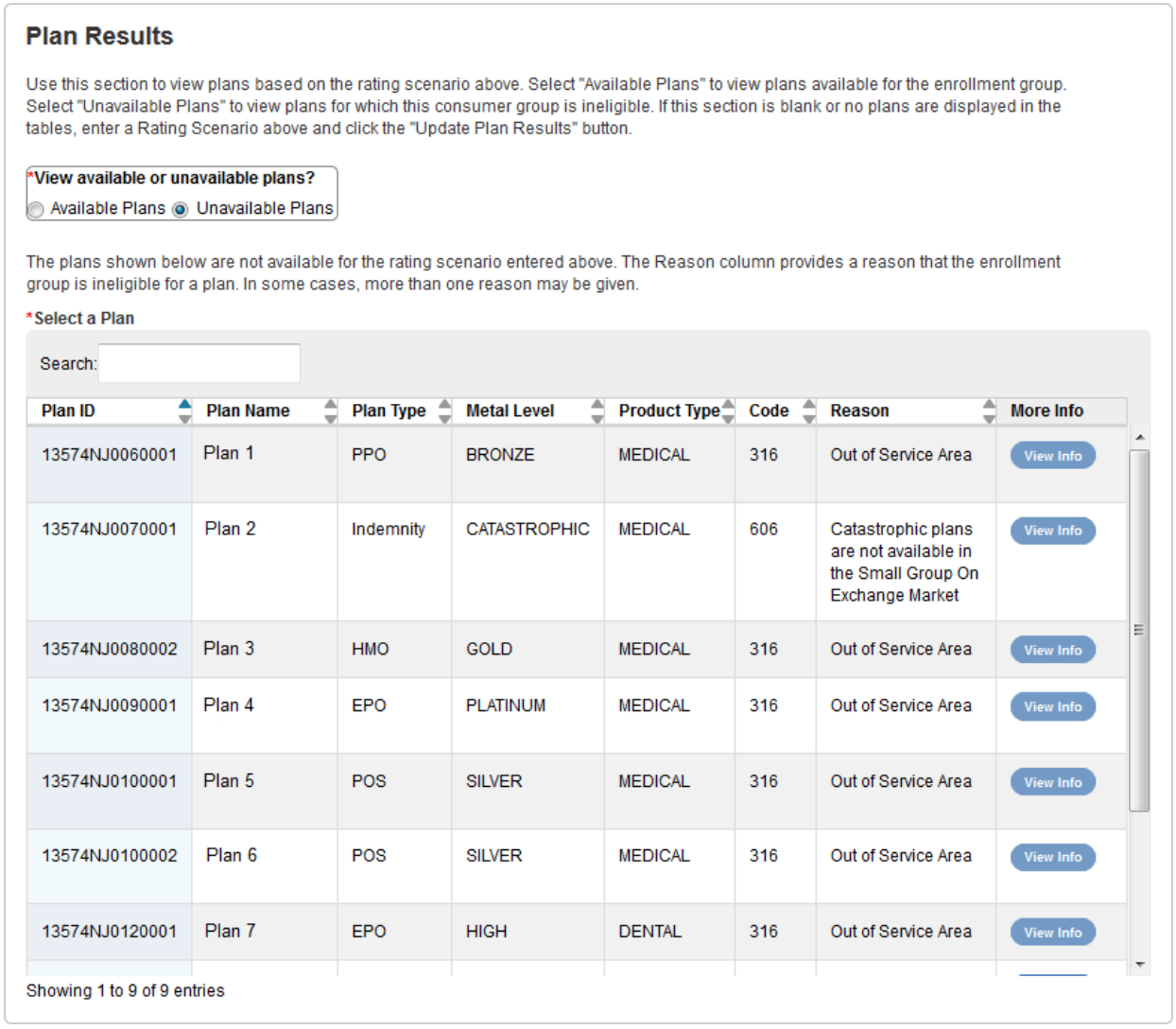

Figure 9: Plan Results – Unavailable Plans after *View Info* Button is clicked

You can search the list of plans by Plan ID, Plan Name, Market Type, Plan Type, Metal Level, or Product Type (see Table 9).

For available plans, select the plan by clicking on it. After you select a plan, click the ***View Plan*** button to open the Plan Details Page. If no plans are found as available or unavailable for the entered criteria, the available plans table will be blank, and you will see a pop-up that says, "No Plans Available for Input Criteria."

Table 9: Plan Results – Available Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text

Field Name	Description	Value
Market Type (pre-populated)	Market Type.	• Individual • Small Group (SHOP)
Plan Type (pre-populated)	Network design for the plan.	• PPO • HMO • POS • EPO • Indemnity
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans, • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans, • High • Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	• Medical • Dental

Table 10 describes the fields for unavailable plans in the Select a Plan section on the Rating Scenario Page.

Table 10: Plan Results – Unavailable Plans Table Fields

Field Name	Description	Value
Plan ID (pre-populated)	14-digit HIOS Plan ID (Standard Component).	Alpha Numeric
Plan Name (pre-populated)	Plan Marketing Name.	Text
Market Type (pre-populated)	Market Type.	• Individual • Small Group (SHOP)
Plan Type (pre-populated)	Network design for the plan.	• PPO • HMO • POS • EPO • Indemnity

Field Name	Description	Value
Metal Level (pre-populated)	Coverage level for the plan.	For medical plans, • Platinum • Gold • Silver • Bronze • Catastrophic For dental plans, • High • Low
Product Type (pre-populated)	Indicates whether the plan is Medical or Stand Alone Dental. Plans with embedded dental will appear as Medical.	• Medical • Dental

5.4 Plan Details Page

The Plan Details Page displays the details of the rating scenario used to generate the plan data, and the page also displays plan details to mimic Plan Compare. To access the Plan Details Page, click a plan within the Plan Results table to highlight the plan, and then click the ***View Plan*** button. The corresponding Plan Details page will load in a new tab in your browser.

5.4.1 Plan Details – Rating Scenario Section

Below the header in the Plan Details you will find the Ratings Scenario section. This section allows you to quickly view the variables entered in the Rating Scenario page to generate the plan being viewed. The ***Print*** button allows you to print the page with your browser's standard print feature. Please note that the other lines on the left side of the page ('Link,' 'Email,' and 'Add to Shopping Bag') are inactive. These links have been included as placeholders to mimic Plan Compare display.

Figure 10 shows the Rating Scenario section for a sample scenario used to generate an Individual Market plan.

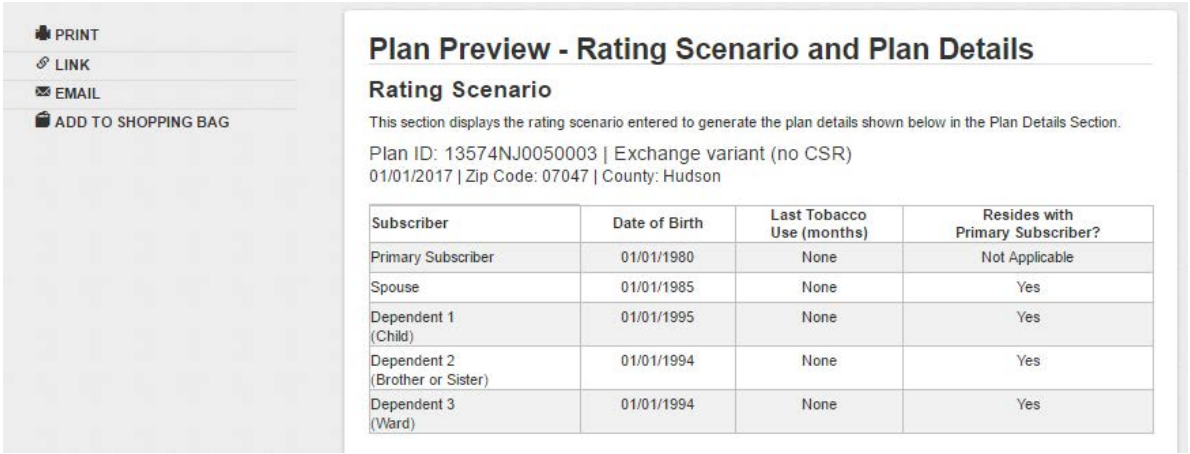

Figure 10: Plan Details Page – Rating Scenario Section

Table 11 describes the fields on the Ratings Scenario section of the Plan Details Page for Individual and Small Group (SHOP).

Table 11: Plan Details Page – Ratings Scenarios

Field Name	Description
Effective date of coverage	The effective date of coverage for the rating scenario in a MM/DD/YYYY format.
Plan ID and CSR Variant	Displays the 14-digit HIOS Plan ID (Standard Component) and CSR Plan Variant: • Exchange variant (no CSR) • 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 CSR Variant does not display for Small Group (SHOP).
Effective Date	The effective date of coverage.
Zip code	The 5 digit zip code that a plan is registered in.
County name	The name of the US county that the plan is registered in.
Subscriber name and relationship for each subscriber	The type of subscriber and dependent relationship for the subscriber/dependent: • Primary Subscriber • Spouse • Life partner • Child • Brother or Sister • Ward
Date of birth for each subscriber and/or dependent	The date of birth in DD/MM/YYYY format for each subscriber and/or dependent.
Number of months since last tobacco use for each subscriber	The number of months since last tobacco use: • 0 = current tobacco user • > 0 = previous tobacco user • Blank = no tobacco use
Indicator for residence with the primary subscriber for each dependent	Indicates if a dependent resides with the primary subscriber: • Yes • No • Not Applicable (Note: Does not display for SHOP.)

5.4.2 Plan Details – Plan Overview

Subsequent to the Ratings Scenario section is the Plan Overview section. This section provides basic information about the plan you've chosen to view. Table 12 describes the fields on the overview section of the Plan Details Page for Individual and Small Group (SHOP). Please note that the CSR Variant field will not display for Small Group (SHOP).

Figure 11 shows the Plan Overview section for a sample plan in the Individual Marketplace.

