Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight (CCIIO)
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Rate and Benefits Information System (RBIS)

User Manual

Version: 10.00.00
Last Modified: June 10, 2014

APPROVALS

Submitting Organization's Approving Authority:

Signature	Printed Name	Date	Phone Number

Position Title

TABLE OF CONTENTS

LIST OF EXHIBITS

RBIS User Manual Change History

February 2014 Revisions

The following updates have been made to Section10 to explain the changes to the Attestation page:

- Section 10.1 – Updated Attestation agreement text.

May 2014 Revisions

Significant updates have been made to the guide for the v. 10 RBIS release. Changes reflect use of 2014 templates from FFM for Benefits, Rates, Service Area and Business Rules. Templates for Individual and Small Group plans have been consolidated together. The following is a list of changes made to this document.

Section 2: Getting Started

2.1.1 Updated references to submission materials available in RBIS.

2.1.3.3 Created a new section with screenshots to walk users through enabling Add-In support for the Plans and Benefits template.

2.4.1 Updated sequence of steps for logging into RBIS. Updated screenshots of HIOS Home Page and option to access RBIS.

Section 3: Process Overview

3.2 Minor changes to update references from .csv files to .xml. Updated template names in the section discussing removal of template data by XOSC.

Section 4: RBIS Home Page

4 Updated screenshot of RBIS Home Page.

Section 5: Submission Materials

5.1 Updated screenshot of Small Group Submission Materials.

5.2 Updated screenshot of Small Group Submission Materials.

*Deleted section on the Enhanced Submission Process.

Section 6: Templates

Updates in this section were made to consolidate the sections for Individual/Family Plan and Small Group into one section that describes the four common templates in use.

6 Added a list of template names common to both market types.

6.1 Updated this section to describe the Plan Benefits Template common to both market types. Included new screenshots of the template and error messages.

6.1.1 Created a new section for the Plans Benefits template Add-In module along with a new screenshot.

6.1.2 Created a new section for the AV calculator.

6.2 Updated this section to describe the Service Area Template common to both market types. Included new screenshots of the template and error messages.

6.3 Updated this section to describe the Rates Template common to both market types. Included new screenshots of the template and error messages.

6.4 Updated this section to describe the Business Rules Template common to both market types. Included new screenshots of the template and error messages.

6.5 Updated the description of the template validation and finalization process based upon the common templates.

Section 7: Data Upload

7 Updated the screenshot of the Data Upload tab from RBIS.

7.1.1 Updated the screenshots of the Upload windows for both Individual and Small Groups. Also updated screenshots with detail of the file browse and upload buttons.

7.2 Updated the screenshot of the View Uploaded Files window.

7.3.1 Updated the list of template validations performed.

7.3.2 Updated the list of template cross-check validations performed.

Section 8: Validate Data

This section has been modified and reorganized to contain an updated view of the validation process.

8 Updated screenshot of the Validate Data tab in RBIS.

8.1.1 Updated screenshots for the View All Plans options for both Individual and Small Group plans.

8.1.1.3 Updated screenshot for "No Data Received from Issuer" message.

8.1.1.3.1 Updated screenshot for "You have indicated that there is no data to report" message. Updated screenshot for downloading a view of the plan benefits. Updated screenshot of the plan benefits information returned.

*Removed screenshot and text related to viewing benefits and cost share data via the onscreen link.

8.1.1.4 Updated screenshot of Validation Status options.

8.1.2.1 Updated the description of search criteria and included a new screenshot of Search by Scenario for Small Group market.

8.1.2.2 Updated description of search criteria and included a new screenshot of Search by Scenario for Individual market.

8.1.2.3 Updated screenshot of Verify Zip functionality.

8.1.2.4 Updated screenshot of the Search by Scenario results table.

Section 9: Attestation

9.1 Updated screenshot of the Attestation screen.

9.2 Updated screenshot of the Attestation Unavailable screen.

Section 10: Resubmission

10.3 Updated screenshot of the Email Opt-Out option.

Section 11: Appendices

11.2 Updated tables containing lists of email error messages for the Plans Benefits, Service Area and Rates templates.

11.2.5 Updated the table with the list of cross check error messages.

11.3 Minor updates in this section to change references from .csv to .xml and to update the maximum file size to be 50 MB.

11.4 Significant updates to the tables in this section containing data dictionary definitions for fields from the Plans Benefits, Service Area, Rates and Business Rules templates.

11.5 Minor updates to remove gender and rating area from the list of information collected in the Rates template.

11.5.1 Updated screenshot of the Business Rules template.

11.5.2 Updated the age rules listed based upon the current template.

11.5.3 Updated screenshot of the Rates template. Updated tables of subscriber types and subscriber types/scenarios for both Individual and Group based rates. Included a new section on relationship types included in the Business Rules template.

11.5.4 Updated the three rate calculation scenarios based upon the templates in use. Each scenario includes new description text, tables of values and mockups of the rate values returned.

11.6 Significant updates to the tables in this section containing data elements from the Plans Benefits and Business Rules templates. The data elements listed have been updated to reflect the values stored in the XML after conversion for storage in the RBIS database.

1 INTRODUCTION

The Center for Consumer Information and Insurance Oversight (CCIIO), a division of the Department of Health and Human Services (HHS), is charged with helping implement many provisions of the Affordable Care Act. CCIIO oversees the implementation of the provisions related to private health insurance including providing oversight for the Issuer-based data exchanges that populate http://www.healthcare.gov.

To facilitate this charge, the Health Insurance Oversight System (HIOS) allows the government to collect data from individual and small group market Issuers. The collected data is aggregated with other data sources and made public on a consumer-facing website. The Rate and Benefits Information System (RBIS) web site gathers detailed plan benefit and eligibility data. This user manual explains the features and other aspects related to the use of the RBIS web site.

2 GETTING STARTED

2.1 MINIMUM REQUIREMENTS

2.1.1 Supported Applications

RBIS supports all templates to be downloaded and completed in the following Microsoft Excel versions: 2003, 2007 and 2010. The templates and associated submission materials are provided in the following formats:

Plans and Benefits Add-In module - .xlam
Plans and Benefits - .xlsm (macro enabled xls worksheet)
AV Calculator for Plans and Benefits - .xlsm
Service Areas - .xls
Rates - .xls
Business Rules - .xls

The RBIS web site supports Firefox versions 4.0 and above or Internet Explorer Versions 8 and above.

2.1.2 Macro Security Level Setting

The RBIS Templates use macros to perform the built-in functions including the Validation and finalization processes. It is imperative that Excel's macro security level settings are set to allow macros. The following are the Excel macro security level settings:

- **Excel 2003**: Macro security level should be "**Medium**". Instructions for setting the level once the spreadsheet is open will be covered in *Section 2.1.3: Set-up Considerations*. This will allow the User to pick and choose which macros to work with versus which to not enable.
- **Excel 2007 or later**: Macros should be set to "**Disable all macros with notification**." Instructions will be provided in *Section 2.1.3: Set-up Considerations*.

2.1.3 Set-up Considerations

Configuration on the computer must be set to satisfy the following requirements for the Issuer Data Form to work properly:

- Use Microsoft Excel version 2003, 2007 or 2010.
- Enable the Excel standard toolbar.

2.1.3.1 Excel Version 2003

Set Excel macro security settings to "***Medium"*** *(recommended)* for Excel 2003:

1. Select ***Tools*** from the menu bar.
2. Select ***Macro*** on the dropdown menu.
3. Select ***Security***.
4. Select ***Medium (recommended)***.
5. Select ***OK***.
6. When the workbook is opened, the workbook will fully function.

2.1.3.2 Excel Version 2007

Set Excel macro security settings to "***Disable all macros with notifications***" for Excel 2007:

1. Click the ***Office Button*** in the upper left corner of the window and then click the ***Excel Options*** button at the bottom of the menu.
2. Select ***Trust Center*** on the left navigation pane and then click ***Trust Center Setting***.
3. Select ***Macro Settings*** on the left navigation pane and then select the radio button in front of ***Disable all macros with notification***.
4. Select on ***OK*** from the Trust Center window. Select on ***OK*** from the Excel Option window.
5. When the workbook is opened, select the ***Options***.
6. Select ***Enable this content***.
7. Select ***OK***.

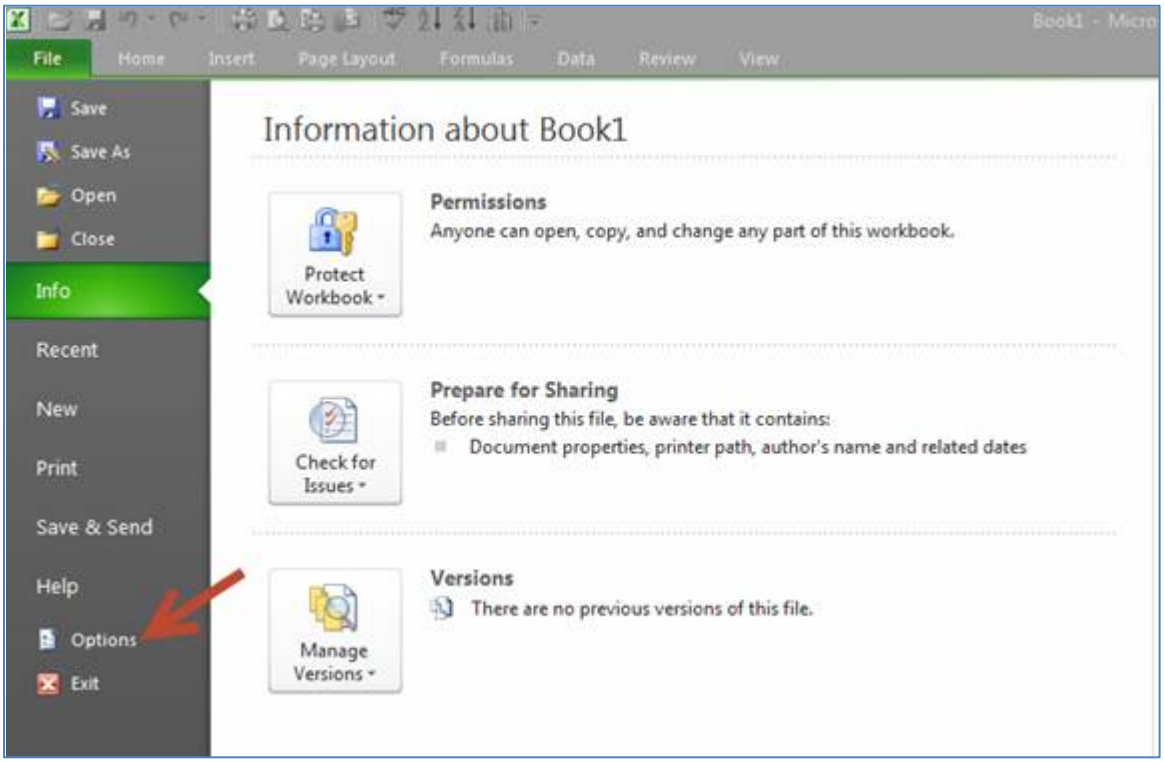
2.1.3.3 Excel Version 2010

Set Excel macro security settings to "***Disable all macros with notifications***" for Excel 2010. The process is similar to the process described above for Excel 2007.

Follow the steps below to locate and enable the Add-In for the Plans and Benefits template:

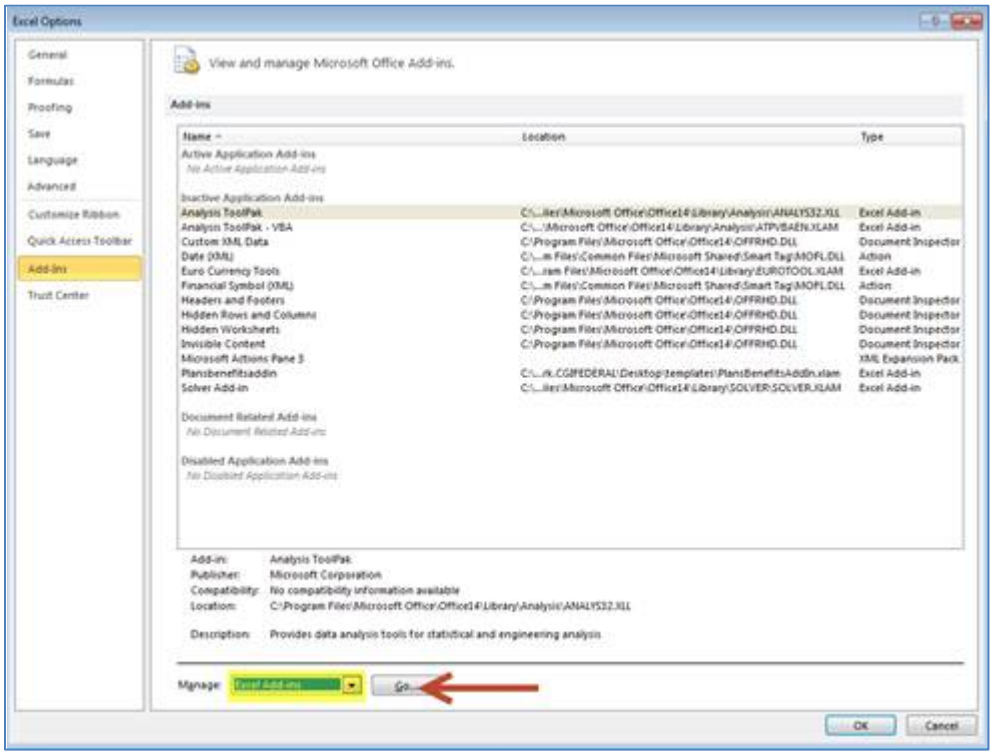
1. From the File menu, click ***Options*** (refer to Exhibit 2-1 below)

Exhibit 2-1: Selecting Excel Options



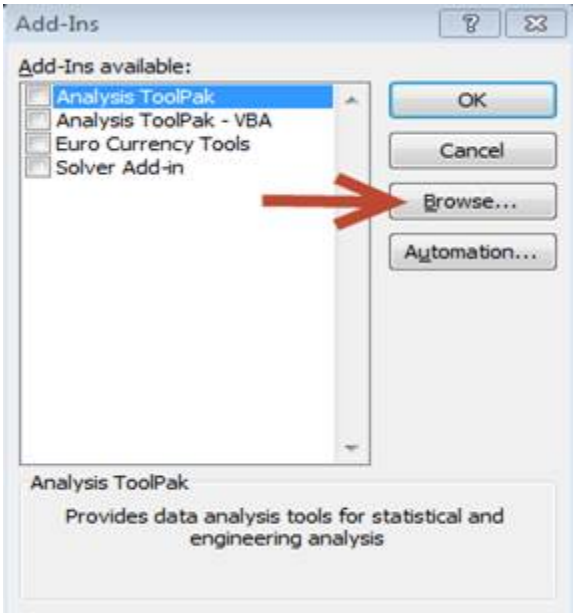
2. Select ***Add-Ins*** and click ***Go*** (refer to Exhibit 2-2 below).

Exhibit 2-2: Manage Excel Add-Ins



3. From the Add-Ins popup, click ***Browse*** (refer to Exhibit 2-3 below).

Exhibit 2-3: Browse for Excel Add-Ins

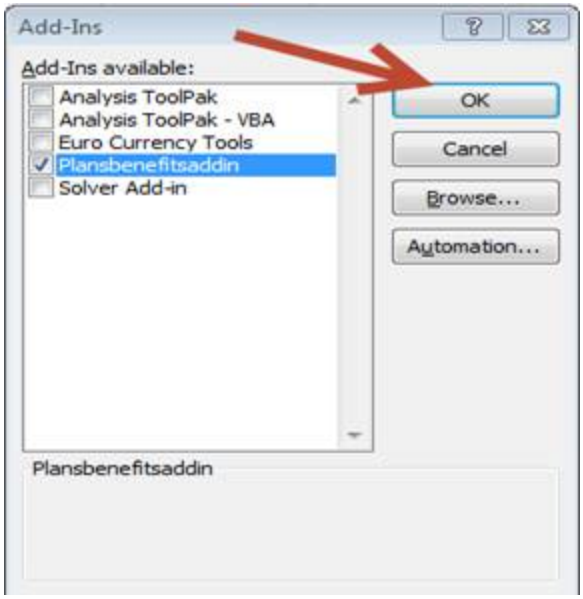


4. From the file dialog box, find the add-in file on your machine and clikc OK (refer to Exhibit 2-4 below).

Exhibit 2-4: Browse for Excel Add-Ins

5. The add-in file is now available (refer to Exhibit 2-5 below).

Exhibit 2-5: Excel Add-In is Now Available



2.2 EXCHANGE OPERATIONS SUPPORT CENTER

If you need assistance with registering as a User, submitting data, reviewing and validating data, or other technical website functions, please contact the Exchange Operations Support Center (XOSC).

Phone Number: 1-855-267-1515
Email Address: CMS_FEPS@cms.hhs.gov

The XOSC hours of operation are 9:00 AM to 6:00PM ET, Monday through Friday.

2.3 USER REGISTRATION

Issuers must first be a registered User in HIOS in order to gain access into RBIS. A User can be registered in HIOS by being added as a contact for an Issuer. If you have questions, please refer to the HIOS User guide or call the XOSC. Any access requests outside of the normal HIOS process must be submitted for CCIIO approval via the XOSC at 1-855-267-1515 or via email at CCIIOPlanFinder@cms.hhs.gov.

2.4 ACCESSING THE SYSTEM

2.4.1 Log-In

Users who are registering with HIOS for the first time will receive a user name (their listed contact email address) and a randomly generated password. This information should be used to access the system. Users will be required to customize their password after the first login.

1. Login to the CMS Enterprise Portal. Select ***HIOS*** from the list of available applications in the upper left portion of the window. Next, select ***Access HIOS***. See Exhibit 2-6 below.
2. On the HIOS Main Page, Select the **Rate & Benefits Information Systems (RBIS)** link. See Exhibit 2-7 below.
3. Select the "Access the RBIS System" link on the RBIS Submissions tab. See Exhibit 2-8 below.
4. You will be navigated to the RBIS Home Page.

Exhibit 2-6: HIOS Access Screen

Exhibit 2-7: HIOS Main Page

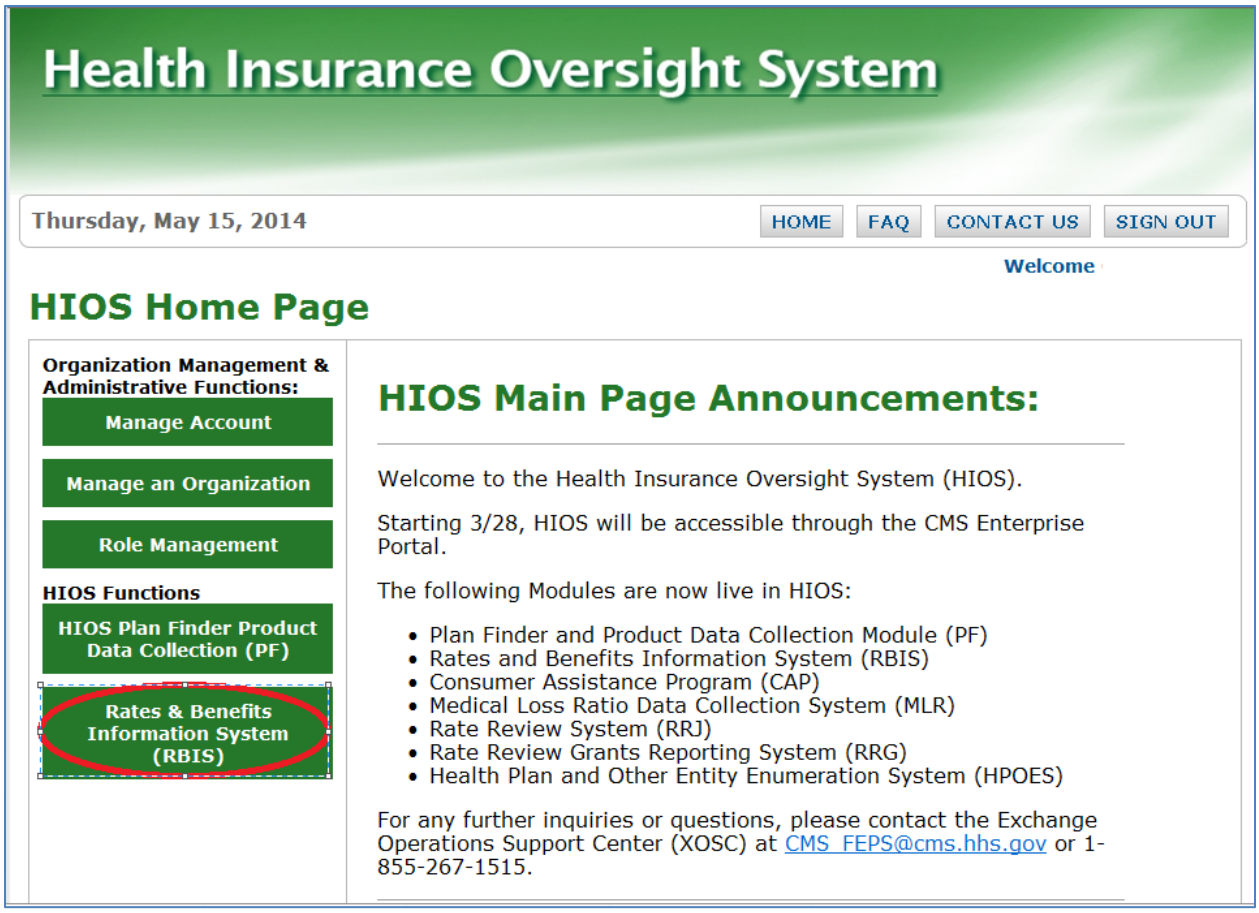
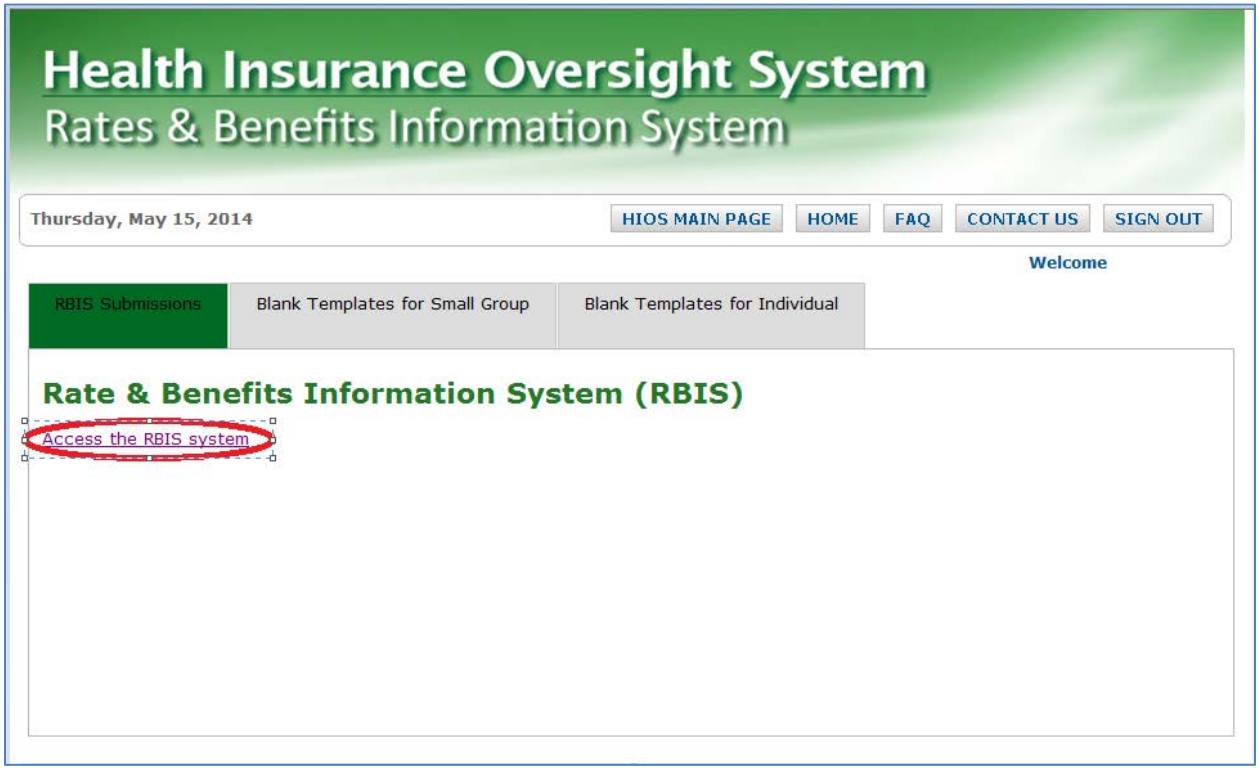


Exhibit 2-8: Selecting "Access the RBIS System" from the RBIS Submissions Tab



3 PROCESS OVERVIEW

The RBIS System is designed to automate the data Submission, Validation, and Attestation processes. All tasks must be completed within the submission window for data to be displayed on Healthcare.gov.

3.1 ROLE OVERVIEW

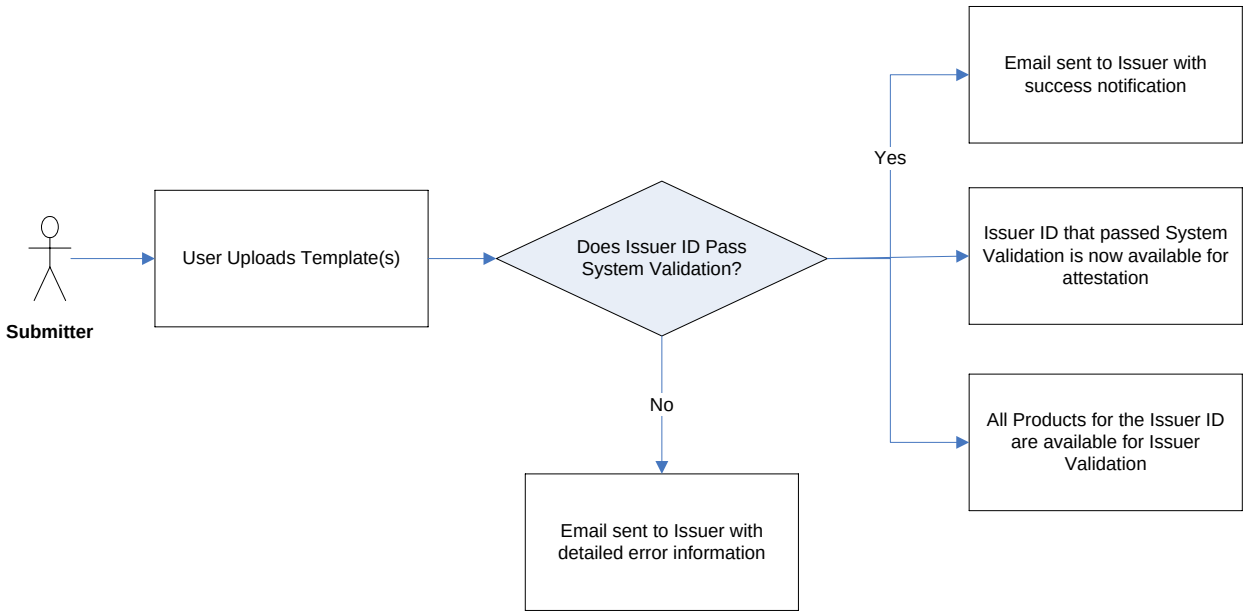
There are three different User roles that you can be assigned for RBIS:

- Submitter Role: The User is responsible for and is allowed to submit data for any Issuer for which they have submitter permissions. They will be notified via email of any errors during the submission process.
- Validator Role: The User is responsible for validating that the data submitted is correct. They are allowed to validate products for any Issuer for which they have a Validation role.
- Attester Role: The User is responsible for attesting to data submitted by all Issuers for which they have permission. The Attester role is limited to the Issuer's Chief Executive Officer (CEO) or Chief Financial Officer (CFO).

3.2 SUBMITTER PROCESS

The Submission Process in RBIS is represented in Exhibit 3-1 below.

Exhibit 3-1: RBIS Submitter Role



The Submission process starts with downloading the Blank or Pre-populated templates. The templates need to be downloaded and saved to the local machine. When the templates have all the required data populated, the data entered will need to be validated by selecting the ***Validate*** Button. When the template passes Validation, the ***Finalize*** Button will need to be selected to save a finalized xml file that can be uploaded.

The Submission Contact's role in RBIS begins after the User uploads template(s) into the system. Once uploaded, the template(s) will go through a series of System Validations. The first set of Validations consists of very brief checks to ensure basic correctness. These include checking the file name and file format. These Validations occur automatically upon template upload.

The second set of System Validations will cross-check the template(s) to ensure all the necessary data has been submitted for each Issuer ID. These Validations run on a pre-set schedule daily and only occur if templates have successfully passed the first set of Validations.

If the templates fail either of these Validations, the Submission Contact will receive an email notifying them that the template(s) failed System Validation. The Submitter will then be required to correct the errors listed in the email and resubmit the file in RBIS. Alternatively, the Submitter will receive an email if the template(s) pass System Validation.

Emails will be sent to the Submitter for the following reasons:

- The template(s) fail template Validation(s).