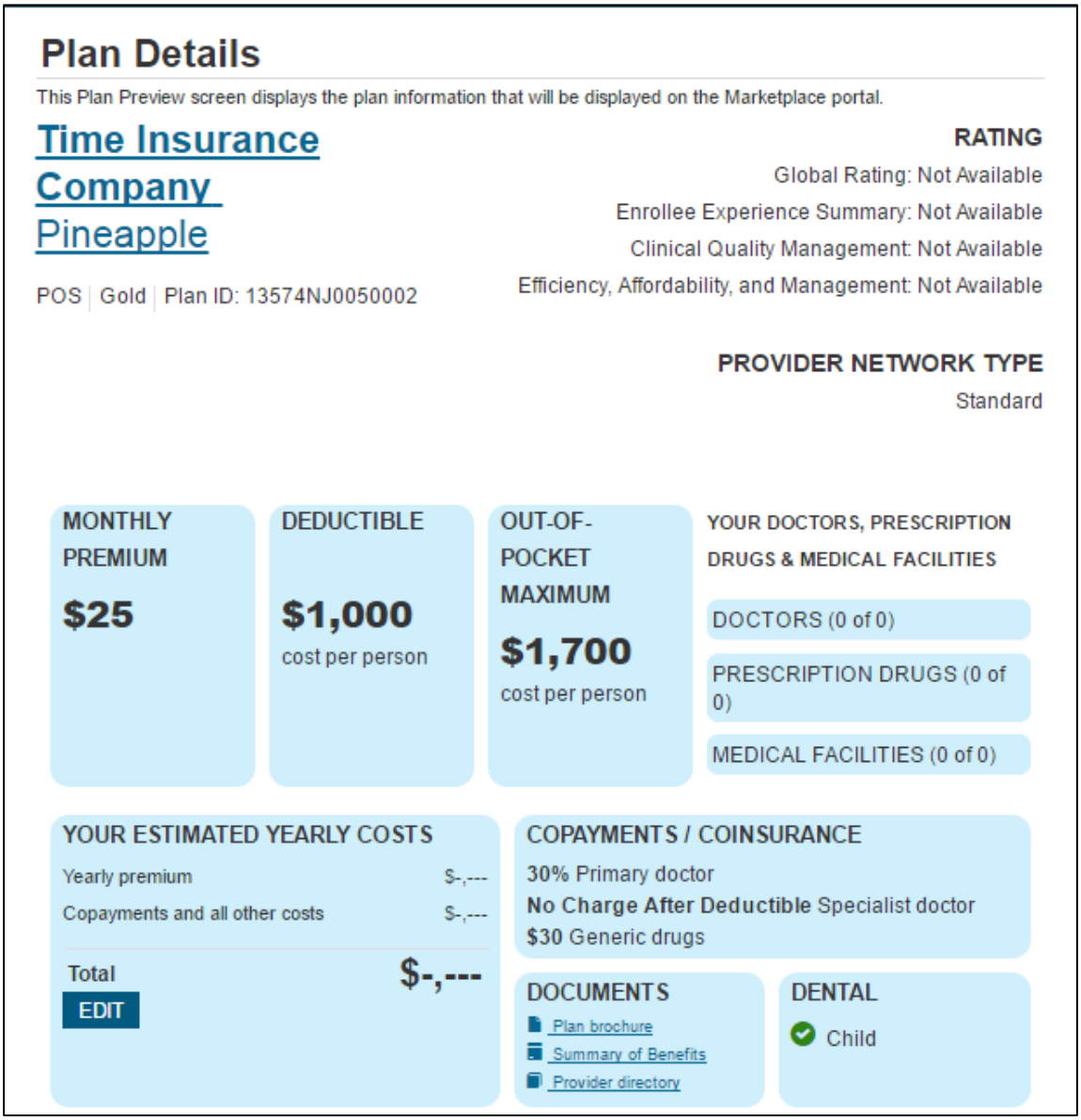

Figure 11: Plan Details Page – Overview Fields

Table 12: Plan Details Page – Overview Fields

Field Name	Description
Plan Name	Displays the Issuer Marketing Name (pulled from HIOS “Marketplace” tab), plus the Plan Variant Marketing Name (pulled from the Cost Share Variances tab of the Plans and Benefits template). If the Issuer Marketing name is blank, displays the Issuer Legal Name (pulled from HIOS), plus the Plan Variant Marketing Name.

Field Name	Description
Plan ID and CSR Variant	Displays the 14-digit HIOS Plan ID (Standard Component) and CSR Variant. CSR Variant does not display for Small Group (SHOP). CSR Variant does not display in Individual Market Plan Compare or FF-SHOP Plan Compare.
Plan Attributes	Displays the following details of the selected plan, in this order (if applicable): 1) Plan Type. 2) Level of Coverage. 3) CSR Plan Variant: • Exchange variant (no CSR) • 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. 4) "National Provider Network" displays if the "National Network" field in the Plans and Benefits template is equal to "Yes." No text displays if the "National Network" field is equal to "No."
Rating	Displays ratings in a 1-5 stars format for the selected plan: • Global Rating • Enrollee Experience Summary • Clinical Quality Management • Efficiency, Affordability and Management Note: If data is not available for a plan, the Rating will display "Not Available"
Provider Network Type	Displays the Network Type as provided by CMS and indicates whether the plan's network is: • Broad • Standard • Limited Note: If data is not available for a plan, the Provider Network Type will display "Not Available"
Monthly Premium	Displays the monthly premium amount that the rating engine calculates based on the individuals in the enrollment group (and effective date for SHOP plans). For Stand Alone Dental Plans, displays either "Guaranteed premium" or "Estimated premium" along with the premium amount, based on the "Guaranteed vs. Estimated Rates" field in the Plans and Benefits template. Note: Estimated premiums are not supported in SHOP Plan Compare.

Field Name	Description
Deductible	The deductible field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a) If Individual In-Network value is $X, display "$X"; else, if this value is "Not Applicable", b) If Individual Combined In/Out-Network value is $X, display "$X"; else, if this value is "Not Applicable", c) Display "Not Applicable". If the enrollment group size is greater than one (at least one dependent) d) If both Family Per Group and Family Per Person are $X (including $0), then display both as "$X total cost" and "$X cost per person" i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. e) If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display "$X total cost" and do not display a per person value. i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. f) If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display "$X cost per person" and do not display a per group value. i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. If medical and drug deductibles are integrated, then the combined medical and drug deductible displays in the overview section. "Included in Combined Medical & Drug Deductible" displays in the prescription drug coverage details section. If medical and drug deductibles are not integrated, only the medical deductible displays in the overview section. The drug deductible displays in the prescription drug coverage details section. In-Network Tier 2 and Out-of-Network deductibles do not display in Plan Preview or Plan Compare.

Field Name	Description
Out-of-Pocket Maximum	The Out-of-Pocket Maximum field will show data for both one person and multiple people enrollment groups: 1. If the enrollment group size is one (no dependents) a) If Individual In-Network value is $X, display "$X"; else, if this value is "Not Applicable", b) If Individual Combined In/Out-Network value is $X, display "$X"; else, if this value is "Not Applicable", c) Display "Not Applicable". 2. If the enrollment group size is greater than one (at least one dependent) a) If both Family Per Group and Family Per Person are $X (including $0), then display both as "$X total cost" and "$X cost per person" i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. b) If Family Per Group is $X (including $0) and Family Per Person is Not Applicable (for both In-Network and Combined In/Out-Network), then display "$X total cost" and do not display a per person value. i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. c) If Family Per Group is Not Applicable (for both In-Network and Combined In/Out-Network) and Family Per Person is $X (including $0), then display "$X cost per person" and do not display a per group value. i) Use In-Network value if it is $X ii) If In-network value is "Not Applicable", use Combined In/Out-Network value. If medical and drug maximum out-of-pocket amounts are integrated, then the combined medical and drug maximum displays in the overview section. "Included in Combined Medical & Drug Maximum Out-of-Pocket" displays in the prescription drug coverage details section. If medical and drug maximums are not integrated, only the medical amount displays on this part of the page. The drug MOOP displays in the prescription drug coverage details section. In-Network Tier 2 and Out-of-Network MOOP values do not display in Plan Preview or Plan Compare.

Field Name	Description
Your Doctors, Prescription & Medical Facilities	This field is included to provide a mimic what will display in Plan Compare. If a consumer includes doctor, prescription and medical facility data then this field will populate based on the plan. The field includes: • Doctors • Prescription Drugs • Medical Facilities Note: In Plan Preview this is a placeholder and will not display doctors, drugs, or facilities as covered or not covered.
Your Estimated Yearly Costs	This field is included to mimic what will display in Plan Compare. Based on consumer data this field will populate in Plan Compare with estimated annual costs for: • Yearly Premiums • Copayments and all other costs Note: In Plan Preview this is a placeholder and will not display doctors, drugs, or facilities as covered or not covered.
Copay ($)/Coinsurance (%)	For Primary Doctor, Specialist Doctor, or Generic Prescription, displays cost-sharing information according to the Copay/Coinsurance mapping logic in section 5.4.1. Displays information from the following fields in the Plans and Benefits template: • Primary Care Visit to Treat an Injury or Illness • Specialist Visit • Generic Drugs
Dental	Indicates whether the plan includes dental coverage. If the plan only offers Child Dental, displays “Dental: Child” If the plan only offers Adult Dental, displays “Dental: Adult” If the plan offers both, displays “Dental: Child & Adult.” If the plan offers neither, displays “Dental: Not Covered.” A plan is considered to cover adult dental benefits if it covers all three of the following benefits: • Routine Dental Services (Adult) • Basic Dental Care (Adult) • Major Dental Care (Adult) A plan is considered to cover child dental benefits if it covers all three of the following benefits: • Dental Check-Up for Children • Basic Dental Care (Child) • Major Dental Care (Child)

Field Name	Description
Documents	The “Plan Brochure” field displays the Plan Brochure URL as entered in the Plans and Benefits template. The “Summary of Benefits” field displays the Summary of Benefits & Coverage URL as entered in in the Plans and Benefits template. Note: Stand Alone Dental Plans do not show this link in Plan Compare. The “Provider Directory” field displays the Network URL as entered in the Network ID template.

5.4.3 Plan Details – Benefits Sections

The Plan Details page contains nine collapsible sections that list coverage information for specific benefits, displayed in the same way as Individual Market Plan Compare. Copay, coinsurance, deductible and maximum out-of-pocket amounts display according to the same logic found in sections 5.4.1 and 5.4.2. (Note: SHOP benefits display similarly in Plan Preview but do not follow the same display logic in FF-SHOP Plan Compare.)

You can view more detailed plan information for medical plans by expanding any of the following fields:

- Costs for Medical Care
- Prescription Drug Coverage
- Access to Doctors and Hospitals
- Hospital Services
- Cost and Coverage Examples
- Adult Dental Coverage
- Child Dental Coverage
- Medical Management Programs
- Other Benefits

Stand-alone dental plans will display only the Adult Dental Coverage and Child Dental Coverage fields.

You will be able to view benefits for SHOP plans in the Plan Preview module that will not display in FF-SHOP Plan Compare. Additionally, the Plan Preview module does not display some of the benefits for SHOP plans that FF-SHOP Plan Compare displays. Please see Appendix A for more details.

Figure 12 shows the Medical Care Coverage section of the Plan Details page after it has been expanded.

Costs for medical care	Collapse -
Deductible	$1,000 per person; $2,000 per group
Out-of-pocket maximum	$1,700 per person; $4,000 per group
Primary care doctor visit	30% In-Network; 30% Out-of-Network
Specialist visit	No Charge After Deductible In-Network; No Charge After Deductible Out-of-Network
X-rays and diagnostic imaging	$30/15% In-Network; $30/15% Out-of-Network
Laboratory and outpatient professional services	15% In-Network; 15% Out-of-Network
Outpatient facility	30% In-Network; 30% Out-of-Network
Outpatient professional services	30% In-Network; 30% Out-of-Network
Hearing aids	No Charge In-Network; No Charge Out-of-Network; 1 Item(s) per 2 Years; Limits and Exclusions Apply
Routine eye exam for adults	Not Covered
Routine eye exam for children	$30/15% In-Network; $30/15% Out-of-Network; 1 Exam(s) per Year; Limits and Exclusions Apply
Eyeglasses for children	$30/15% In-Network; $30/15% Out-of-Network; 1 Item(s) per Year; Limits and Exclusions Apply
Health Savings Account eligible plan	No

Figure 12: Plan Details – Costs for Medical Care Section

Table 13 describes the fields in the Medical Care Coverage section of the Plan Details Page.

Table 13: Plan Details – Costs for Medical Care Section Fields

Field Name	Description
Deductible	For one-person enrollment groups (no dependents): • If the Individual In-Network value equals a dollar amount, then the Individual In-Network value displays (as "$X"). • If the Individual In-Network value equals "Not Applicable" and the Individual Combined In/Out-Network value equals a dollar amount, then the Individual Combined In/Out Network value displays (as "$X"). • If the Individual In-Network and Combined In/Out-Network values both equal "Not Applicable," then "Not Applicable" displays. For enrollment groups with more than one person (one or more dependents), displays both "Per Person" and "Per Group" amount. Per Person Logic: • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as "$X Per Person"). • If the Family In-Network Per Person value equals "Not Applicable," and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as "$X Per Person"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal "Not Applicable," then "Not Applicable" displays. Per Group Logic: • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as "$X Per Group"). • If the Family In-Network Per Group value equals "Not Applicable" and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as "$X Per Group"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal "Not Applicable," then "Not Applicable" displays. In-Network Tier 2 and out-of-network deductibles do not display in Plan Preview or Plan Compare.

Field Name	Description
Out-of-pocket maximum	For one-person enrollment groups (no dependents): • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as "$X"). • If the Individual In-Network maximum equals "Not Applicable" and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as "$X"). • If Individual In-Network and Combined In/Out-Network maximums both equal "Not Applicable," "Not Applicable" displays. For enrollment groups with more than one person (one or more dependents), displays both "Per Person" and "Per Group" amount. Per Person Logic: • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as "$X Per Person"). • If the Family In-Network Per Person maximum equals "Not Applicable," and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as "$X Per Person"). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal "Not Applicable," then "Not Applicable" displays. Per Group Logic: • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as "$X Per Group"). • If the Family In-Network Per Group maximum equals "Not Applicable" and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as "$X Per Group"). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal "Not Applicable," then "Not Applicable" displays. In-Network Tier 2 and out-of-network maximums do not display in Plan Preview or Plan Compare.
Primary care doctor visit	Provides cost sharing information for the benefit "Primary Care Visit to Treat an Injury or Illness," found in the Plans and Benefits template.
Specialist visit	Provides cost sharing information for the benefit "Specialist Visit," found in the Plans and Benefits template.
X-Rays and diagnostic imaging	Provides cost sharing information for the benefit "X-rays and Diagnostic Imaging," found in the Plans and Benefits template.
Laboratory and outpatient professional services	Provides cost sharing information for the benefit "Laboratory and Outpatient Professional Services," found in the Plans and Benefits template.
Outpatient facility	Provides cost sharing information for the benefit "Outpatient Facility Fee (e.g. Ambulatory Surgery Center)," found in the Plans and Benefits template.

Field Name	Description
Outpatient professional services	Provides cost sharing information for the benefit “Outpatient Surgery Physician/Surgical Services,” found in the Plans and Benefits template.
Hearing aids	Provides cost sharing information for the benefit “Hearing Aids,” found in the Plans and Benefits template.
Routine eye exam for adults	Provides cost sharing information for the benefit “Routine Eye Exam for Adults,” found in the Plans and Benefits template.
Routine eye exam for children	Provides cost sharing information for the benefit “Routine Eye Exam for Children,” found in the Plans and Benefits template.
Eyeglasses for children	Provides cost sharing information for the benefit “Eyeglasses for Children,” found in the Plans and Benefits template.
Health Savings Account eligible plan	Indicates whether this plan is HSA-eligible, based on the “HSA Eligible” field in the Plans and Benefits template.

Figure 13 shows the Prescription Drug Coverage section of the Plan Details Page.

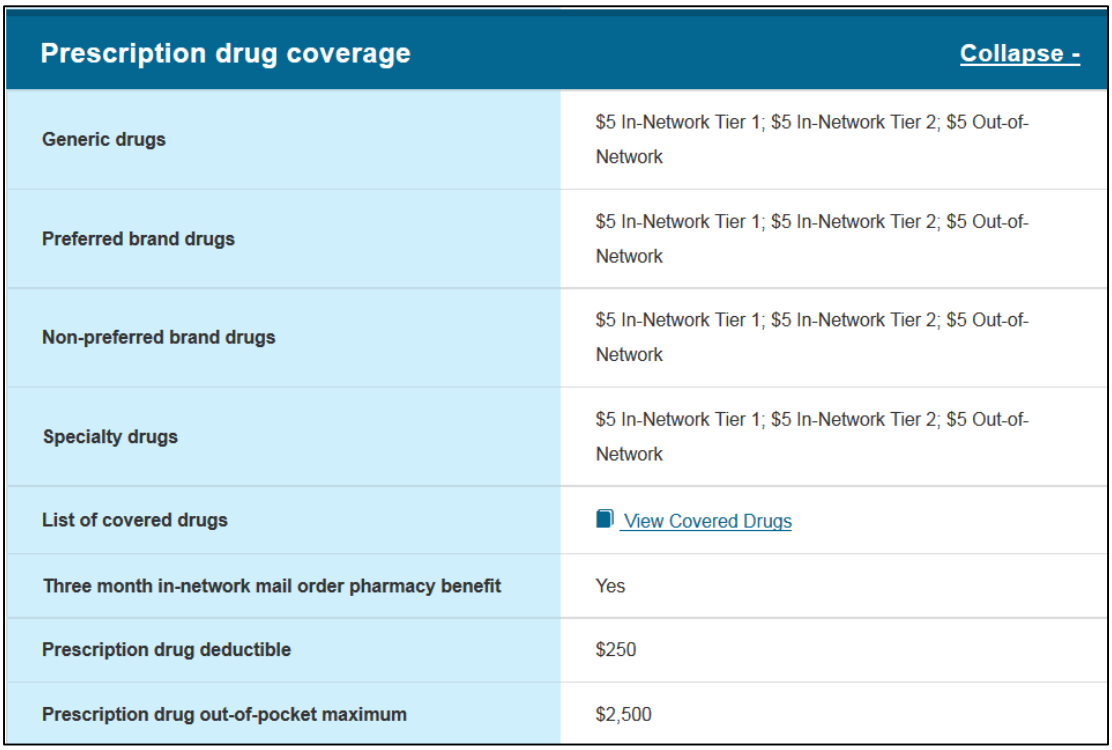

Figure 13: Plan Details – Prescription Drug Coverage Section

Table 14 describes the fields in the Prescription Drug Coverage section of the Plan Details page.

Table 14: Plan Details – Prescription Drug Coverage Section Fields

Field Name	Description
Generic drugs	Provides cost sharing information for the benefit “Generic Drugs,” found in the Plans and Benefits template.

Field Name	Description
Preferred brand drugs	Provides cost sharing information for the benefit “Preferred Brand Drugs,” found in the Plans and Benefits template.
Non-preferred brand drugs	Provides cost sharing information for the benefit “Non-Preferred Generic Drugs,” found in the Plans and Benefits template.
Specialty drugs	Provides cost sharing information for the benefit “Specialty Drugs,” found in the Plans and Benefits template.
List of covered drugs	Provides a link to the plan’s list of covered drugs from the “Formulary URL” in the Plans and Benefits template.
Three month in-network mail order pharmacy benefit	Indicates whether this plan offers three month In-Network mail order pharmacy benefits. If either the “3 Month In Network Mail Order Pharmacy Benefit Offered?” or “3 Month Out of Network Mail Order Pharmacy Benefit Offered?” fields are listed as “Yes” in the Prescription Drug template, displays “Yes”; otherwise, displays “No.”

Field Name	Description
Prescription drug deductible	If medical and drug deductibles are integrated, displays “Included in Combined Medical & Drug Deductible.” Otherwise, the logic below applies. If medical and drug deductibles are not integrated, display depends on the enrollment group size. If the enrollment group size is one (no dependents): • If the Individual In-Network prescription drug deductible equals a dollar amount, then the Individual In-Network deductible displays (as “$X”). • If the Individual In-Network prescription drug deductible equals “Not Applicable” and the Individual Combined In/Out-Network prescription drug deductible equals a dollar amount, then the Individual Combined In/Out Network deductible displays (as “$X”). • If the Individual In-Network and Combined In/Out-Network prescription drug deductibles both equal “Not Applicable,” then “Not Applicable” displays. If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” amount. Per Person Logic: • If the Family In-Network Per Person value equals a dollar value, then the Family In-Network Per Person value displays (as “$X Per Person”). • If the Family In-Network Per Person value equals “Not Applicable,” and the Family Combined In/Out-Network Per Person value equals a dollar amount, then the Family Combined In/Out-Network Per Person value displays (as “$X Per Person”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person values both equal “Not Applicable,” then “Not Applicable” displays. Per Group Logic: • If the Family In-Network Per Group value equals a dollar amount, then the Family In-Network Per Group value displays (as “$X Per Group”). • If the Family In-Network Per Group value equals “Not Applicable” and the Family Combined In/Out-Network Per Group value equals a dollar amount, then the Family Combined In/Out-Network Per Group value displays (as “$X Per Group”). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group values both equal “Not Applicable,” then “Not Applicable” displays.