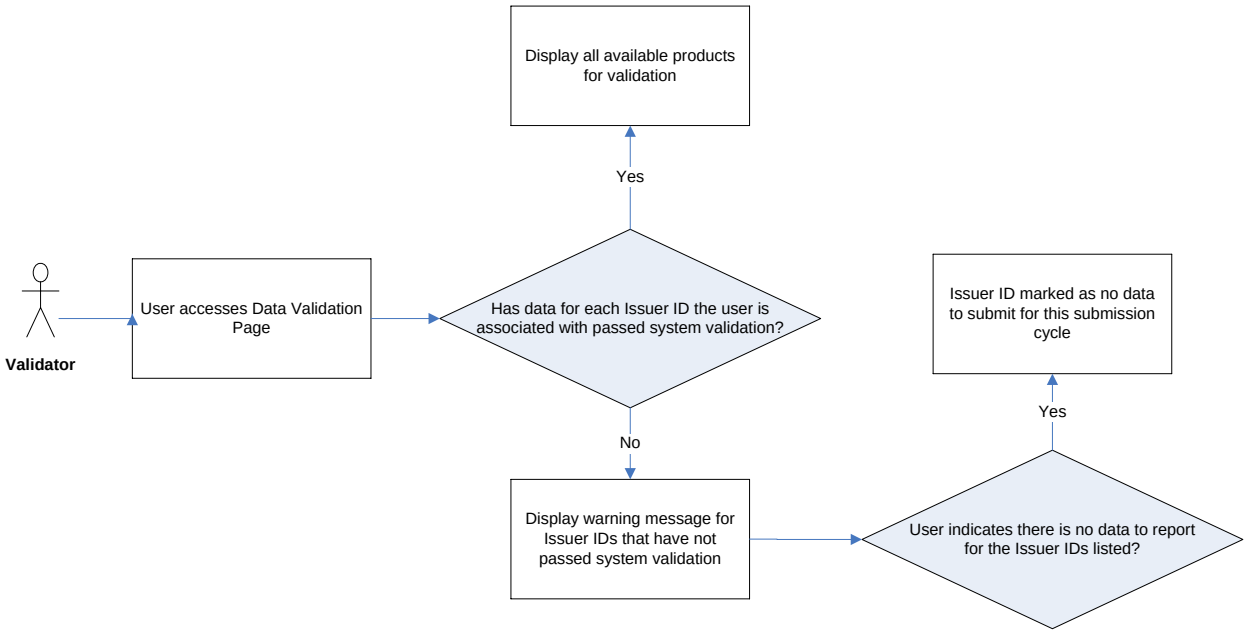
- The template(s) fail cross-check Validations.
- The template(s) pass both sets of Validations.

If there are any issues with data, Submitters may resubmit the template(s). Resubmissions will overwrite previous Submissions, but will not remove any data during the interim refresh, which will occur every two weeks. If you need a submitted Plan Benefit, Service Area, Rate or Business Rule row removed, please contact the XOSC. If data is resubmitted, it must be revalidated.

3.3 VALIDATOR PROCESS

The Validation Process in RBIS is represented below in Exhibit 3-2.

Exhibit 3-2: RBIS Validator Role



The Validation Contact's role in RBIS begins when Validation becomes available for Issuer ID(s) associated with their User ID. In order for Validation to become available, data for the Issuer ID(s) that the User is associated with must pass System Validation. Once data has passed System Validation, the data available for each Issuer ID will be displayed on the Validate Data screen in RBIS and the Validator will receive an e-mail. Users will see all Issuer IDs for which they have permissions and can submit their Validation decisions for each Issuer's Plans.

If there is no data to be uploaded for the listed Issuer ID(s), the Validator may indicate this on the Validate Data tab. Once Issuer ID(s) have been marked as "no data to report," a new warning message is displayed stating that the User has indicated that there is no data to report for the listed Issuer IDs.

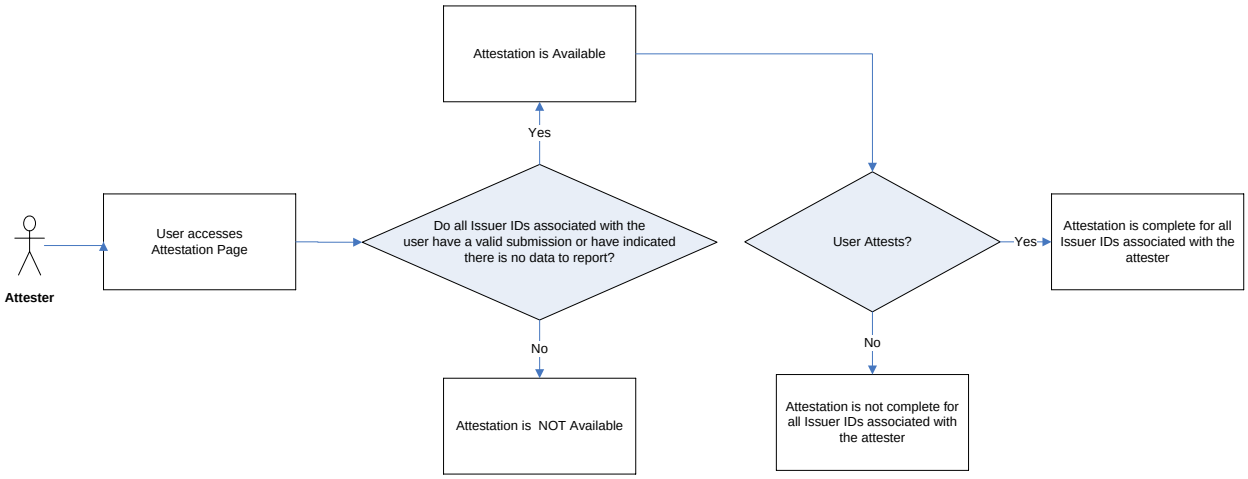
Issuer IDs must be validated to appear on Healthcare.gov.

If there are any issues with data, Submitters can resubmit submissions. Each submission for an Issuer ID overwrites previous submissions. If data is resubmitted, it must be revalidated.

3.4 ATTESTER PROCESS

The Attestation Process in RBIS is represented below in Exhibit 3-3.

Exhibit 3-3: RBIS Attester Role



The Attestation Contact's role in RBIS will begin when Attestation becomes available for ***all*** Issuer ID(s) for which the User is associated. Attestation will not be available until all Issuer IDs associated with the User have a valid submission or it is indicated that there is no data to report. Once Attestation is available, the Attester must read the Attestation agreement and provide an electronic signature confirming that they attest to the accuracy of the submitted data. Users should use caution when completing Attestation, as it can only be completed **one time per submission window**.

3.5 RESUBMISSION PROCESS

The resubmission process is much like the submission process. After an Issuer has re-submitted data in RBIS, the templates will go through both Template Validation as well as overall Plan Cross-check Validation. Template specific System Validations will be performed prior to the Cross-check Validations.

The resubmission process allows the Issuer to change or update any data currently in the RBIS system. The Issuer may also add new data or correct any previously failed data during this time.

Please refer to *Section 11* for further instructions on the Resubmission process.

3.6 HEALTHCARE.GOV REFRESH

During the submission window, which is ten weeks in duration, there will be updates to the data displayed on Healthcare.gov. During this time, the Issuer is able to review data submitted during

the submission window on Healthcare.gov. There will be several interim refreshes and a single final refresh during each submission window. The behavior of the refreshes is detailed below.

3.6.1 Interim Refresh

This will occur every two weeks during the submission window.

- This will be a scheduled process which will occur every two weeks during the submission window.
- No Plans currently on Healthcare.gov will be removed.
- All Issuer and Product data for plans that meet the following criteria will move to Healthcare.gov:
  - Validated
  - Attested
  - Open in HIOS
  - Not Suppressed in HIOS
  - Not CCIIO suppressed
  - Not Expired

3.6.2 Final Refresh

This will occur at the end of each submission window.

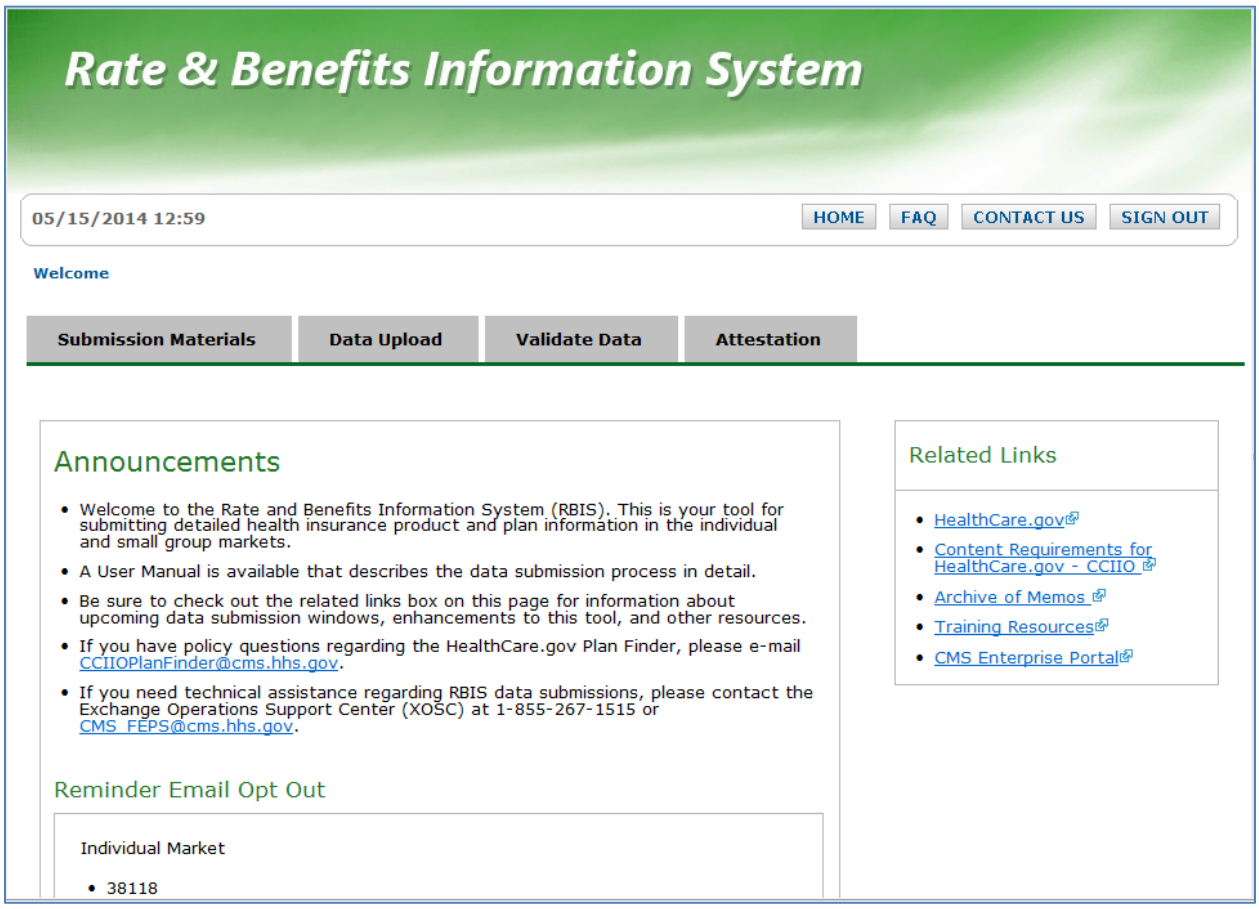
- Plans currently on Healthcare.gov can be removed.
- All Issuer and Product data for plans that meet the following criteria will move to Healthcare.gov:
  - Validated
  - Attested
  - Open in HIOS
  - Not Suppressed in HIOS
  - Not CCIIO suppressed
  - Not Expired

4 RBIS HOME PAGE

Users will arrive on the RBIS Home Page welcome screen when accessing RBIS via the link on HIOS.

The RBIS Home Page is displayed below in Exhibit 4-1.

Exhibit 4-1: RBIS Home Page



4.1 RBIS ANNOUNCEMENTS

The home page of the RBIS web site will display an Announcement section. This section will include helpful information, such as news, status updates, notable dates or events, and more. Additionally, it displays an informational list of all Issuer IDs for which a User is associated.

4.2 RBIS RELATED LINKS

The home page of the RBIS web site contains a Related Links section. This section will include links that are useful to the Users, such as Healthcare.gov, the CCIIO website, training materials, and more.

4.3 USER ASSOCIATION TABLE

The home page of the RBIS web site contains a table at the bottom of the page. This provides a convenient opportunity to view and confirm all Issuers and roles for which your User is responsible.

5 SUBMISSION MATERIALS

The Submission Materials tab has the following:

- Instructions and Reference Materials
- Templates for Submitting Plan data
- Pre-Populated Templates for Submitting Plan data

5.1 INSTRUCTIONS AND REFERENCE MATERIALS

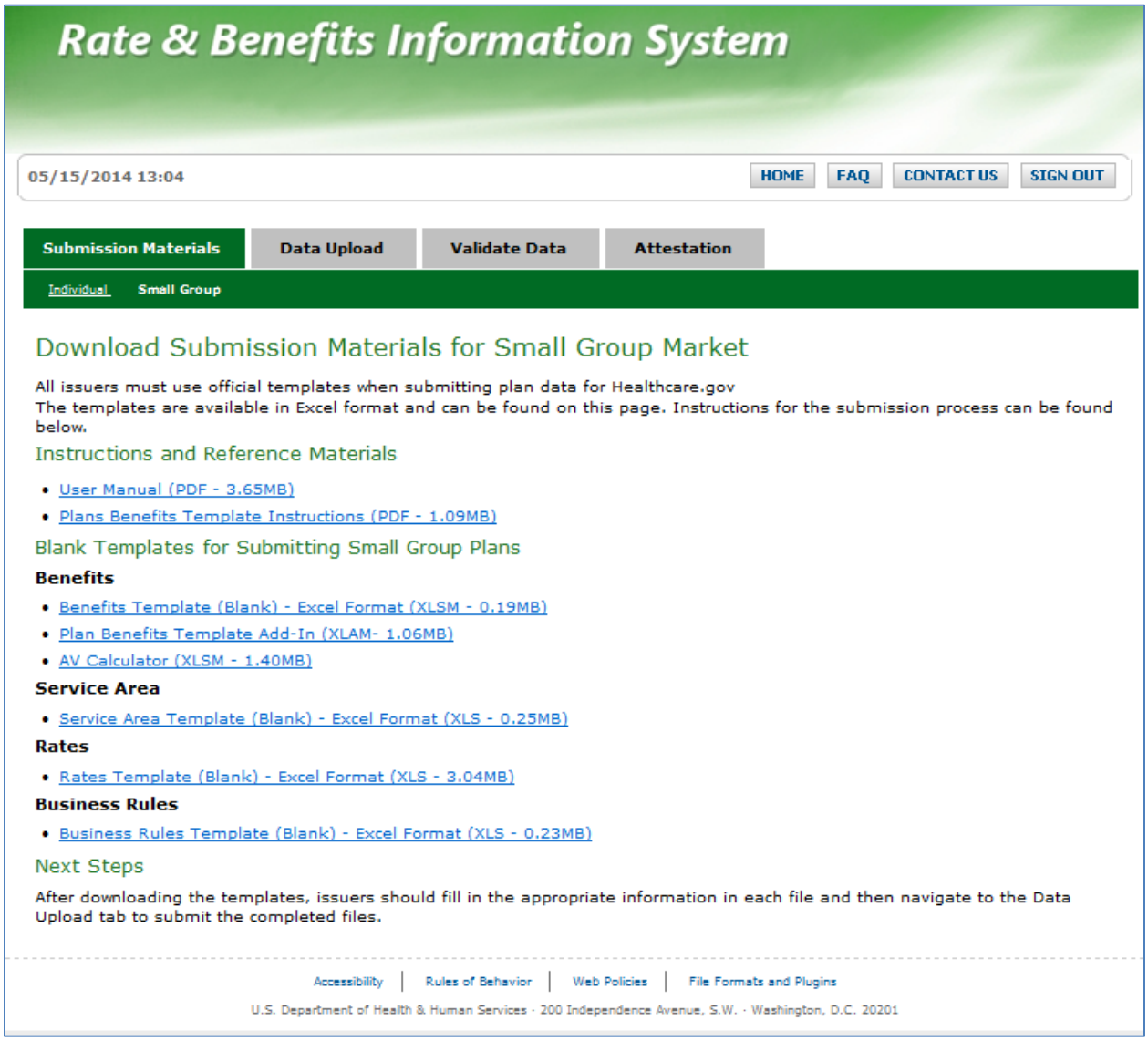
The links below in Exhibit 5-1 will allow Users to view and access the latest version of the User Manual.