Field Name	Description
Prescription drug out-of-pocket maximum	If medical and drug maximums are integrated, displays “Included in Combined Medical & Drug Maximum Out-of-Pocket.” Otherwise, the logic below applies. If medical and drug maximums are not integrated, display depends on the enrollment group size. If the enrollment group size is one (no dependents): • If the Individual In-Network maximum equals a dollar amount, the Individual In-Network maximum displays (as “$X”). • If the Individual In-Network maximum equals “Not Applicable” and the Individual Combined In/Out-Network maximum equals a dollar amount, the Individual Combined In/Out Network maximum displays (as “$X”). • If Individual In-Network and Combined In/Out-Network maximums both equal “Not Applicable,” “Not Applicable” displays. If the enrollment group size is greater than one (at least one dependent), displays both “Per Person” and “Per Group” maximum. Per Person Logic: • If the Family In-Network Per Person maximum equals a dollar maximum, then the Family In-Network Per Person maximum displays (as “$X Per Person”). • If the Family In-Network Per Person maximum equals “Not Applicable,” and the Family Combined In/Out-Network Per Person maximum equals a dollar amount, then the Family Combined In/Out-Network Per Person maximum displays (as “$X Per Person”). • If the Family In-Network Per Person and Family Combined In/Out-Network Per Person maximums both equal “Not Applicable,” then “Not Applicable” displays. Per Group Logic: • If the Family In-Network Per Group maximum equals a dollar amount, then the Family In-Network Per Group maximum displays (as “$X Per Group”). • If the Family In-Network Per Group maximum equals “Not Applicable” and the Family Combined In/Out-Network Per Group maximum equals a dollar amount, then the Family Combined In/Out-Network Per Group maximum displays (as “$X Per Group”). • If the Family In-Network Per Group and Family Combined In/Out-Network Per Group maximums both equal “Not Applicable,” then “Not Applicable” displays.

Figure 14 shows the Access to Doctors and Hospitals section of the Plan Details page.

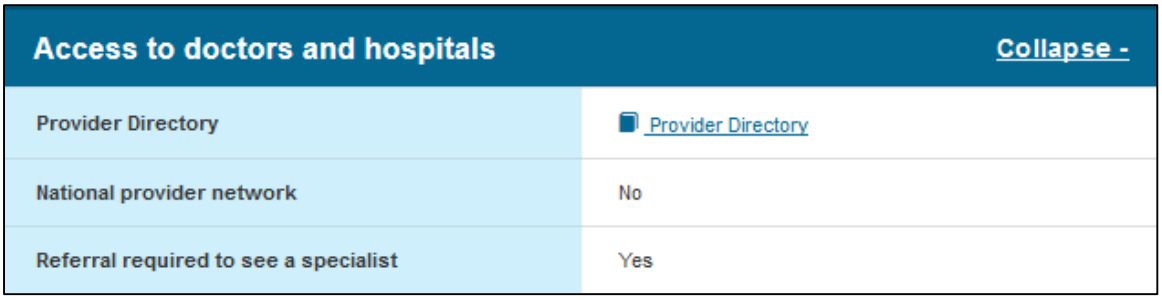

Figure 14: Plan Details – Access to Doctors and Hospitals Section

Table 15 describes the fields in the Access to Doctors and Hospitals section of the Plan Details page.

Table 15: Plan Details – Access to Doctors and Hospitals Section Fields

Field Name	Description
Provider Directory	Provides a link to the plan's provider directory from the "Network URL" field in the Network template.
National provider network	Indicates whether this plan is a national provider network, based on the "National Network" field in the Plans and Benefits template.
Referral required to see a specialist	Indicates whether this plan requires a referral to see a specialist, based on the "Is a Referral Required for Specialist?" field in the Plans and Benefits template.

Figure 15 shows the Hospital Services section of the Plan Details page.

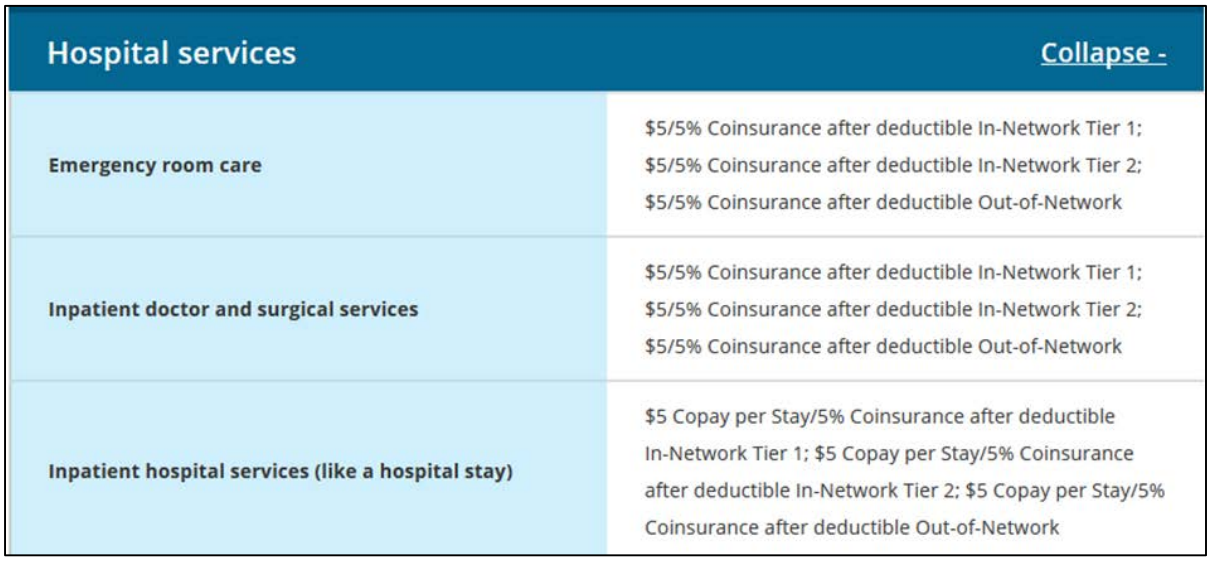

Figure 15: Plan Details – Hospital Services Section

Table 16 describes the fields in the Hospital Services section of the Plan Details page.

Table 16: Plan Details – Hospital Services Section Fields

Field Name	Description
Emergency room care	Provides cost sharing information for the benefit “Emergency Room Care,” found in the Plans and Benefits template.
Inpatient doctor and surgical services	Provides cost sharing information for the benefit “Inpatient Physician and Surgical Services,” found in the Plans and Benefits template.
Inpatient hospital services (like a hospital stay)	Provides cost sharing information for the benefit “Inpatient Hospital Services,” found in the Plans and Benefits template.

Figure 16 shows the Cost and Coverage Examples section of the Plan Details page.

Figure 16: Plan Details – Cost and Coverage Examples Section

Table 17 describes the fields in the Cost and Coverage Examples section of the Plan Details page.

Table 17: Plan Details – Cost and Coverage Examples Section Fields

Field Name	Description
Total cost for a healthy pregnancy and normal delivery	Displays the sum of the following four values from the Plans and Benefits template: • Having a Baby – Deductible • Having a Baby – Copayment • Having a Baby – Coinsurance • Having a Baby – Limit Displays “Not Available” if “Deductible,” “Copayment,” “Coinsurance” or “Limit” are blank in the Plans and Benefits template.
Total cost of managing type 2 diabetes	Displays the sum of the following four values from the Plans and Benefits template: • Having Diabetes – Deductible • Having Diabetes – Copayment • Having Diabetes – Coinsurance • Having Diabetes – Limit Displays “Not Available” if “Deductible,” “Copayment,” “Coinsurance” or “Limit” are blank in the Plans and Benefits template.

Field Name	Description
Total cost of treatment of a simple fracture	Displays the sum of the following four values from the Plans and Benefits template: • Treatment of a simple fracture – Deductible • Treatment of a simple fracture – Copayment • Treatment of a simple fracture – Coinsurance • Treatment of a simple fracture – Limit Displays "Not Available" if "Deductible," "Copayment," "Coinsurance" or "Limit" are blank in the Plans and Benefits template. For Plan Year 2017 this field will not display in Plan Compare.

Figure 17 shows the Adult Dental Coverage section of the Plan Details page.

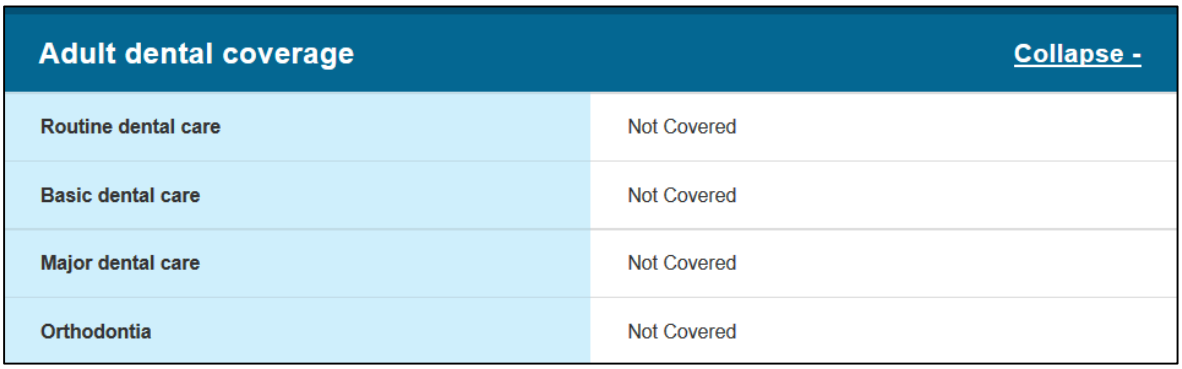

Figure 17: Plan Details – Adult Dental Coverage Section

Table 18 describes the fields in the Adult Dental Coverage section of the Plan Details page.

Table 18: Plan Details – Adult Dental Coverage Section Fields

Field Name	Description
Routine dental care	Provides cost sharing information for the benefit "Routine Dental Services (Adult)," found in the Plans and Benefits template.
Basic dental care	Provides cost sharing information for the benefit "Basic Dental Care – Adult," found in the Plans and Benefits template.
Major dental care	Provides cost sharing information for the benefit "Major Dental Care – Adult," found in the Plans and Benefits template.
Orthodontia	Provides cost sharing information for the benefit "Orthodontia – Adult," found in the Plans and Benefits template.
Provider directory (Stand-alone dental plans only)	Provides a link to the plan's list of in-network dentists, from the "Network URL" field in the Plans and Benefits template. (Note: Found in the summary section on the Plan Details page.)

Figure 18 shows the Child Dental Coverage section of the Plan Details page.

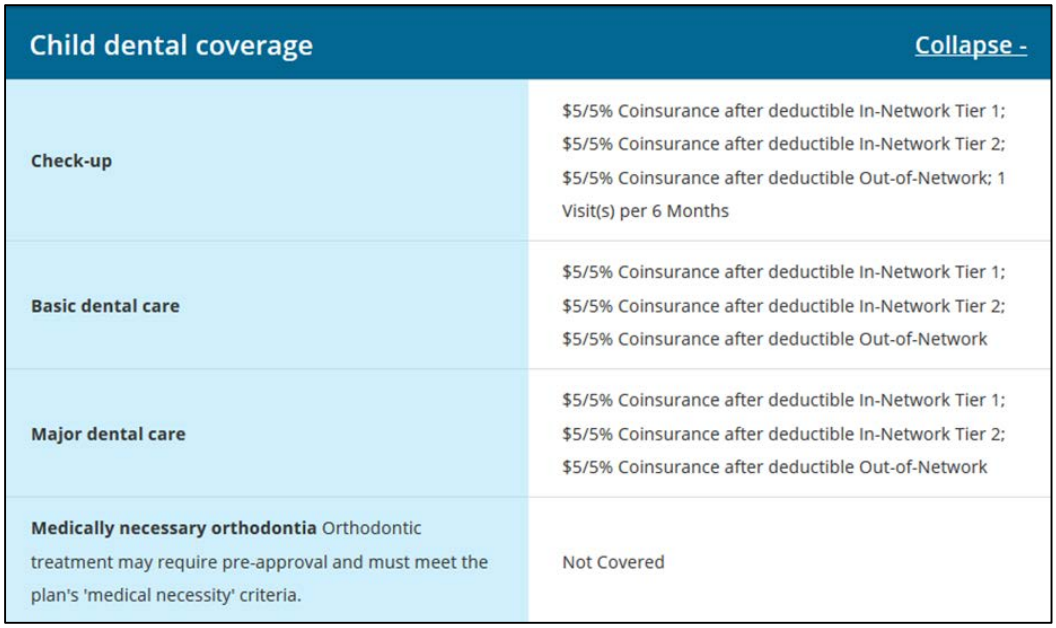

Figure 18: Plan Details – Child Dental Coverage Section

Table 19 describes the fields in the Child Dental Coverage section of the Plan Detail page.

Table 19: Plan Details – Child Dental Coverage Section Fields

Field Name	Description
Check-up	Provides cost sharing information for the benefit “Dental Check-Up for Children,” found in the Plans and Benefits template.
Basic dental care	Provides cost sharing information for the benefit “Basic Dental Care – Child,” found in the Plans and Benefits template.
Major dental care	Provides cost sharing information for the benefit “Major Dental Care – Child,” found in the Plans and Benefits template.
Medically necessary orthodontia	Provides cost sharing information for the benefit “Orthodontia – Child,” found in the Plans and Benefits template.

Figure 19 shows the Medical Management Programs section of the Plan Details page.

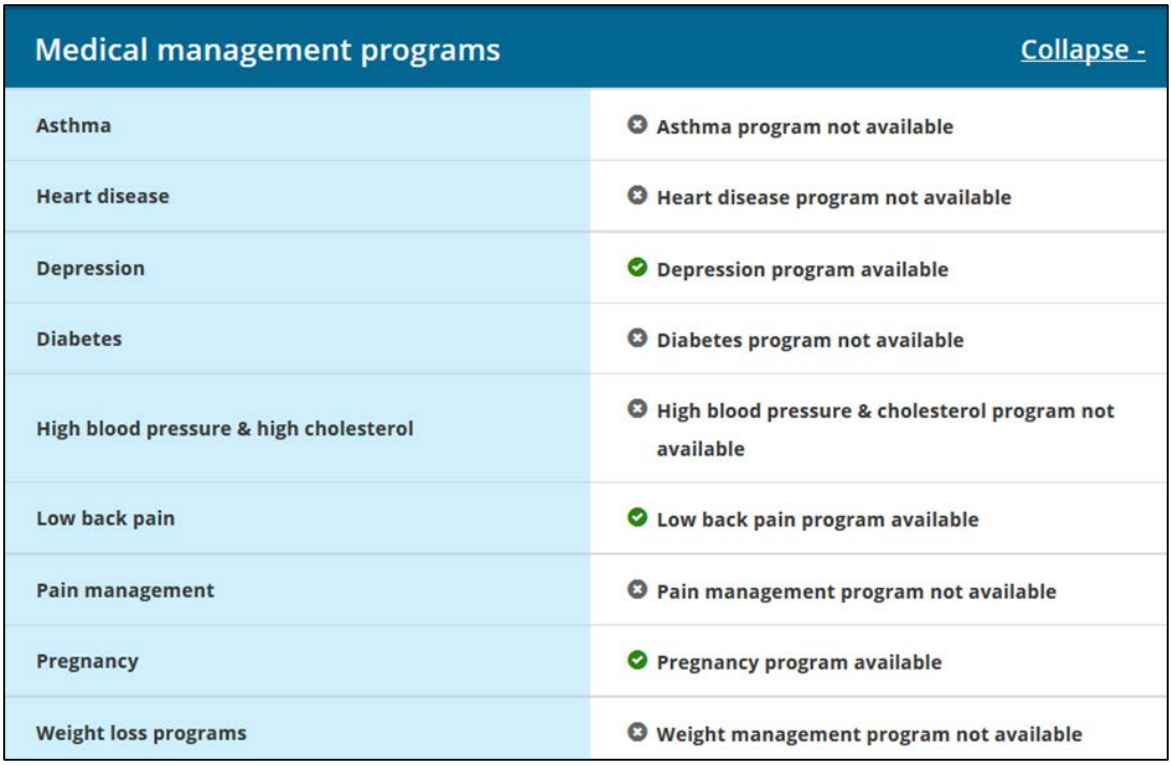

Figure 19: Plan Details – Medical Management Programs Section

Table 20 describes the fields in the Medical Management Programs section of the Plan Details page. All of the information in this section comes from the "Disease Management Program Offered" field in the Plans and Benefits template.

Table 20: Plan Details – Medical Management Programs Section Fields

Field Name	Description
Asthma	Indicates whether this plan offers an asthma medical management program.
Heart disease	Indicates whether this plan offers a heart disease medical management program.
Depression	Indicates whether this plan offers a depression medical management program.
Diabetes	Indicates whether this plan offers a diabetes medical management program.
High blood pressure & high cholesterol	Indicates whether this plan offers a head blood pressure and high cholesterol medical management program.
Low back pain	Indicates whether this plan offers a low back pain medical management program.
Pain management	Indicates whether this plan offers a pain management medical management program.
Pregnancy	Indicates whether this plan offers a pregnancy medical management program.
Weight loss programs	Indicates whether this plan offers a weight loss medical management program.

Figure 20 shows the Other Benefits section of the Plan Details page.

Other benefits	Collapse -
Acupuncture	Not Covered
Chiropractic care	$50/75% In-Network; $100/80% Out-of-Network; 30 Visit(s) per Year
Infertility treatment	Not Covered
Mental/behavioral health outpatient services	$50/75% In-Network; $100/80% Out-of-Network
Mental/behavioral health inpatient services	$50 Copay per stay/75% In-Network; $100 Copay per stay/80% Out-of-Network
Habillitative services	$50/75% In-Network; $100/80% Out-of-Network; Limits and Exclusions Apply
Bariatric services	Not Covered
Outpatient rehabilitative services	$50/75% In-Network; $100/80% Out-of-Network; Limits and Exclusions Apply
Skilled Nursing Facility care	$50 Copay per stay/75% In-Network; $100 Copay per stay/80% Out-of-Network; 100 Days per Admission
Private-duty nursing	$50/75% In-Network; $100/80% Out-of-Network; 500 Dollars per Year

Figure 20: Plan Details – Other Benefits Section

Table 21 describes the fields in the Other Benefits section of the Plan Details page.

Table 21: Plan Details – Other Benefits Section Fields

Field Name	Description
Acupuncture	Provides cost sharing information for the benefit "Acupuncture," found in the Plans and Benefits template.
Chiropractic care	Provides cost sharing information for the benefit "Chiropractic Care," found in the Plans and Benefits template.
Infertility treatment	Provides cost sharing information for the benefit "Infertility Treatment," found in the Plans and Benefits template.
Mental/behavioral health outpatient services	Provides cost sharing information for the benefit "Mental/Behavioral Health Outpatient Services," found in the Plans and Benefits template.
Mental/behavioral health inpatient services	Provides cost sharing information for the benefit "Mental/Behavioral Health Inpatient Services," found in the Plans and Benefits template.
Habilitative services	Provides cost sharing information for the benefit "Habilitation Services," found in the Plans and Benefits template.
Bariatric services	Provides cost sharing information for the benefit "Bariatric Surgery," found in the Plans and Benefits template.
Outpatient rehabilitative services	Provides cost sharing information for the benefit "Outpatient Rehabilitative Services," found in the Plans and Benefits template.
Skilled Nursing Facility care	Provides cost sharing information for the benefit "Skilled Nursing Facility," found in the Plans and Benefits template.
Private-duty nursing	Provides cost sharing information for the benefit "Private-Duty Nursing," found in the Plans and Benefits template.

5.4.4 Plan Details – Benefit Cost Sharing Logic

In the expandable sections, Tier 1 In-Network, Tier 2 In-Network, and Out-of-Network cost sharing for each benefit display, along with any quantitative limits. There is also a link that provides explanatory text for limits and exclusions; if you click the link, a pop-up box displays the Exclusions and Explanations text entered in the Plans and Benefits template for the benefit.

The following logic determines how coinsurance and copay information displays:

1. If the coinsurance is equal to "100%," "Not Covered" displays.
2. If both the copay and coinsurance are greater than zero but the coinsurance is less than 100%, both the copay and coinsurance display with their text qualifiers (such as "50% Coinsurance after deductible").
3. If the copay is greater than $0 and the coinsurance equals "0%," "0% Coinsurance after deductible," "No Charge," "No Charge after deductible," or "Not Applicable," only the copay displays with the copay qualifier. Likewise, if the coinsurance is greater than 0% and the copay equals "$0," "$0 Copay after deductible," "$0 Copay before deductible," "No Charge," "No Charge after deductible," or "Not Applicable," only the coinsurance displays with the coinsurance qualifier.
4. "No Charge" displays if:
    a. The copay equals "$0," "$0 Copay before deductible," or "No Charge" and the coinsurance equals "0%," "No Charge," or "Not Applicable."

b. The copay equals “Not Applicable” and the coinsurance equals “0%” or “No Charge.”