Exhibit 5-1: Instructions and Reference Materials (Example for the Small Group Market)

5.2 DOWNLOAD SUBMISSION MATERIALS

The User can access and download Submission Materials under the Submission Materials Tab. For updating and creating new products, the User can download Pre-populated templates for completion from this page. Simply select which template to download from the list by selecting the template hyperlinks. The Small Group Market Submission Materials Link is displayed below in Exhibit 5-2. Note that the submission materials for Individual plans will have the same set of templates available to download.

Exhibit 5-2: Download Data Submission Materials (Example from the Small Group Market)



6 TEMPLATES

All Issuers must use official templates when submitting plan data through RBIS. Both Individual and Small Group markets utilize the same set of Excel templates. There are four templates available for download by the Users that must be completed in order to submit new Plan data into RBIS:

- Plans Benefits Template
- Service Area Template
- Rates Template
- Business Rules Template

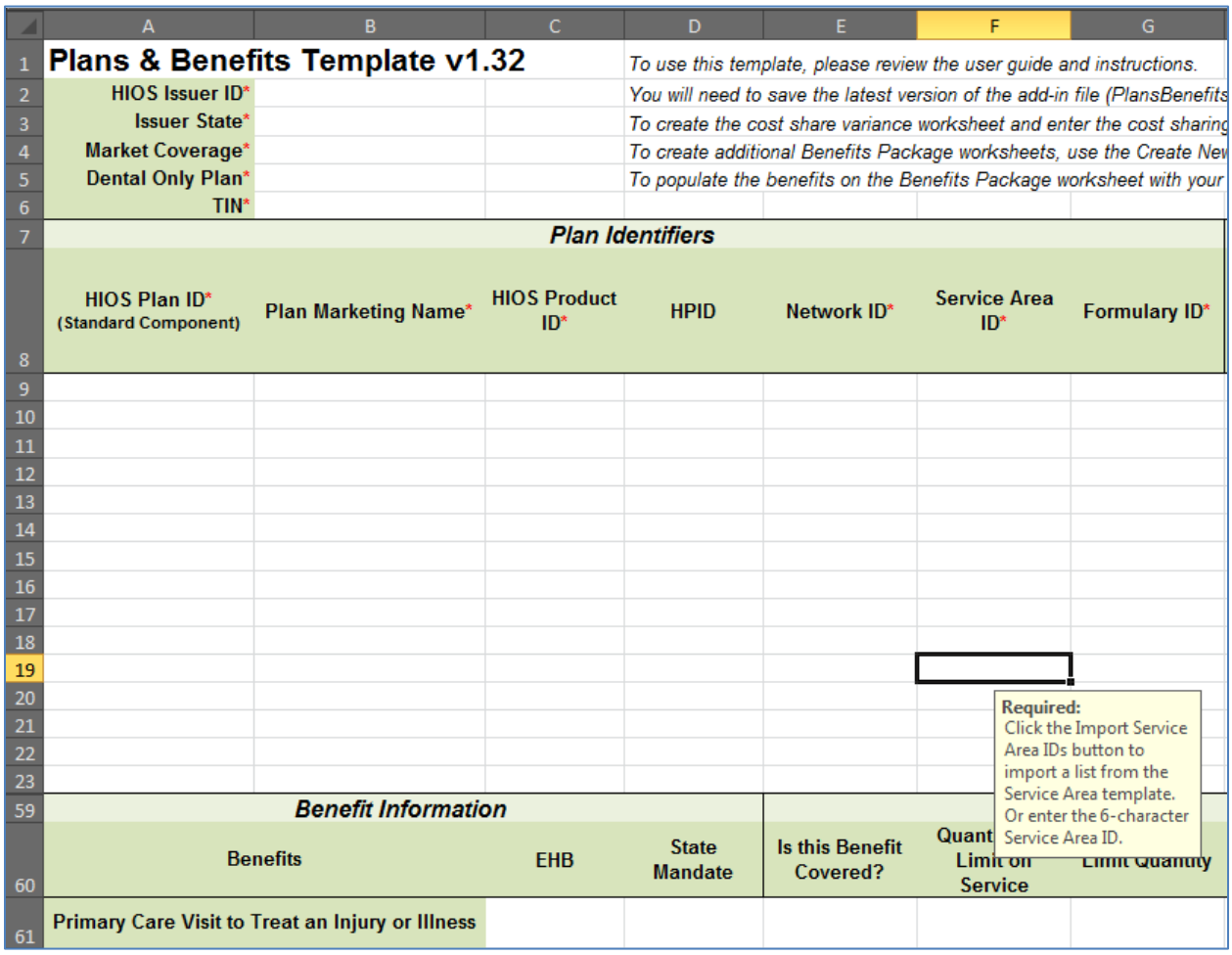
The specifics of each template are detailed in the following sections.

6.1 PLANS BENEFITS TEMPLATE

The Plans Benefits Template provides the capability for Users to submit benefits and cost share data to RBIS. The template includes instructions on how Users should utilize the Plans Benefits Add-In to complete the template.

The Plans Benefits template is displayed below in Exhibit 6-1.

Exhibit 6-1: Plans Benefits Template for Individual and Small Group Plans



If the User enters an invalid character or value, the template will produce an error similar to those displayed in Exhibits 6-2 and 6-3. Selecting "Retry" will redirect the User back to the cell with the invalid entry and allow the User to re-enter the correct value. Selecting "Cancel" will redirect the User back to the cell with the invalid entry and clear the data. Selecting "Help" will open the Microsoft Office Excel Help screen.

Exhibit 6-2: Invalid Data – Format is Invalid

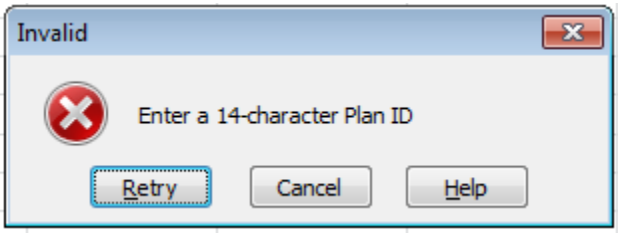
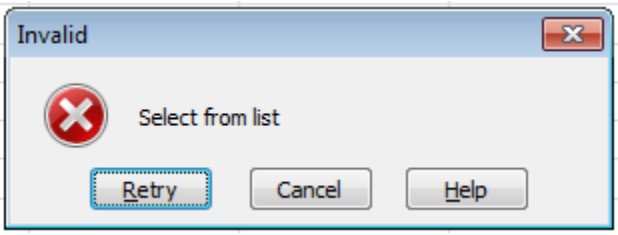


Exhibit 6-3: Invalid Data – Value Supplied is not Valid



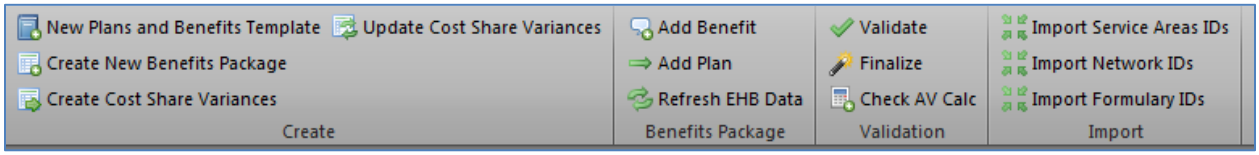
For further instructions on how to download the Plans Benefits template, please refer to *Section 5.2.*

6.1.1 Plans Benefits Template Add-In

In addition to the Plans Benefits Template, a link is available on the Submission Materials tab to download the Plans Benefits Excel Add-In, which provides additional functionality for the template. Using this Add-In, a User may Validate and Finalize data in the template in preparation for uploading the data to RBIS.

Additional functions that are available via the Plans Benefits Add-In are shown below in Exhibit 6-4.

Exhibit 6-4: Benefits Add-In Module Available Functions



For further instructions on how to download the Add-In module, please refer to *Section 5.2.* Instructions for enabling the Add-In module are found in *Section 2.1.3.3*.

6.1.2 AV Calculator

A link is available on the Submission Materials tab to download a Stand-Alone Actuarial Value (AV) Calculator which can be used in conjunction with the Plans Benefits Template to determine an estimate of network liability for a given plan based upon commercial data.

For further instructions on how to download the AV Calculator, please refer to *Section 5.2.*

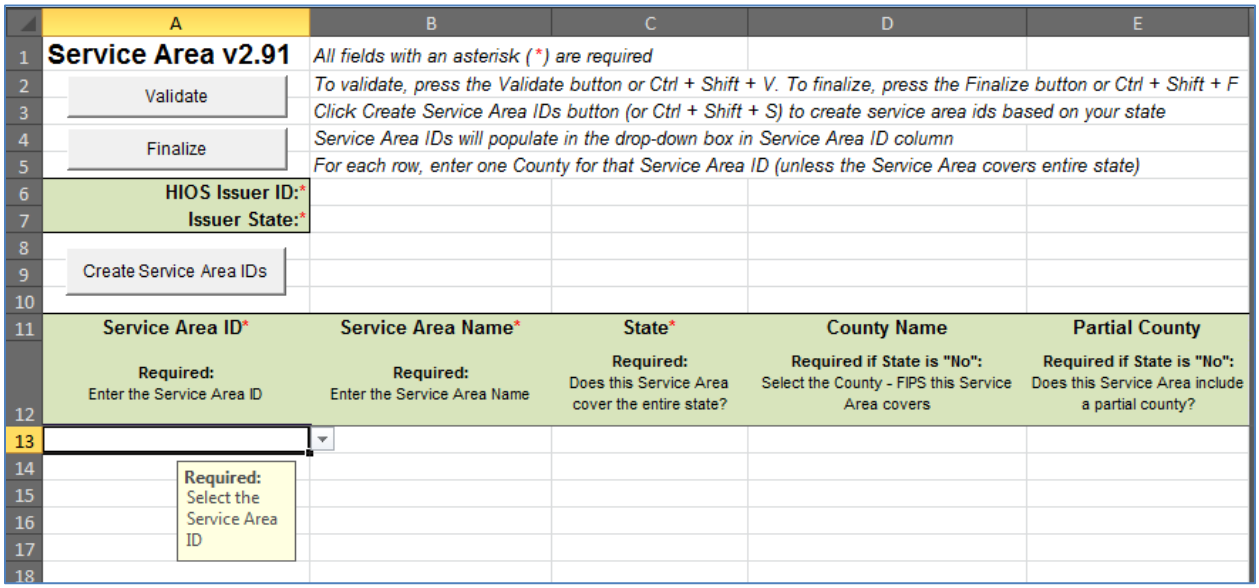
6.2 SERVICE AREA TEMPLATE

The Service Area Template provides the capability for Users to submit data that defines the service areas in which the Issuers operate. The Service Area Template requires that the Service Area ID, Service Area Name, and State fields be completed for each Service Area. The Template also provides the capability to generate Service Area IDs. Users can define a Service Area using FIPS codes and county names if the Service Area does not comprise the entire state.

Federal Information Processing Standards (FIPS) County codes are a five digit federal standard for identifying United States Counties. Exhibit 6-5 below depicts the Service Area Template.

Please refer to *Section 5.2* for further instructions on how to download the Service Area Template.

Exhibit 6-5: Service Area Template for Individual and Small Group Plans



If the User enters an invalid character or value, the template will produce an error similar to those displayed in Exhibits 6-6 and 6-7. Selecting "Retry" will redirect the User back to the cell with the invalid entry and allow the User to re-enter the correct value. Selecting "Cancel" will redirect the User back to the cell with the invalid entry and clear the data. Selecting "Help" will open the Microsoft Office Excel Help screen.

Exhibit 6-6: Invalid Data – Format is Invalid

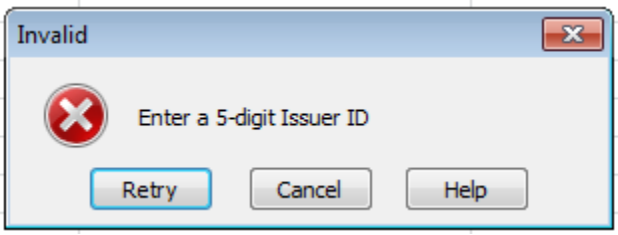
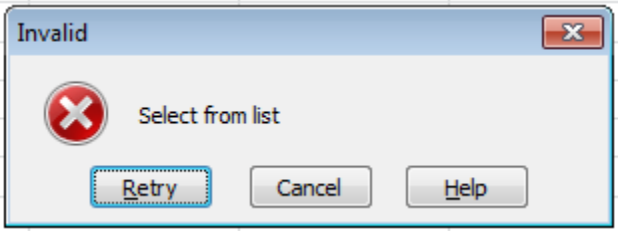


Exhibit 6-7: Invalid Data – Value Supplied is not Valid



6.3 RATES TEMPLATE

The Rates Template provides the ability to enter plan-specific rate values for combinations of rating areas, date, tobacco use, and age. These rates are used to calculate the estimated total monthly premium for plans. The template includes instructions on how Users should fill out the fields.

The Rates Template is displayed below in Exhibit 6-8.

Exhibit 6-8: Rates Template for Individual and Small Group Plans

	A	B	C	D	E
1	**Rates Table Template v2.3**	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*			
2	Validate	*If you are a community rating state, select Family Option under Age and fill in all columns.*			
3		*If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.*			
4	Finalize	*If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.*			
5		*To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.*			
6	**HIOS Issuer ID***				
7	**Federal TIN***				
8	**Rate Effective Date***				
9	**Rate Expiration Date***				
10	Add Sheet				
11					
12	**Plan ID***	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
13	**Required:** Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
14					
15	**Required:** Enter 14-character Plan ID (format 12345XX1234567)				
16					
17					
18					
19					
20					

We recognize that there may be a very significant number of rate combinations for an Issuer's plans. As such, the template has the ability to create additional sheets to add more rates. Select the ***Add Sheet*** button to create an additional sheet in the workbook.

If the User enters an invalid character or value, the template will produce an error similar to those displayed in Exhibits 6-9 and 6-10. Selecting "Retry" will redirect the User back to the cell with the invalid entry and allow the User to re-enter the correct value. Selecting "Cancel"

will redirect the User back to the cell with the invalid entry and clear the data. Selecting "Help" will open the Microsoft Office Excel Help screen.