5. “No Charge after deductible” displays if:

   a. The copay equals “No Charge after deductible,” or “$0 Copay after deductible,” and the coinsurance equals “0%,” “No Charge,” “Not Applicable,” “No Charge after deductible,” or “0% Coinsurance after deductible.”

   b. The copay equals “$0,” “$0 Copay before deductible,” “No Charge,” or “Not Applicable,” and the coinsurance equals “0% Coinsurance after deductible,” or “No Charge after deductible.”

6. “Not Applicable” displays if both the copay and coinsurance equal “Not Applicable.”

Copay qualifiers that include “per Day” or “per Stay” behave according to these same rules. For example, a copay equal to “$25 Copay per Day after deductible” and a coinsurance equal to “No Charge” displays “$25 Copay per Day after deductible.”

“$0 Copay per Stay,” “$0 Copay per Day,” “$0 Copay per Stay before deductible,” and “$0 Copay per Day before deductible” are equivalent to “No Charge.” “$0 Copay per Stay after deductible” and “$0 Copay per Day after deductible” are equivalent to “No Charge after deductible.”

NOTE: This mapping logic does not apply to FF-SHOP Plan Compare. The FF-SHOP Marketplace displays both the copay and coinsurance values for all benefits that are listed as covered in the Plans and Benefits template. The FF-SHOP system display values can be found in Appendix A.

5.4.5 Stand Alone Dental Plan Details

When you view a dental plan, you see the Dental-only Plan Details page, which also displays an overview header and collapsible sections. However, the Dental-only Plan Details page differs in the following ways:

- Monthly premium will display guaranteed or estimated premiums.
- Only Adult Dental coverage and Child Dental coverage will display as collapsible sections.

NOTE: Small Group (SHOP) child-only dental plans will not display in Plan Preview or FF-SHOP Plan Compare.

Figure 21 shows a sample Plan Preview page for a stand-alone dental plan.

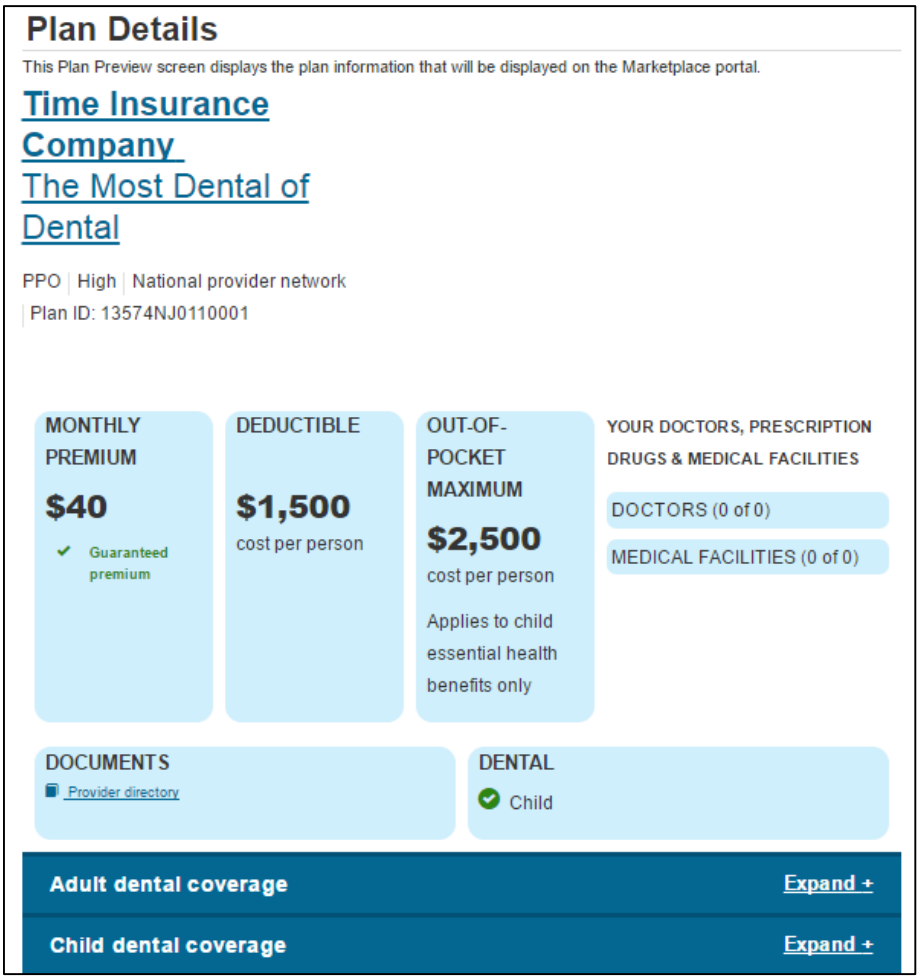

Figure 21: Plan Details Page – Stand-Alone Dental Plan

6 Troubleshooting and Support

6.1 Error Messages

In rare cases, a system error may occur and you will see an error message at the top of the page as shown in Figure 22. If this occurs, log out of HIOS completely, delete your browser's cache history, and try using Plan Preview again. These steps resolve almost all system errors, but if a system error continues to occur, contact the CMS Helpdesk at 1-855-CMS-1515.

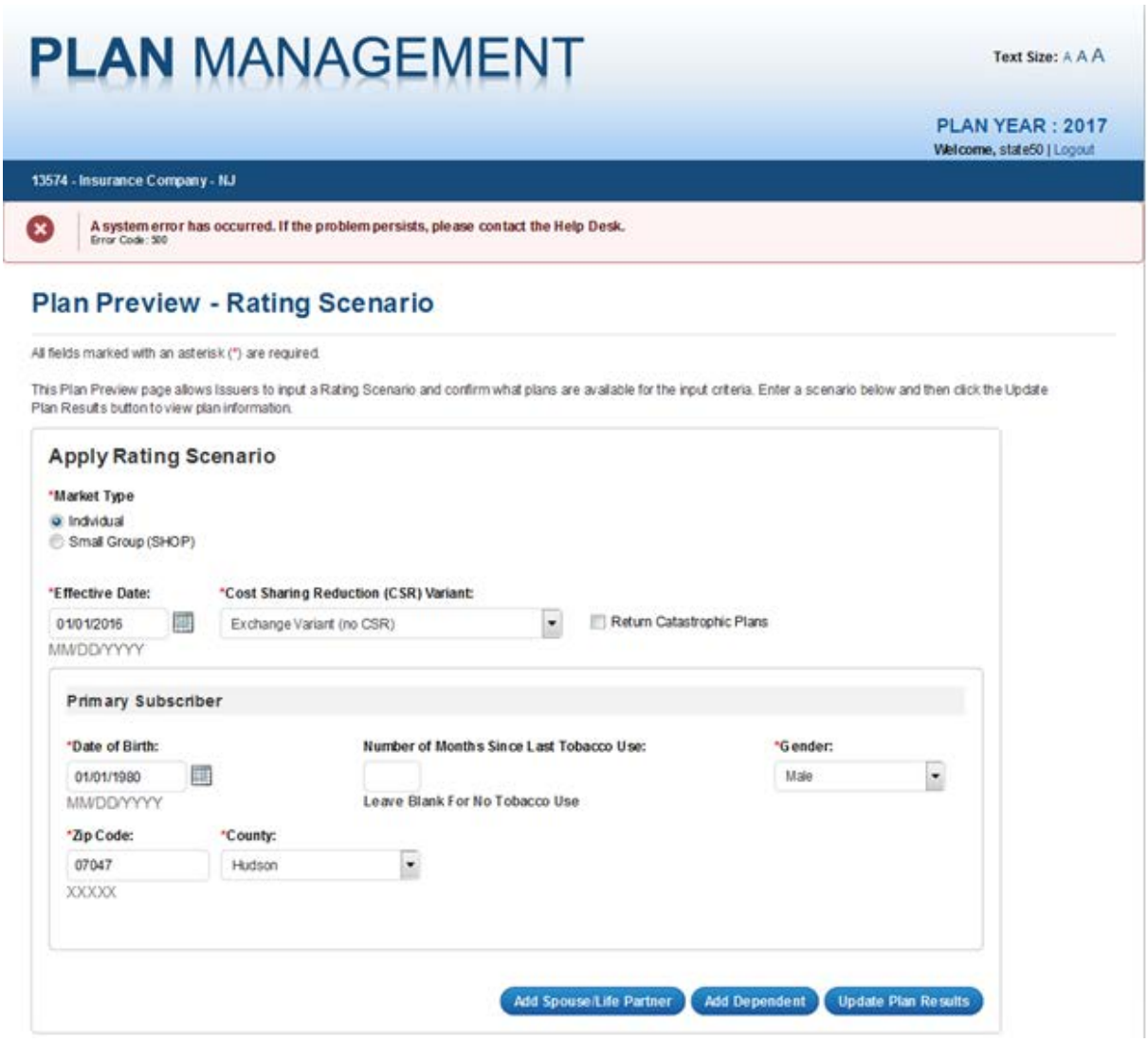

Figure 22: Error Message

On the Rating Scenario Page, you may see errors about required or invalid data fields for either Individual Market (see Figure 23) or SHOP plans (see Figure 24). Errors could be the result of the examples provided in Table 22 (for Individual Market) or Table 23 (for SHOP).

Figure 23 shows potential field errors on the Rating Scenario Page for Individual Market plans.