Exhibit 6-9: Invalid Data – Format is Invalid

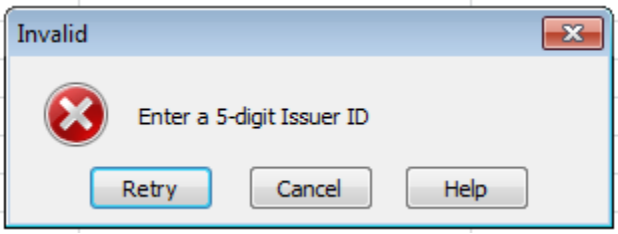
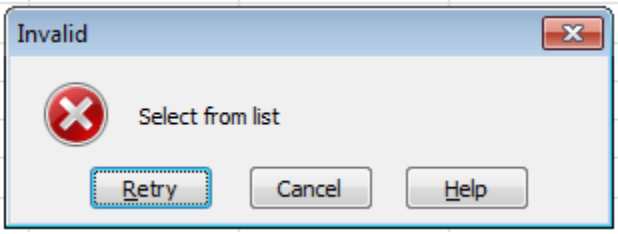


Exhibit 6-10: Invalid Data – Value Supplied is not Valid



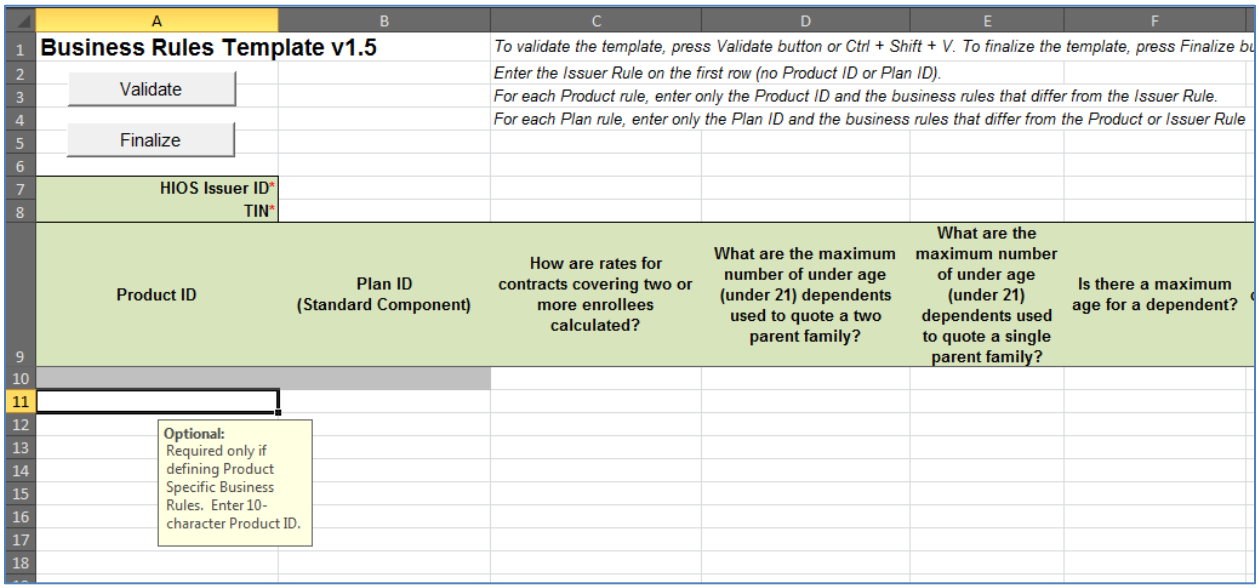
Please refer to *Section 5.2* for further instructions on how to download the Rates template for submission.

6.4 BUSINESS RULES TEMPLATE

The Business Rules template tells the system how to use the rates provided in the Rates Template and the parameters submitted by Users from Healthcare.gov to calculate an estimated total monthly premium. Please refer to Appendix C for more details on how the business rules are provided. The Business Rules Template is completed on an Issuer basis.

The Business Rules Template is displayed below in Exhibit 6-11.

Exhibit 6-3: Business Rules Template for Individual and Small Group Plans



If the User enters an invalid character or value, the template will produce an error similar to those displayed in Exhibits 6-12 and 6-13. Selecting "Retry" will redirect the User back to the cell with the invalid entry and allow the User to re-enter the correct value. Selecting "Cancel" will redirect the User back to the cell with the invalid entry and clear the data. Selecting "Help" will open the Microsoft Office Excel Help screen.

Exhibit 6-12: Invalid Data – Format is Invalid

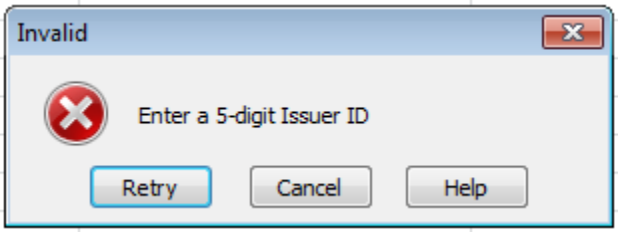
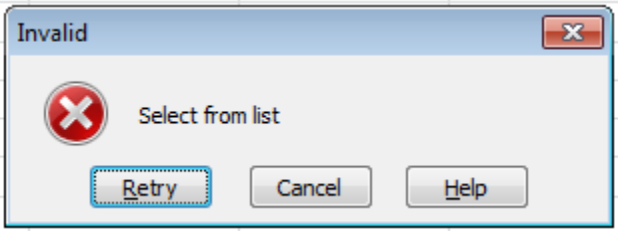


Exhibit 6-13: Invalid Data – Value Supplied is not Valid



For further instructions on how to download the Business Rules Template, please refer to *Section 5.2*.

6.5 TEMPLATE VALIDATION & FINALIZATION PROCESSES

Each template contains two buttons: ***Validate*** and ***Finalize.*** Note that for the Plans Benefits template, these buttons are available via the Plans Benefits Add-In.

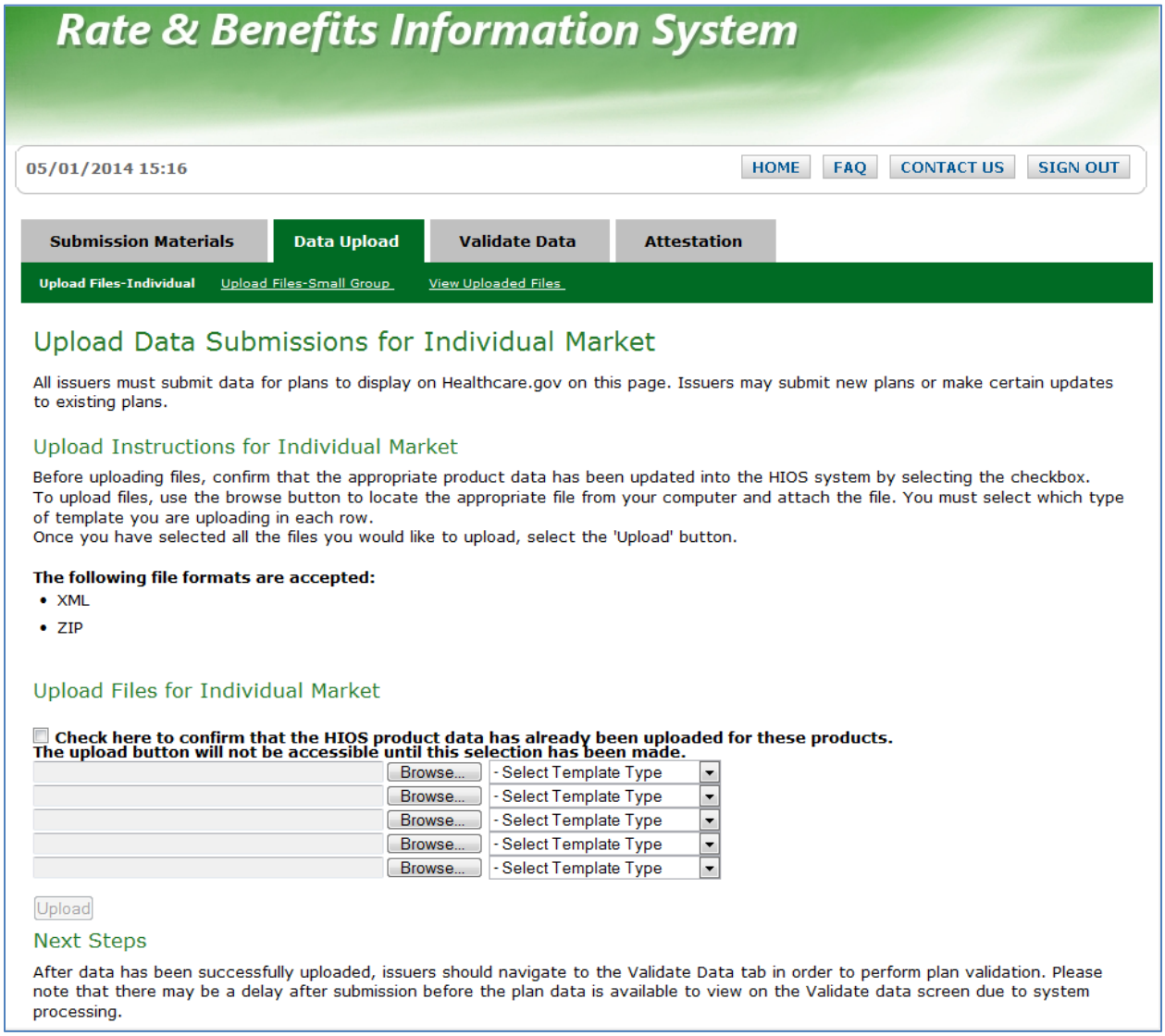
Selecting the ***Validate*** button runs a Validation check against the data entered within the templates. When Validation has successfully completed, selecting the ***Finalize*** button will generate an .xml file suitable for the User to upload into the RBIS system. The .xml files generated by the templates will replace some of the data on the spreadsheet with corresponding codes to make the upload process more efficient. A table of the codes and their meanings per template can be found in Appendix F - Plans Benefits and Business Rules Template .xml Codes.

7 DATA UPLOAD

The Data Upload tab is broken up into three subsections:

- Upload Files – Individual
- Upload Files – Small Group
- View Uploaded Files

Exhibit 7-1: Data Upload Tab



7.1 DATA UPLOAD – SMALL GROUP AND INDIVIDUAL MARKET

Submitter Users can upload submission materials for the Small Group and Individual Markets via their respective Upload Files page links under the Data Upload tab. All Issuers must submit data for Plans to display on Healthcare.gov. Please refer to Exhibit 7-1 above.

7.1.1 Upload Files

Before uploading files, Users must confirm that the appropriate Product data has been uploaded into the HIOS system by selecting the checkbox displayed below in Exhibit 7-2 and Exhibit 7-3.

Exhibit 7-2: HIOS Product Data Upload Confirmation – Small Group

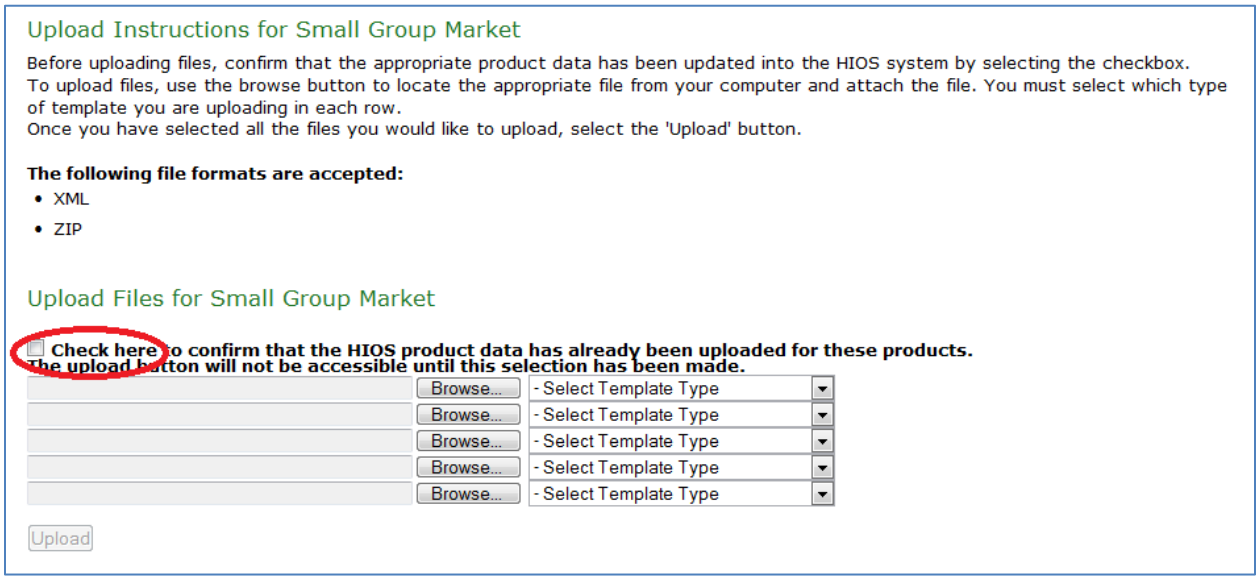
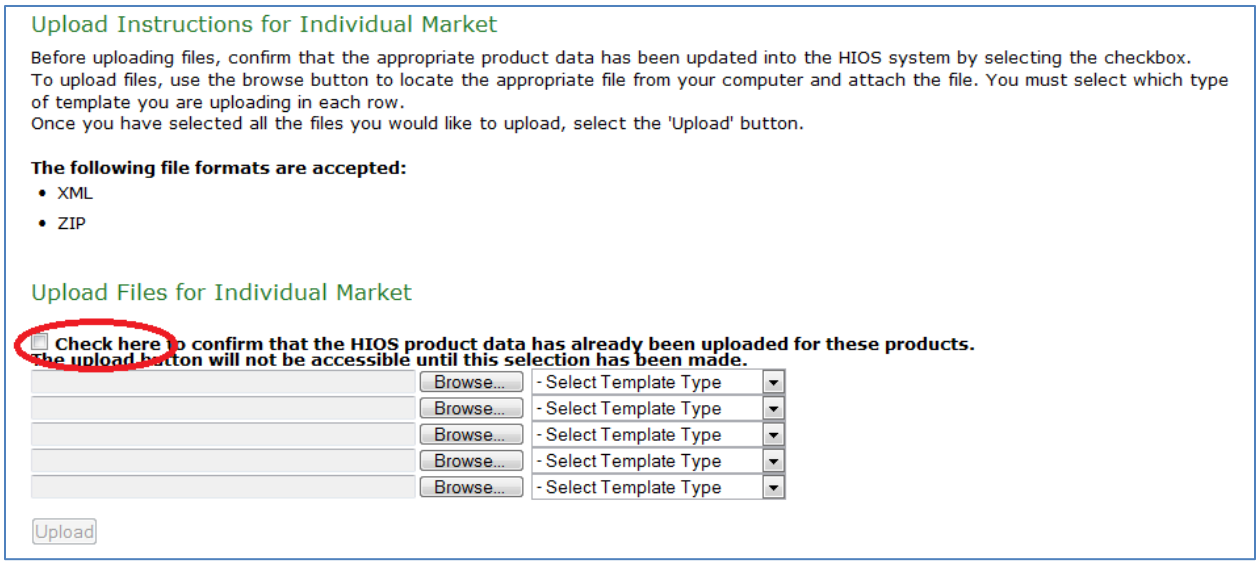
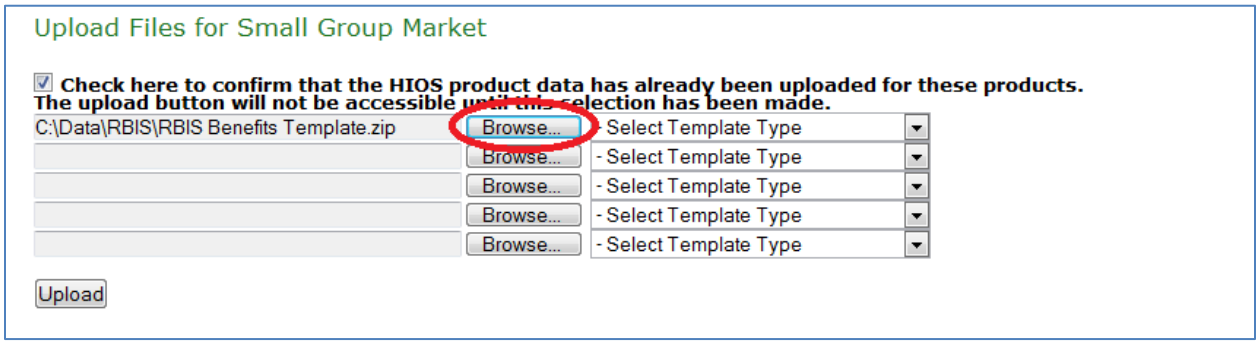