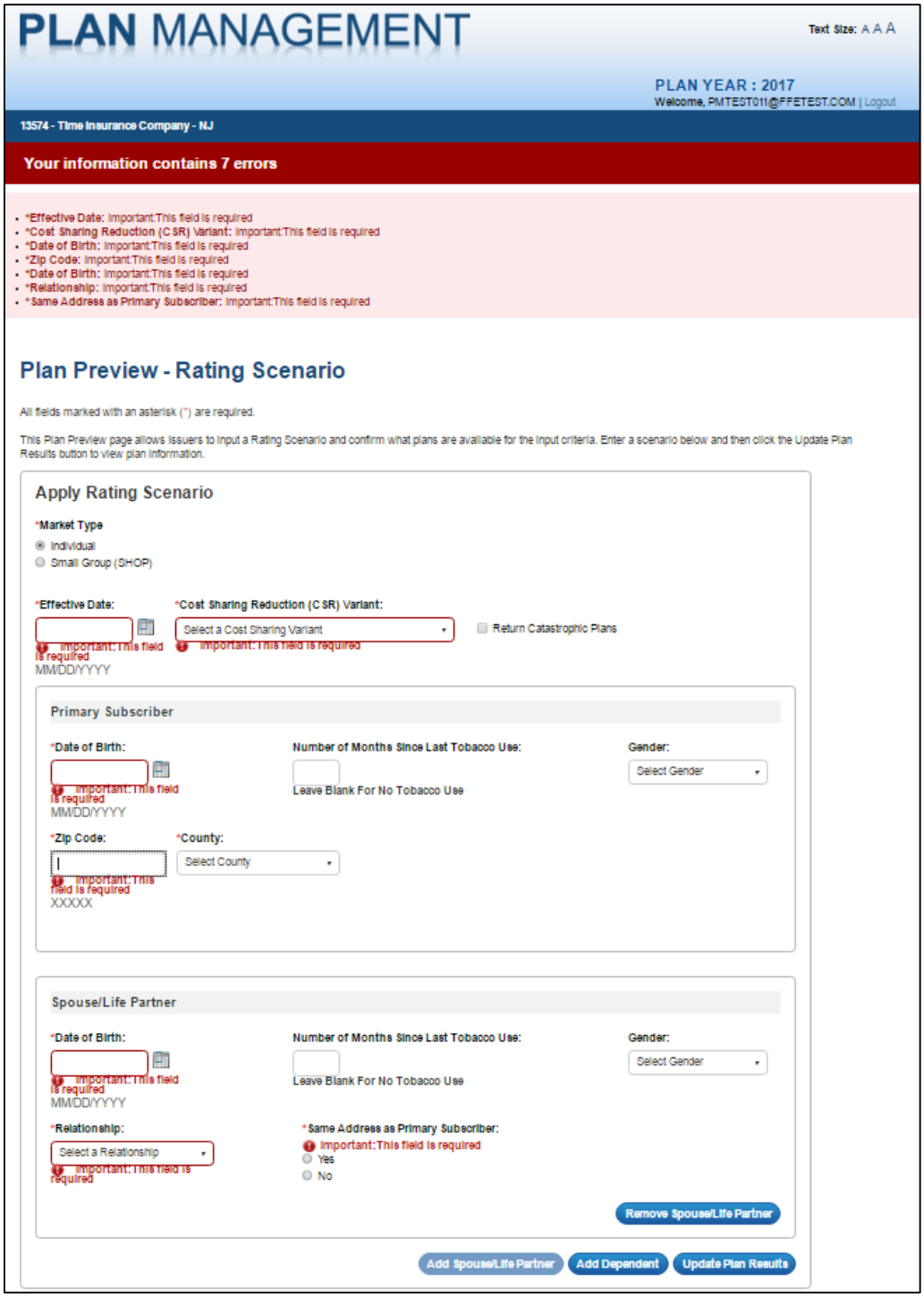

Figure 23: Individual Market Plan Field Validation Errors

Table 22 describes potential validation error messages that display on the top of the Rating Scenario page for Individual Market plans.

Table 22: Individual Market Plan Field Validation Error Messages

Error Message Reason	Error Message Text
User did not select a state	State: Important: This field is required.
User enters an effective date prior to 1/1/2017 or after 12/31/2017	Effective Date: Important: Please enter a valid date.
User enters an effective date with fewer than 8 digits	Effective Date: Important: This is not a valid date.
User does not enter an effective date	Effective Date: Important: This field is required.
User does not select Cost Sharing Variant	Cost Sharing Reduction (CSR) Variant: Important: This field is required.
User does not enter date of birth for primary subscriber	Date of Birth: Important: This field is required.
User enters invalid date of birth for primary subscriber	Date of Birth: Important: This is not a valid date.
User enters incorrect zip code	Zip Code: Important: This field is required.
User does not select a county	County: Important: This field is required.
User does not enter date of birth for dependent	Date of Birth: Important: This field is required.
User enters invalid date of birth for dependent	Date of Birth: Important: This is not a valid date.
User does not enter relationship for dependent	Relationship: Important: This field is required.
User does not select whether the dependent resides with the primary subscriber	Same address as primary: Please select at least 1 item(s).
No plans are available	No Plans Available for Input Criteria.

Figure 24 shows potential field errors on the Rating Scenario Page for SHOP plans.

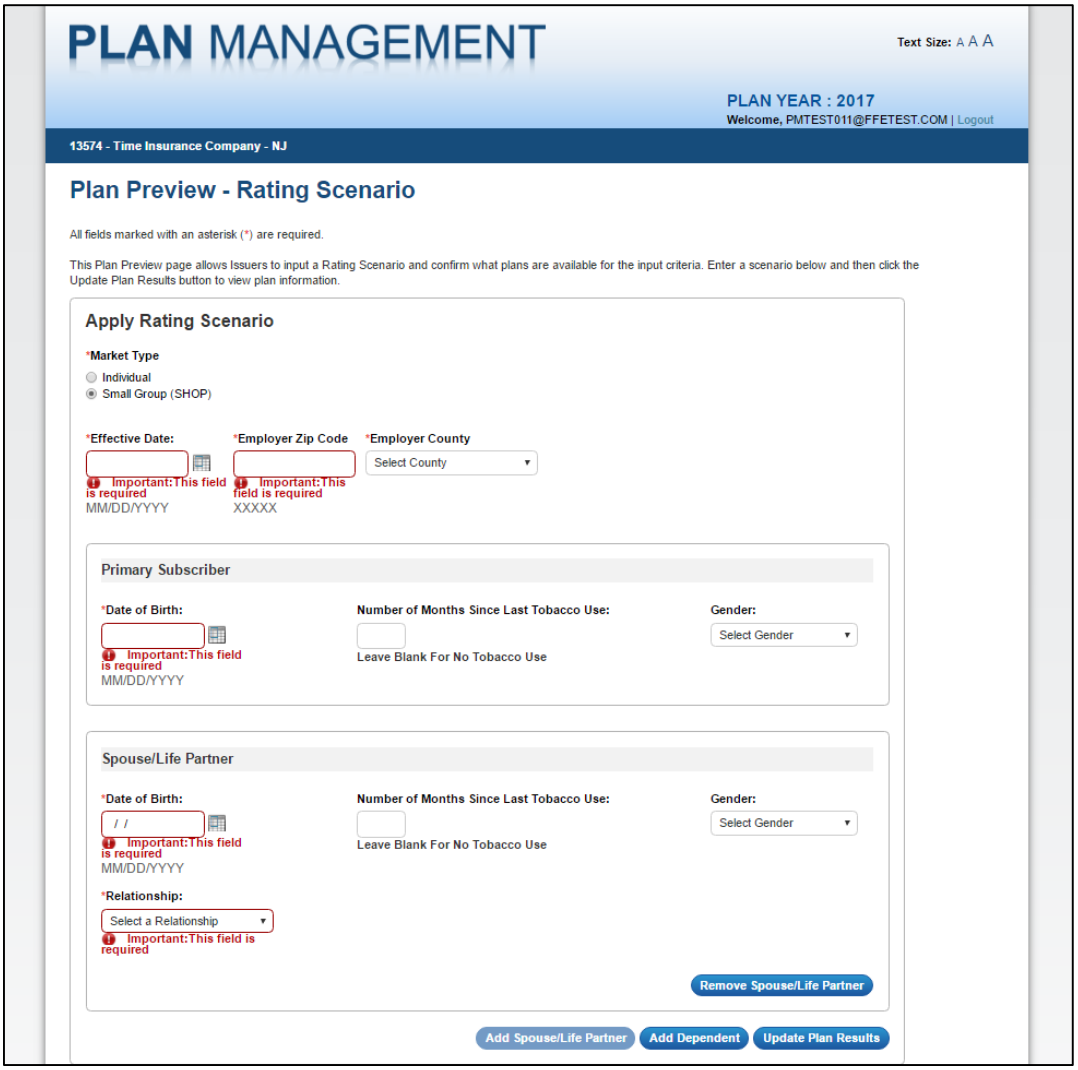

Figure 24: SHOP Plan Field Validation Errors

Table 23 describes potential validation error messages that display on the top of the Rating Scenario page for SHOP plans.

Table 23: SHOP Plan Field Validation Error Messages

Error Message Reason	Error Message Text
User did not select a state	State: Important: This field is required.
User enters an effective date prior to 1/1/2017 or after 12/31/2016	Effective Date: Important: Please enter a valid date.
User enters an effective date with fewer than 8 digits	Effective Date: Important: This is not a valid date.
User does not enter an effective date	Effective Date: Important: This field is required.
User does not enter date of birth for primary subscriber	Date of Birth: Important: This field is required.
User enters invalid date of birth for primary subscriber	Date of Birth: Important: This is not a valid date.
User enters incorrect zip code	Zip Code: Important: This field is required.
User does not select a county	County: Important: This field is required.
User does not enter date of birth for dependent	Important: This field is required.
User enters invalid date of birth for dependent	Important: This is not a valid date.
User does not enter relationship for dependent	Important: This field is required.
No plans are available	No Plans Available for Input Criteria.

6.2 Support

Table 24 below provides a list of contacts.

Table 24: 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

Appendix A: Plan Preview Module v. FF-SHOP Plan Compare

2017 Plan Preview allows you to preview both Individual Market and Small Group (SHOP) plans.

The Ratings Scenario page of Plan Preview includes a radio button that allows you to view either Individual Market or Small Group (SHOP) plans. The system displays Small Group (SHOP) plan rates and benefits using the same format and logic as the Individual Market. On SHOP preview pages, you must enter an employer zip code and county, and the CSR information and enrollee residence fields will be hidden.

SHOP plans shown on the Plan Details page in the Plan Preview module might not appear in exactly the same way when shown in FF-SHOP Plan Compare. The Plan Preview module only displays select copay or coinsurance values based on the mapping logic outlined in section 5.4.1. On the other hand, FF-SHOP Plan Compare displays the raw copay and coinsurance values that were entered into the Plans and Benefits template. Plan Preview displays a disclaimer regarding these differences on the Plan Details page for SHOP plans.

The images in the example below show how copay and coinsurance values display in FF-SHOP Plan Compare versus Plan Preview for Inpatient Hospital Services.

Figure 25 shows how Inpatient Hospital Services information displays in FF-SHOP Plan Compare.