Exhibit 7-3: HIOS Product Data Upload Confirmation – Individual



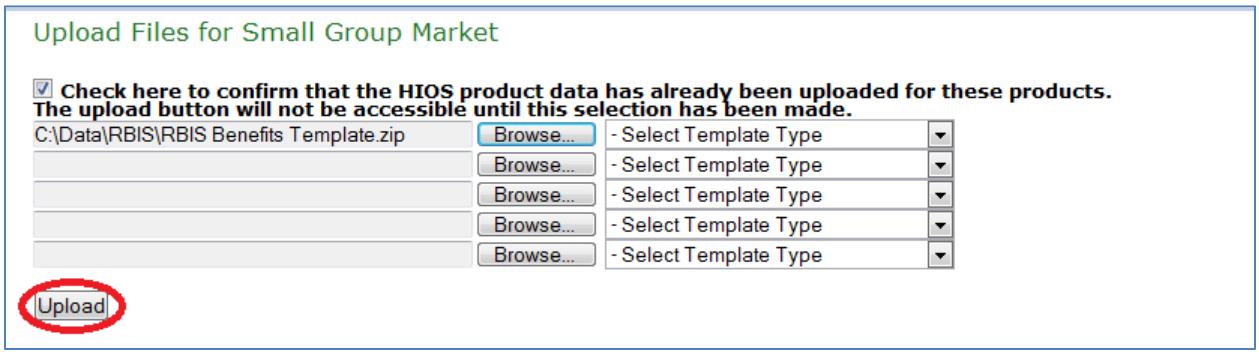
To upload files, the submitter will need to select the browse button to locate and attach the appropriate .xml or .zip file saved to the computer. Please refer to Exhibit 7-4 for an example. After selecting the file to upload, the correct template type must be selected for the template that is being uploaded. Users should remember to select only completed, FINALIZED files for submission. All files must be 50 MB or smaller.

Exhibit 7-4: Files Selected to Upload (Example is from Small Group)



Once all of the files to be uploaded have been selected, the Template Type must be selected from the dropdown and the "Upload" button must be selected in order for the file upload process to begin. Please refer to Exhibit 7-5.

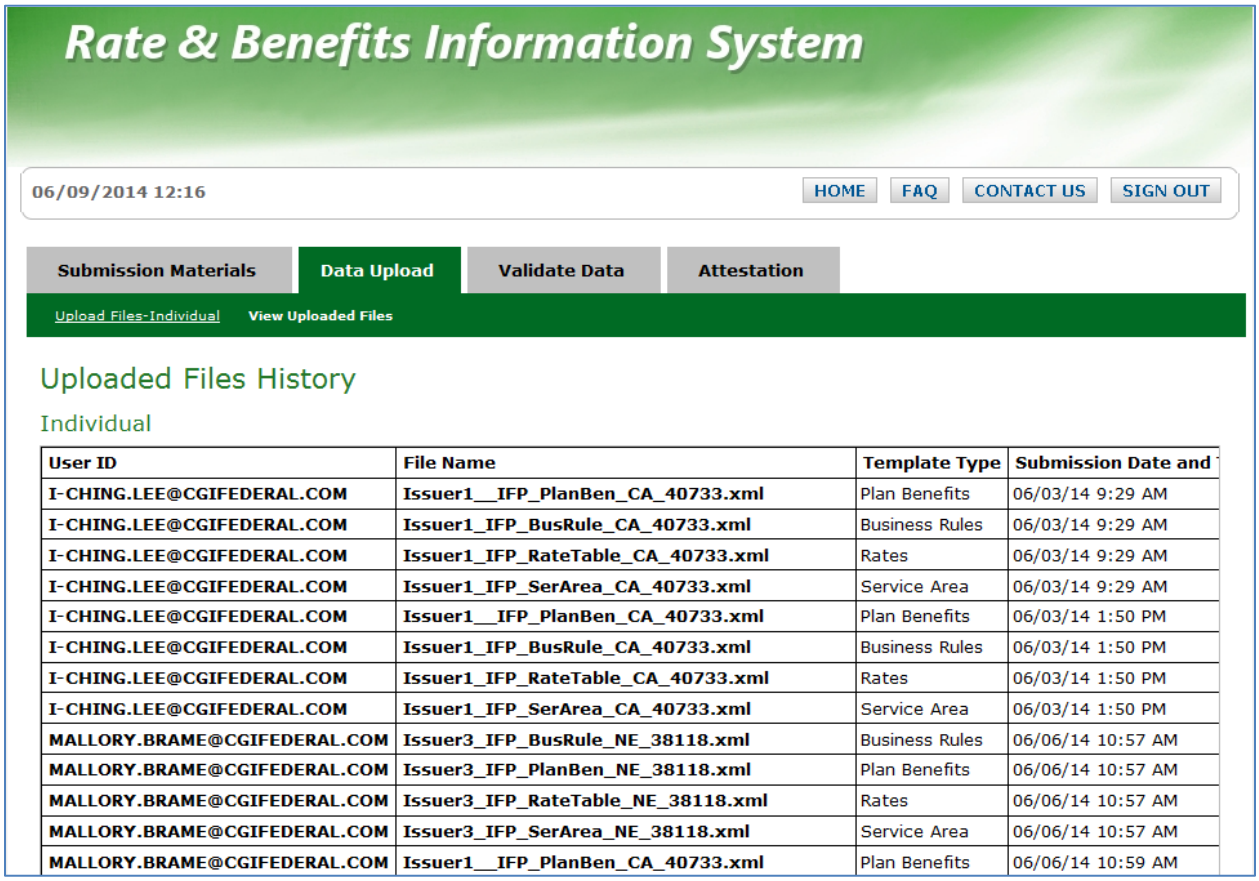
Exhibit 7-5: Upload Files



7.2 VIEW UPLOADED FILES FOR SMALL GROUP AND INDIVIDUAL MARKETS

Once files have been successfully uploaded, the User may view their upload file history for both the Small Group and Individual Markets on the View Upload Files page. All files that have been uploaded during the current submission window will be displayed on this page. Please refer to Exhibit 7-6.

Exhibit 7-6: View Uploaded Files



User ID	File Name	Template Type	Submission Date and
I-CHING.LEE@CGIFEDERAL.COM	Issuer1__IFP_PlanBen_CA_40733.xml	Plan Benefits	06/03/14 9:29 AM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_BusRule_CA_40733.xml	Business Rules	06/03/14 9:29 AM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_RateTable_CA_40733.xml	Rates	06/03/14 9:29 AM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_SerArea_CA_40733.xml	Service Area	06/03/14 9:29 AM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1__IFP_PlanBen_CA_40733.xml	Plan Benefits	06/03/14 1:50 PM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_BusRule_CA_40733.xml	Business Rules	06/03/14 1:50 PM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_RateTable_CA_40733.xml	Rates	06/03/14 1:50 PM
I-CHING.LEE@CGIFEDERAL.COM	Issuer1_IFP_SerArea_CA_40733.xml	Service Area	06/03/14 1:50 PM
MALLORY.BRAME@CGIFEDERAL.COM	Issuer3_IFP_BusRule_NE_38118.xml	Business Rules	06/06/14 10:57 AM
MALLORY.BRAME@CGIFEDERAL.COM	Issuer3_IFP_PlanBen_NE_38118.xml	Plan Benefits	06/06/14 10:57 AM
MALLORY.BRAME@CGIFEDERAL.COM	Issuer3_IFP_RateTable_NE_38118.xml	Rates	06/06/14 10:57 AM
MALLORY.BRAME@CGIFEDERAL.COM	Issuer3_IFP_SerArea_NE_38118.xml	Service Area	06/06/14 10:57 AM
MALLORY.BRAME@CGIFEDERAL.COM	Issuer1__IFP_PlanBen_CA_40733.xml	Plan Benefits	06/06/14 10:59 AM

Columns displayed in the Uploaded Files History include:

- User ID
- File Name
- Template Type
- Submission Date and Time
- Request ID

If an Issuer has not uploaded any files, there will not be an upload history.

7.3 SUBMISSION COMPLETE

After an Issuer has uploaded their data, the templates will go through both Template Validation as well as an overall Plan Cross-Check Validation. Template-specific System Validations will be performed prior to the Cross-Check Validations.

7.3.1 Template Validations

Before any Plans for an Issuer ID are available for Cross-Check Validation, all Plans for that Issuer ID must pass Template Validation. The Template Validations will additionally ensure that the file format is appropriate and correct. The Template Validations include, but are not limited to the following:

- Making certain the Issuer ID is valid
- Checking to ensure that the data entered in each field matches the appropriate data type
- Validating that the template matches the template type
- Ensuring that the User ID submitting the file is associated with all Issuer IDs for which they are submitting data
- Making sure each Product ID listed is a valid Product
- Making sure each Plan ID listed is a valid Plan ID
- Making sure all required fields are complete for each Template
- Verifying that all FIPS Codes are valid and exist within the Issuer ID's associated state

As soon as the Template Validation has been completed, the User will receive notification via email with the results of Template Validation for each Issuer ID associated with the uploaded template(s). The e-mail will include the following information:

- List of errors for each occurrence (if applicable)
- List of files submitted
- Issuer ID
- Issuer Name
- Market Type
- Outcome of System Validations
- Template type of each file
- Time of submission
- List of warnings. (if applicable)

In the event that an Issuer ID fails Template Validations, the User must correct the errors listed in the e-mail and re-submit. If an Issuer ID passes Template Validations, it must then pass Cross-Check Template Validations before it is eligible for Issuer Validation in RBIS.

7.3.2 Cross-Check Validations

After templates have successfully completed Template Validations, they must also pass Cross-Check Validations. The Plan Cross-Check Validations include, but are not limited to:

- Validating that all Individual and Small Group Plans cited in the Rates Template have benefits information in the Plans Benefits Template
- Validating that all Individual and Small Group Plans cited in the Benefits Template have Rate information in the Rates Template
- Validating that Service Areas cited in the Benefits Template have Service Area information in the Service Areas Template
- Validating that Business Rule information from the Business Rules Template exists for every Issuer ID

Cross-Check Validations are run daily on a pre-set schedule. Once Cross-Check Validations have been completed, Issuers will receive an email for each Issuer ID associated with the uploaded template(s). The email will include the following information:

- List of errors for each occurrence (if applicable)
- List of files submitted
- Issuer ID
- Issuer Name
- Market type
- Outcome of System Validations
- Template type of each file
- Time of submission
- List of warnings. (if applicable)

In the event that an Issuer ID fails Cross-Check Validations, the User will receive an email with the total number of errors, but will not receive more than 1000 errors due to size constraints. The ID will not be re-checked until another template with the Issuer ID is uploaded. Users must correct the errors listed in the email before the ID is eligible for Issuer Validation. (Correcting errors might only require uploading a template that had not been uploaded at the time of the Cross-check Validation.) If an Issuer ID passes Cross-Check Validations, the User will receive an email indicating the Cross-check Validations have completed successfully.

The error email will list the first 1000 errors. Example email: "Thank you for using the Rate and Benefits Information System (RBIS) to submit your data. At this time, we have completed Cross Reference Validation of the file(s) you submitted and have identified error(s) with one or more of the file(s) submitted. Your submission has resulted in 18 error(s), Because of size constraints, we can only display the first 1000 error(s)..." Please contact the Exchange Operation Support Center (XOSC) at CMS_FEPS@cms.hhs.gov or 1-855-267-1515.

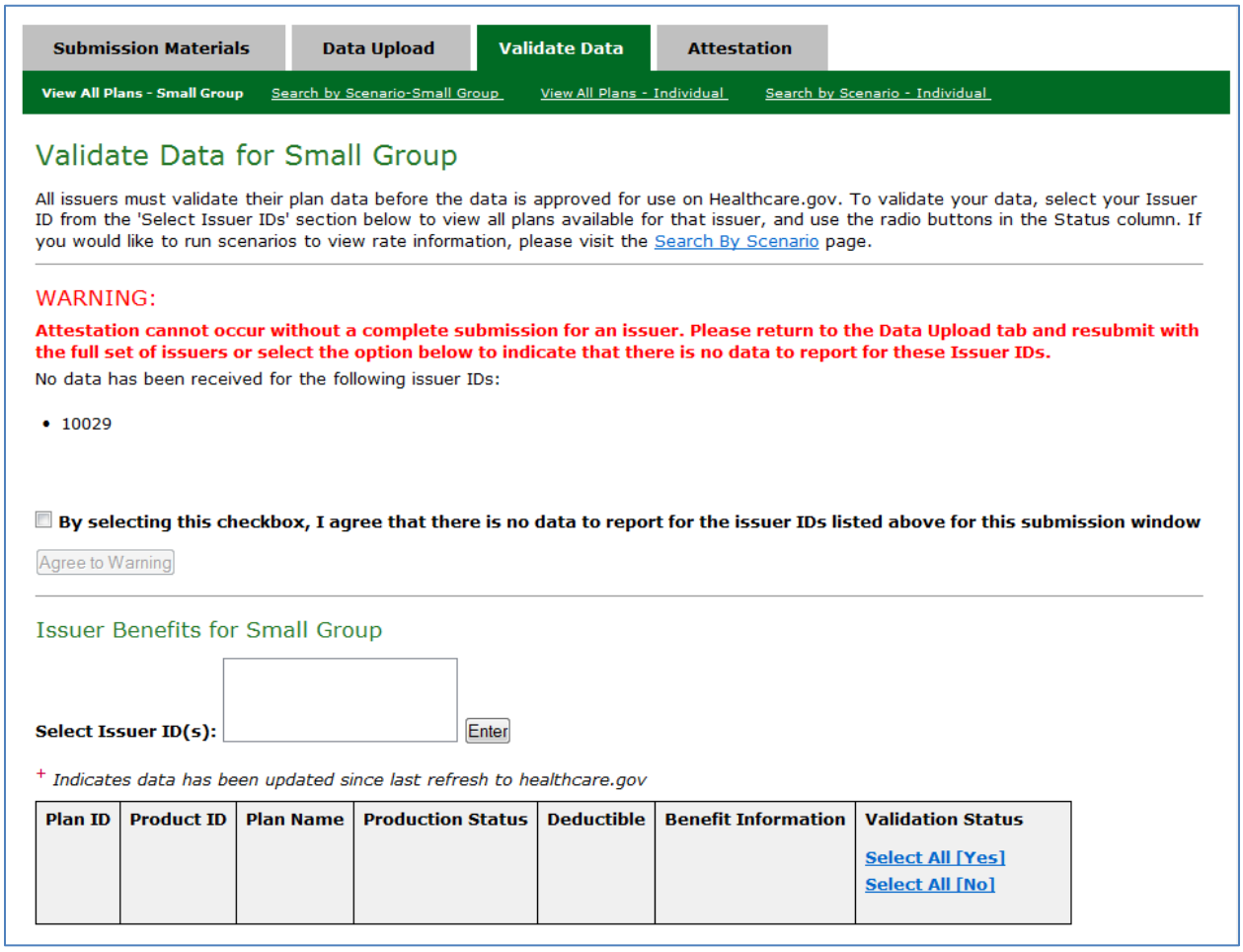
8 VALIDATE DATA

The Validate Data tab is broken up into four subsections

- View All Plans -Small Group
- Search by Scenario -Small Group
- View All Plans -Individual
- Search by Scenario -Individual

The layout of this tab is shown in Exhibit 8-1 below.