	In Network (Tier 1)	In Network (Tier 2)	Out of Network
Inpatient Hospital Services (e.g., Hospital Stay)			
Copay	$20		$30
Coinsurance	20%		30%

Figure 25: Inpatient Hospital Services in FF-SHOP Plan Compare

Figure 26 shows how Inpatient Hospital Services information displays in Plan Preview.

Inpatient hospital services (like a hospital stay)	$5 Copay per Stay/5% Coinsurance after deductible In-Network Tier 1; $5 Copay per Stay/5% Coinsurance after deductible In-Network Tier 2; $5 Copay per Stay/5% Coinsurance after deductible Out-of-Network

Figure 26: Inpatient Hospital Services in Plan Preview

Table 25 shows the FF-SHOP enhancements to the plan details page beginning with Open Enrollment 2017.

Table 25: FF-SHOP Enhancements

Issuer Input	Current UI Display	Future Display	Notes
100% in Coinsurance field	Coinsurance: 100%	Coinsurance: Not Covered	Copay for corresponding benefit will display as entered in the template
No Charge in Copay field (and there is a corresponding coinsurance)	Copay: No Charge	Copay: Not Applicable	Coinsurance for corresponding benefit will display as entered in the template

Table 26 shows the differences in the fields that display on the Plan Detail pages of Plan Preview and FF-SHOP Plan Compare.

Table 26: Plan Preview and FF-SHOP Plan Compare – Benefit Displays

Benefit or Field	Template	Displays in SHOP Plan Preview?	Displays in the FF-SHOP Plan Compare?
Primary Care Visit to Treat an Injury or Illness	Plans and Benefits	Yes	Yes
Specialist Visit	Plans and Benefits	Yes	Yes
Other Practitioner Office Visit (Nurse, Physician Assistant)	Plans and Benefits	No	No
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Plans and Benefits	Yes	No
Outpatient Surgery Physician/Surgical Services	Plans and Benefits	Yes	No
Hospice Services	Plans and Benefits	No	No
Non-Emergency Care When Traveling Outside the U.S.	Plans and Benefits	No	No
Routine Dental Services (Adult)	Plans and Benefits	Yes	Yes
Infertility Treatment	Plans and Benefits	Yes	Yes
Long-Term/Custodial Nursing Home Care	Plans and Benefits	No	No
Private-Duty Nursing	Plans and Benefits	Yes	Yes
Routine Eye Exam (Adult)	Plans and Benefits	Yes	Yes
Urgent Care Centers or Facilities	Plans and Benefits	No	No
Home Health Care Services	Plans and Benefits	No	No
Emergency Room Services	Plans and Benefits	Yes	Yes
Emergency Transportation/Ambulance	Plans and Benefits	No	No
Inpatient Hospital Services (e.g., Hospital Stay)	Plans and Benefits	Yes	Yes

Benefit or Field	Template	Displays in SHOP Plan Preview?	Displays in the FF-SHOP Plan Compare?
Inpatient Physician and Surgical Services	Plans and Benefits	Yes	Yes
Bariatric Surgery	Plans and Benefits	Yes	Yes
Cosmetic Surgery	Plans and Benefits	No	No
Skilled Nursing Facility	Plans and Benefits	Yes	Yes
Prenatal and Postnatal Care	Plans and Benefits	No	No
Delivery and All Inpatient Services for Maternity Care	Plans and Benefits	No	No
Mental/Behavioral Health Outpatient Services	Plans and Benefits	Yes	Yes
Mental/Behavioral Health Inpatient Services	Plans and Benefits	Yes	Yes
Substance Abuse Disorder Outpatient Services	Plans and Benefits	No	No
Substance Abuse Disorder Inpatient Services	Plans and Benefits	No	No
Generic Drugs	Plans and Benefits	Yes	Yes
Preferred Brand Drugs	Plans and Benefits	Yes	Yes
Non-Preferred Brand Drugs	Plans and Benefits	Yes	Yes
Specialty Drugs	Plans and Benefits	Yes	Yes
Outpatient Rehabilitation Services	Plans and Benefits	Yes	Yes
Habilitative Services	Plans and Benefits	Yes	Yes
Chiropractic Care	Plans and Benefits	Yes	Yes
Durable Medical Equipment	Plans and Benefits	No	No
Hearing Aids	Plans and Benefits	Yes	Yes
Imaging (CT/PET Scans, MRIs)	Plans and Benefits	No	No
Preventive Care/Screening/Immunization	Plans and Benefits	No	No
Routine Foot Care	Plans and Benefits	No	No
Acupuncture	Plans and Benefits	Yes	Yes
Weight Loss Programs	Plans and Benefits	No	No
Routine Eye Exam for Children	Plans and Benefits	Yes	Yes
Eye Glasses for Children	Plans and Benefits	Yes	Yes
Dental Check-Up for Children	Plans and Benefits	Yes	Yes
Rehabilitative Speech Therapy	Plans and Benefits	No	No
Well Baby Visits and Care	Plans and Benefits	No	No
Laboratory Outpatient and Professional Services	Plans and Benefits	Yes	Yes
X-rays and Diagnostic Imaging	Plans and Benefits	Yes	Yes
Basic Dental Care – Child	Plans and Benefits	Yes	Yes

Benefit or Field	Template	Displays in SHOP Plan Preview?	Displays in the FF-SHOP Plan Compare?
Orthodontia – Child	Plans and Benefits	Yes	Yes
Major Dental Care – Child	Plans and Benefits	Yes	Yes
Basic Dental Care – Adult	Plans and Benefits	Yes	Yes
Orthodontia – Adult	Plans and Benefits	Yes	Yes
Major Dental Care – Adult	Plans and Benefits	Yes	Yes
Transplant	Plans and Benefits	No	No
Accidental Dental	Plans and Benefits	No	No
Dialysis	Plans and Benefits	No	No
Allergy Testing	Plans and Benefits	No	No
Chemotherapy	Plans and Benefits	No	No
Radiation	Plans and Benefits	No	No
Diabetes Education	Plans and Benefits	No	No
Prosthetic Devices	Plans and Benefits	No	No
Infusion Therapy	Plans and Benefits	No	No
Treatment for Temporomandibular Joint Disorders	Plans and Benefits	No	No
Nutritional Counseling	Plans and Benefits	No	No
Reconstructive Surgery	Plans and Benefits	No	No
Clinical Trials	Plans and Benefits	No	No
Diabetes Care Management	Plans and Benefits	No	No
Inherited Metabolic Disorder - PKU	Plans and Benefits	No	No
Off Label Prescription Drugs	Plans and Benefits	No	No
Dental Anesthesia	Plans and Benefits	No	No
Prescription Drugs Other	Plans and Benefits	No	No
Congenital Anomaly, including Cleft Lip/Palate	Plans and Benefits	No	No
Early Intervention Services	Plans and Benefits	No	No
Rehabilitative Occupational Therapy	Plans and Benefits	No	No
Rehabilitative Physical Therapy	Plans and Benefits	No	No
Mental Health Other	Plans and Benefits	No	No
Combined Medical and Drug EHB Deductible	Plans and Benefits	Yes	Yes
Drug EHB Deductible	Plans and Benefits	Yes	Yes
Maximum Out of Pocket for Drug EHB Benefits	Plans and Benefits	Yes	Yes
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)	Plans and Benefits	Yes	Yes
Maximum Out of Pocket for Medical EHB Benefits	Plans and Benefits	Yes	Yes

Benefit or Field	Template	Displays in SHOP Plan Preview?	Displays in the FF-SHOP Plan Compare?
Network URL	Network	Yes	Yes
Formulary URL	Prescription Drug	Yes	Yes
Issuer Marketing Name	Administrative	No (pulled from HIOS)	Yes, collected from FF-SHOP logo collection process
3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug	Yes	Yes
Cost and Coverage Examples (Having a Baby and Managing Diabetes)	Plans and Benefits	Yes (Total cost displayed)	Yes (Separate deductible, copay, coinsurance, limit amounts displayed)
Disease Management Programs	Plans and Benefits	Yes	Yes

Table 27 describes the rating and business logic differences between Plan Preview and FF-SHOP Plan Compare.

Table 27: Plan Preview and FF-SHOP Plan Compare – Ratings and Business Logic

Item	Individual	SHOP
Family Tiers	Allows family tier rating (SADP only)	Does not allow family tier rating
Quarterly Rates	Rates set on annual basis	Allows different quarterly rates
Estimated Rates	Allows estimated rates (SADP Only)	Estimated rates are not allowed
CSR Variants	• Exchange Variant (No CSR) • 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	No CSR variants
Address	Service area based on primary subscriber address; Issuers may require dependents to reside with primary subscriber	Only Employer address is used for all employees and dependents on the roster
Domestic partners	As entered in the Rating Business Rules template	Employer can choose if domestic partners are allowed on a plan (may choose same sex or opposite sex partners or both)
Tobacco Rates	Based on number of months since last use (no cessation program exception)	Tobacco rates will not be applied if a regular tobacco user chooses to participate in a tobacco cessation program
Child-only plans	Allows child-only plans	Does not allow child-only plans

Appendix B: Acronyms and Abbreviations

Acronym / Abbreviation	Literal Translation
CMS	Centers for Medicare & Medicaid Services
ECP	Essential Community Providers
HHS	Department of Health and Human Services
HIOS	Health Insurance Oversight System
FFM	Federally Facilitated Marketplace
FF-SHOP	Federally Facilitated Small Business Health Options Program
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
QHP	Qualified Health Plans
SERFF	System for Electronic Rate and Form Filing
SHOP	Small Business Health Options Program
RIDP	Remote Identity Proofing
XOSC	Exchange Operation Support Desk

Appendix C: Plan Suppression and Display Logic

For your reference Table 28 displays the display logic for Plan Preview based on plan certification and suppression.

Table 28: Display Logic for Plan Certification and Suppression

Cross-validation	Certification	Suppression	Plan Preview Display
Not cross-validated	Any	Any	Excluded from display
Cross-validated	None	None	Displays available (based on enrollment criteria)
Cross-validated	Certified	Available	Displays available (based on enrollment criteria)
Cross-validated	Certified	Suspended	Displays available with warning message (based on enrollment criteria)
Cross-validated	Certified	Closed	Displays unavailable with specific reason text
Cross-validated	Certified	Not Applicable	Unexpected case; will display unavailable with reason code
Cross-validated	Not Certified	Not Applicable	Excluded from display
Cross-validated	Decertified	Not Applicable	Excluded from display
Cross-validated	Certified Off-Exchange SADP	Not Applicable	Excluded from display