Exhibit 8-1: Validate Data tab (Example is for Small Group Market)



All Issuers must complete Issuer Validation for their Plans before the data is approved for use on Healthcare.gov.

8.1 VALIDATE DATA

Issuers can validate data from two different views: View All Plans and Search by Scenario. Both views are further segregated by Individual or Small Group plans.

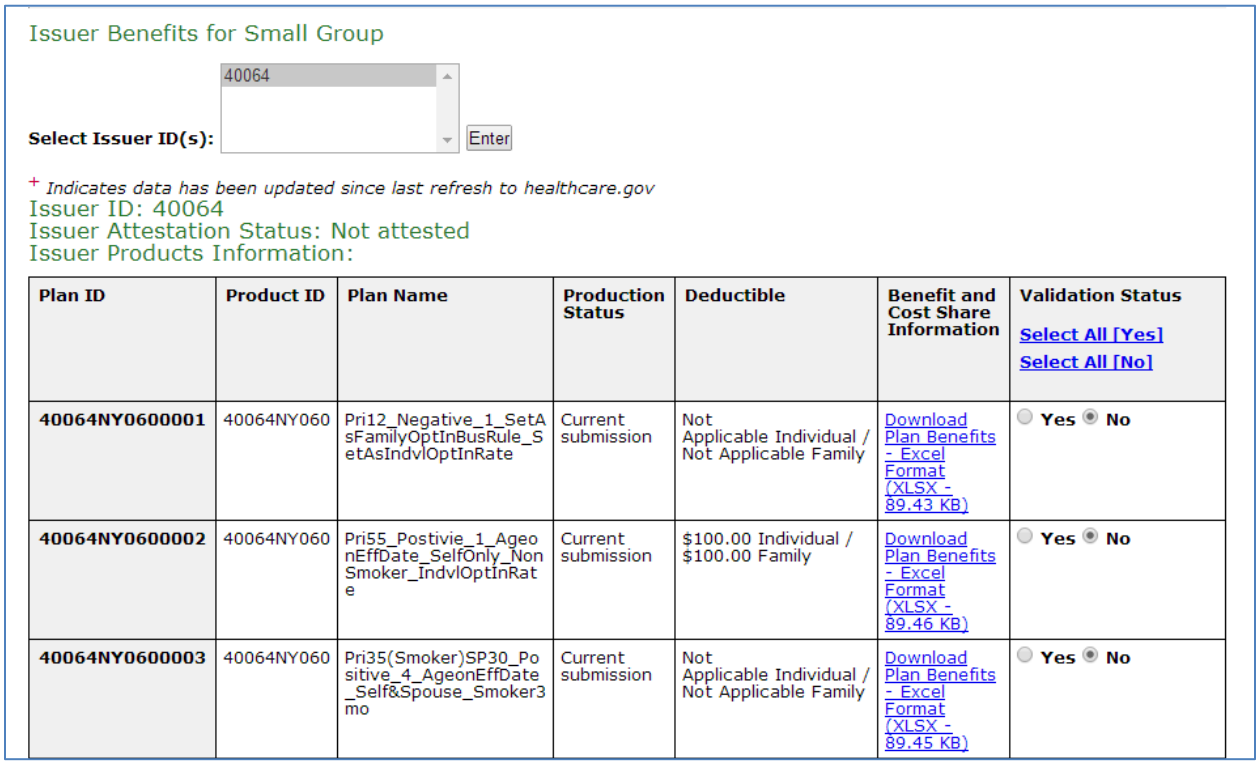
8.1.1 View All Plans Views

The View All Plans page allows Users to validate data by viewing all Plans available for a given Issuer ID. If Users would like to run scenarios, please see the instructions in *8.1.1.3.4 Search by Scenario* for additional information.

8.1.1.1 View Single Issuer ID

To validate data on the View All Plans page, Users must first select the Issuer ID(s) for the Plans they would like to view and validate. Please refer to Exhibit 8-2 and Exhibit 8-3.

Exhibit 8-2: Select Issuer ID(s) for Small Group Market



Issuer Benefits for Small Group

Select Issuer ID(s): 40064 Enter

+ *Indicates data has been updated since last refresh to healthcare.gov*

Issuer ID: 40064
Issuer Attestation Status: Not attested
Issuer Products Information:

Plan ID	Product ID	Plan Name	Production Status	Deductible	Benefit and Cost Share Information	Validation Status Select All [Yes] Select All [No]
40064NY0600001	40064NY060	Pri12_Negative_1_SetAsFamilyOptInBusRule_SetAsIndvlOptInRate	Current submission	Not Applicable Individual / Not Applicable Family	Download Plan Benefits - Excel Format (XLSX - 89.43 KB)	Yes No
40064NY0600002	40064NY060	Pri55_Postivie_1_AgeonEffDate_SelfOnly_NonSmoker_IndvlOptInRate	Current submission	$100.00 Individual / $100.00 Family	Download Plan Benefits - Excel Format (XLSX - 89.46 KB)	Yes No
40064NY0600003	40064NY060	Pri35(Smoker)SP30_Positive_4_AgeonEffDate_Self&Spouse_Smoker3mo	Current submission	Not Applicable Individual / Not Applicable Family	Download Plan Benefits - Excel Format (XLSX - 89.45 KB)	Yes No

Exhibit 8-3: Select Issuer ID(s) for Individual Market

Issuer Benefits for Individual Market

Select Issuer ID(s): 40064 Enter

+ *Indicates data has been updated since last refresh to healthcare.gov*

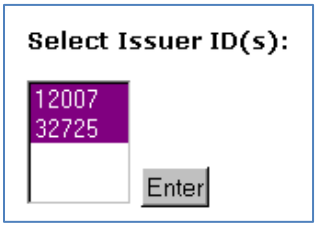
Issuer ID: 40064
Issuer Attestation Status: Not attested
Issuer Products Information:

Plan ID	Product ID	Plan Name	Production Status	Deductible	Benefit and Cost Share Information	Validation Status Select All [Yes] Select All [No]
40064NY0440001	40064NY044	Pri12_Negative_1_SetAsFamilyOptInBusRule_SetAsIndvlOptInRate	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.44 KB)	Yes No
40064NY0440002	40064NY044	Pri55_Postivie_1_AgeonEffDate_SelfOnly_NonSmoker_IndvlOptInRate	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.46 KB)	Yes No
40064NY0440003	40064NY044	Pri55_Positive_5_AgeOnEffDate_SelfOnly_Smoker9months	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.43 KB)	Yes No

8.1.1.2 View Multiple Issuer IDs

To validate data for multiple Issuer IDs at once, Users can hold down Ctrl + click on each Issuer IDs they wish to view together. Please refer to Exhibit 8-4.

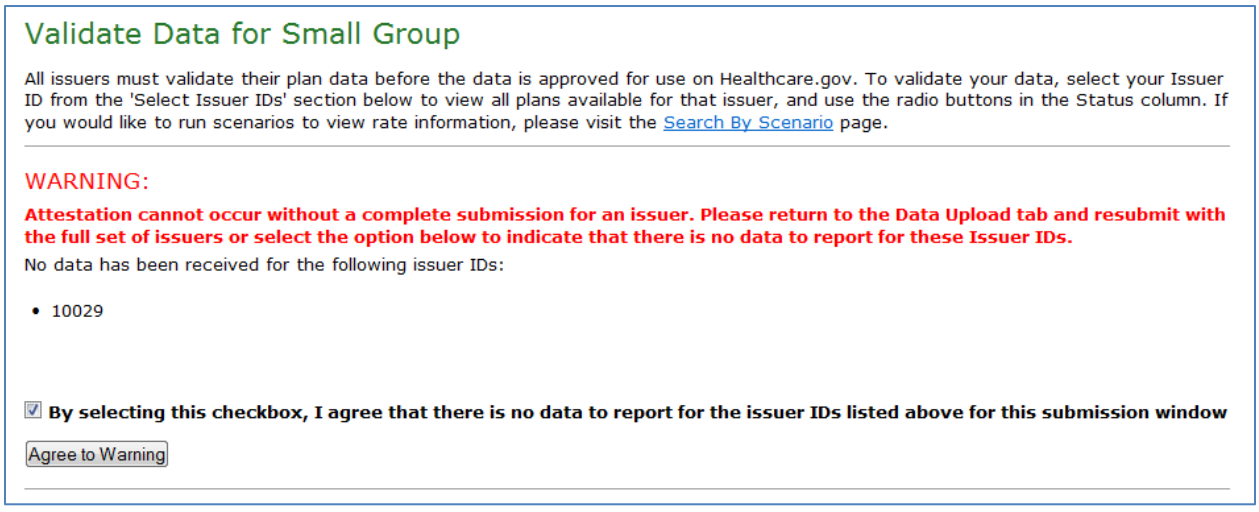
Exhibit 8-4: Issuer ID Multi-Select



8.1.1.3 No Data Received for Issuer ID(s)

If a User has not submitted data for an Issuer ID, a warning message will be displayed. The message will list the Issuer IDs that no data has been received for and explain that Attestation cannot occur without a complete submission for an Issuer. In the event that there is no data to report for the Issuer IDs listed for the current submission window, Users may select the checkbox below to indicate that no data will be submitted and press the "Agree to Warning" button. Please refer to Exhibit 8-5.

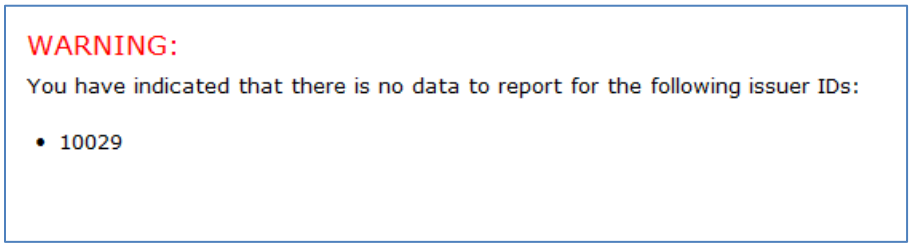
Exhibit 8-5: No Data Received for Issuer ID(s) (Example from Small Group Market)



8.1.1.3.1 No Data to Report for Issuer ID(s)

If a User has not submitted data for an Issuer ID and has agreed that there is no data to report for the current submission window, the following warning message in Exhibit 8-6 will be displayed.

Exhibit 8-6: No Data to Report for Issuer ID(s) (Example from Small Group Market)



When plan information is available and is displayed in the results table, the User may select the "View Benefits" hyperlink next to the applicable Plan ID in the Benefit Information column of the table shown in Exhibit 8-7.

Exhibit 8-7: View Benefit Details for Individual Plans (Example from Individual Market)

Clicking on the "View Benefits" hyperlink will download an excel file containing benefits and cost share data submitted for the selected Plan ID as shown in Exhibit 8-8. The format of the download closely resembles the Plan Benefits template. Please note that any dental only information will not be displayed in the plan benefits information downloaded from RBIS.

Exhibit 8-8: Benefit Details for Individual Plans – Individual Market

	A	B	C	D	E	F	G
1	**Plan Benefits and Cost Share Information**						
2	**HIOS Issuer ID**	40064					
3	**Issuer State**	NY					
4	**Market Coverage**	Individual					
5	**Dental Only Plan**	No					
6	**TIN**						
7	***Plan Identifiers***						
8	**HIOS Plan ID (Standard Component)**	**Plan Marketing Name**	**HIOS Product ID**	**HPID**	**Network ID**	**Service Area ID**	**Formulary ID**
9	40064NY0440001	Pri12_Negative_1_SetAsFamilyOptInBusRule_SetAsIndvlOptInRate	40064NY044	0	NYN001	NYS003	NYF001
45							
46	***Benefit Information***						
47	**Benefits**		**EHB**	**State Mandate**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**
48	**Primary Care Visit to Treat an Injury or Illness**		Yes	No	Covered	No	
49	**Specialist Visit**		Yes	Yes	Covered	No	

8.1.1.4 Validation Status

Using the radio buttons in the Validation Status column, Issuers must decide between the two Validation Status options, Yes or No, for each plan. By selecting "Yes" the User indicates that all data for the given plan is valid and correct. In doing so, the plan passes Issuer Validation. By selecting "No," the User indicates that all data for the given plan is *not* valid. In doing so, the plan fails Issuer Validation. Users may change the Validation Status for all plans for an Issuer ID at one time by selecting either the "Select All [Yes]" or "Select All [No]" link. Users must select the Submit button for the Validation Status to be saved in RBIS. By default the Validation Status is "No". Please refer to Exhibit 8-9.

Exhibit 8-9: Validation Status (Example from Individual Market)

Issuer Benefits for Individual Market

Select Issuer ID(s): 40064 Enter

+ *Indicates data has been updated since last refresh to healthcare.gov*

Issuer ID: 40064

Issuer Attestation Status: Not attested

Issuer Products Information:

Plan ID	Product ID	Plan Name	Production Status	Deductible	Benefit and Cost Share Information	Validation Status Select All [Yes] Select All [No]
40064NY0440001	40064NY044	Pri12_Negative_1_SetAsFamilyOptInBusRule_SetAsIndvlOptInRate	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.44 KB)	Yes No
40064NY0440002	40064NY044	Pri55_Postivie_1_AgeonEffDate_SelfOnly_NonSmoker_IndvlOptInRate	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.46 KB)	Yes No
40064NY0440003	40064NY044	Pri55_Positive_5_AgeOnEffDate_SelfOnly_Smoker9months	Current submission	-	Download Plan Benefits - Excel Format (XLSX - 89.43 KB)	Yes No

8.1.2 Search by Scenario Views

The Search by Scenario section allows Issuers to view and validate data by running scenarios to view information.

8.1.2.1 Search Criteria Required Fields – Small Group

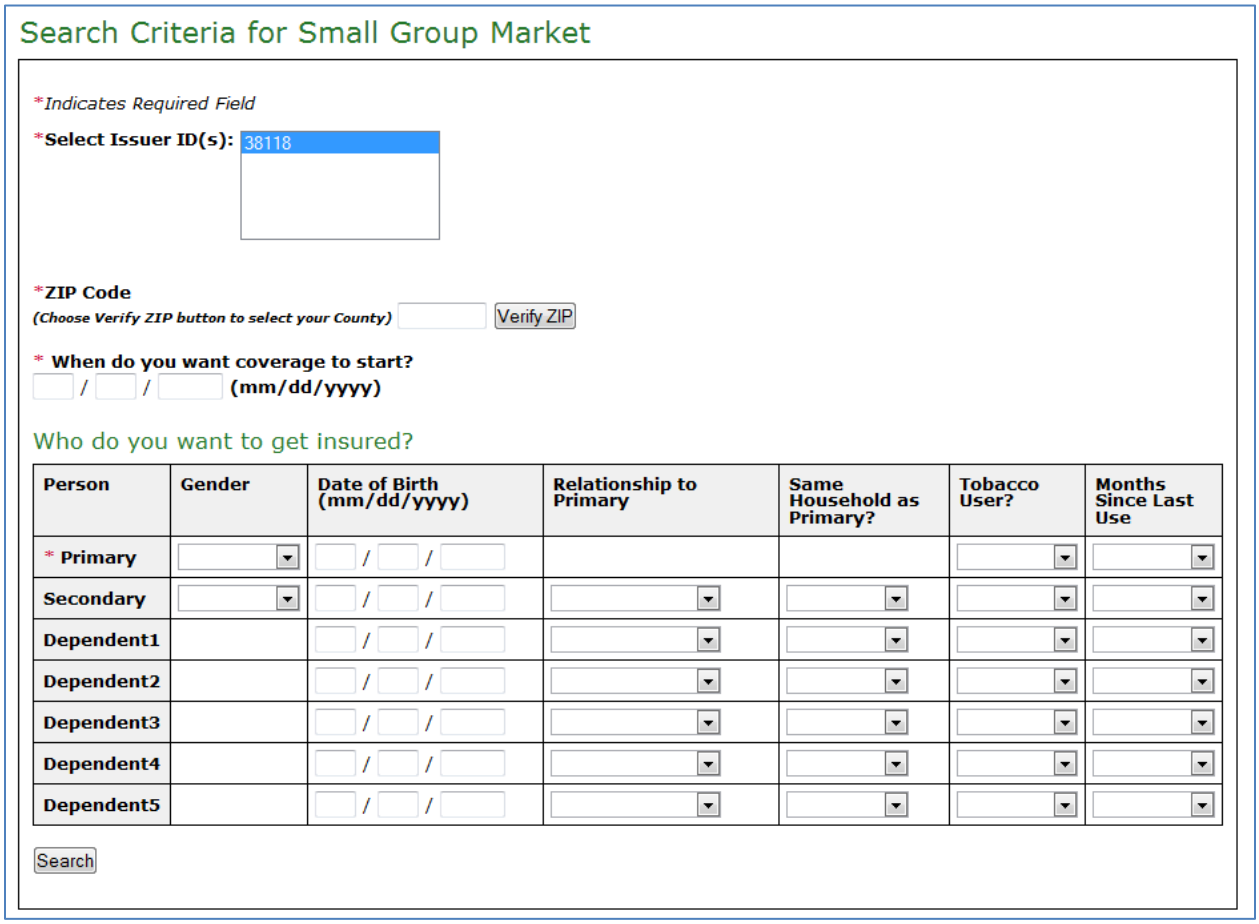
In order to run a small group scenario and view information, the following fields must be completed:

- Issuer ID
- Zip Code
- County
- Coverage Start Date
- Primary Information
  - Gender
  - Date of Birth
  - Tobacco User Status (Y/N) / Months Since Last Use
- Secondary Information (as applicable)
  - Gender
  - Date of Birth
  - Relationship to Primary Subscriber
  - Same Household as Primary Subscriber (Y/N)
  - Tobacco User Status (Y/N) / Months Since Last Use
- Dependent Information (as applicable)
  - Date of Birth

- Relationship to Primary Subscriber
- Same Household as Primary
- Tobacco User Status (Y/N) / Months Since Last Use

Please refer to Exhibit 8-10 for the Search Criteria for Small Group Market screen.

Exhibit 8-10: Search Criteria – Small Group Market



8.1.2.2 Search Criteria Required Fields -- Individual

In order to run an individual scenario and view information, the following fields must be completed:

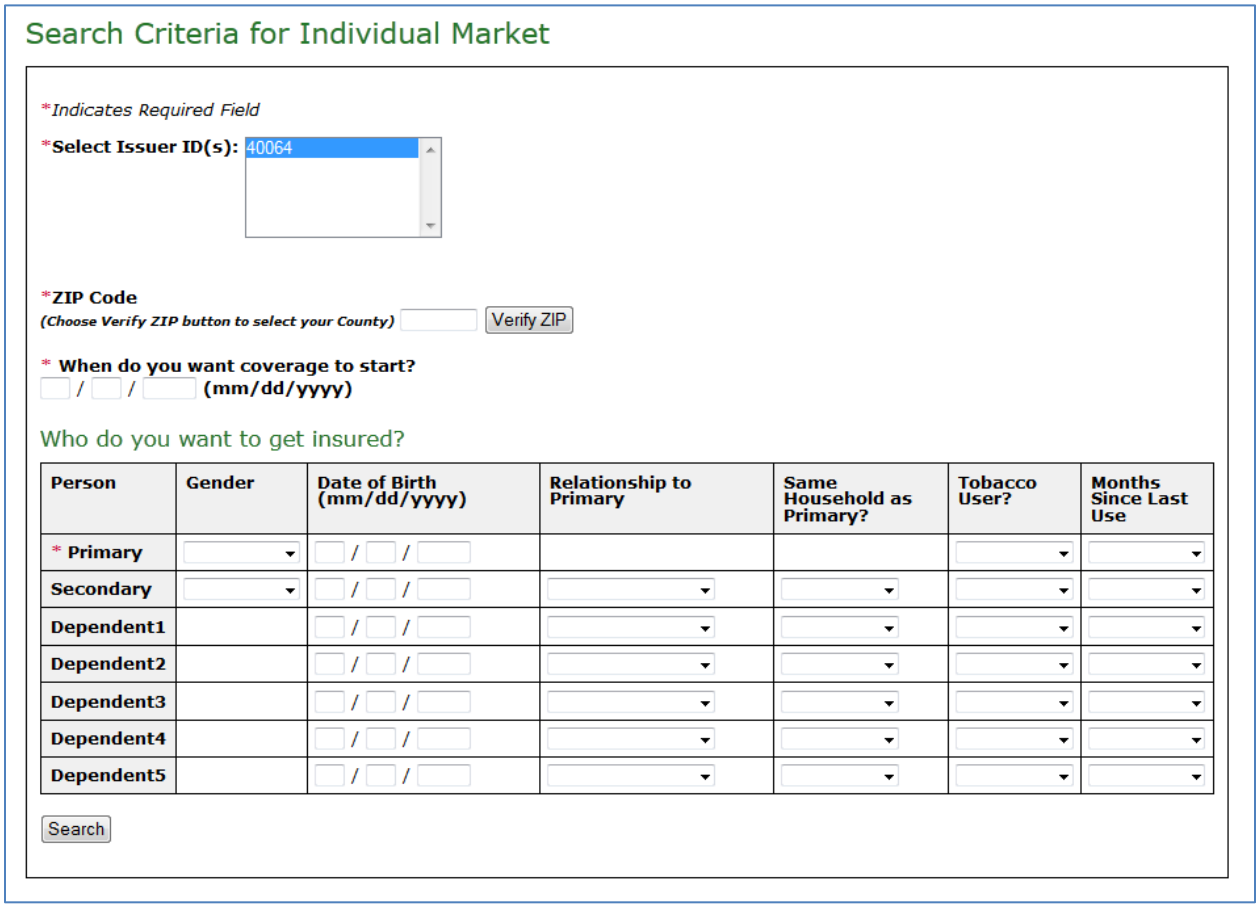
- Issuer ID
- Zip Code
- County
- Coverage Start Date
- Primary Information
  - Gender
  - Date of Birth
  - Tobacco User Status (Y/N) / Months Since Last Use
- Secondary Information (as applicable)

- Gender
- Date of Birth
- Relationship to Primary Subscriber
- Same Household as Primary Subscriber (Y/N)
- Tobacco User Status (Y/N) / Months Since Last Use

- Dependent Information (as applicable)
  - Date of Birth
  - Relationship to Primary Subscriber
  - Same Household as Primary
  - Tobacco User Status (Y/N) / Months Since Last Use

Please refer to Exhibit 8-11 for the Search Criteria for Individual Market screen.

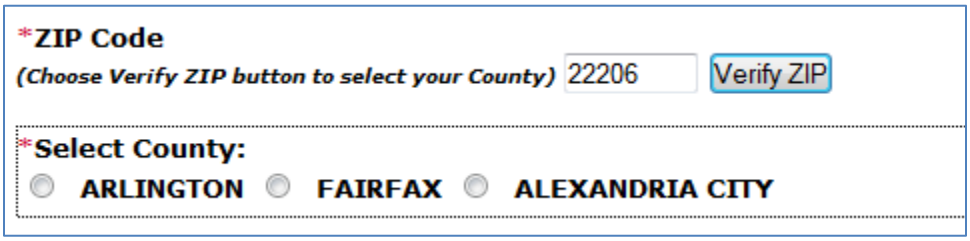
Exhibit 8-11: Search Criteria – Individual Market



8.1.2.3 Zip Code

After a zip code has been entered, Users must select the ***Verify ZIP*** button. The County field will appear and Users must select the appropriate county before selecting the Search button. Please refer to Exhibit 8-12.

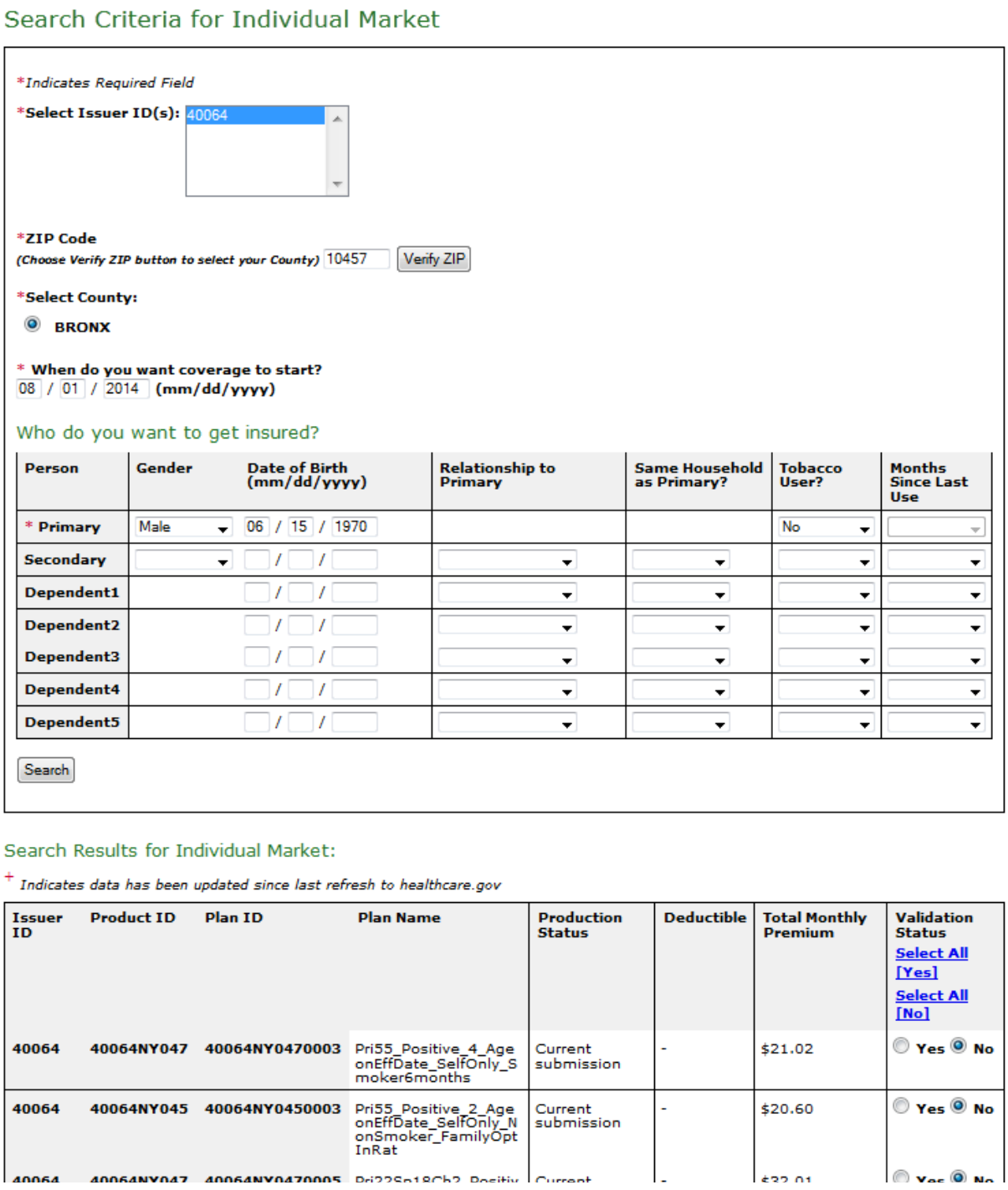
Exhibit 8-12: Zip Code Field



8.1.2.4 Search Results

Once all required fields have been populated, Users can select the Search button to review their results. Please refer to Exhibit 8-13.

Exhibit 8-2: Search by Scenario Results – Individual Market



Search Criteria for Individual Market

*Indicates Required Field

*Select Issuer ID(s): 40064

*ZIP Code

(Choose Verify ZIP button to select your County) 10457 Verify ZIP

*Select County:

BRONX

* When do you want coverage to start?

08 / 01 / 2014 (mm/dd/yyyy)

Who do you want to get insured?

Person	Gender	Date of Birth (mm/dd/yyyy)	Relationship to Primary	Same Household as Primary?	Tobacco User?	Months Since Last Use
* Primary	Male	06 / 15 / 1970			No	
Secondary		/ /				
Dependent1		/ /				
Dependent2		/ /				
Dependent3		/ /				
Dependent4		/ /				
Dependent5		/ /				

Search

Search Results for Individual Market:

+ Indicates data has been updated since last refresh to healthcare.gov

Issuer ID	Product ID	Plan ID	Plan Name	Production Status	Deductible	Total Monthly Premium	Validation Status Select All [Yes] Select All [No]
40064	40064NY047	40064NY0470003	Pri55_Positive_4_AgeonEffDate_SelfOnly_Smoker6months	Current submission	-	$21.02	Yes No
40064	40064NY045	40064NY0450003	Pri55_Positive_2_AgeonEffDate_SelfOnly_NonSmoker_FamilyOptInRat	Current submission	-	$20.60	Yes No
40064	40064NY047	40064NY0470005	Pri22Sp18Ch2_Positiv	Current	-	$32.01	Yes No

Issuers may adjust the Validation Status from the Search Results table. Using the radio buttons in the Validation Status column, Issuers must decide between the two Validation Status options, Yes or No, for each plan. By selecting "Yes," the User indicates that all data for the given plan is valid and correct. In doing so, the plan passes Issuer Validation. By selecting "No" the User indicates that all data for the given plan is *not* valid. In doing so, the plan fails Issuer Validation. Users may change the Validation Status for all plans for an Issuer ID at one time by selecting

either the “Select All [Yes]” or “Select All [No]” link. Users must select the Submit button for the Validation Status to be saved in RBIS.

9 ATTESTATION

All Issuers must attest to the accuracy of their data before the data is approved for use on Healthcare.gov. Users will attest to data for all Issuer IDs. **Users should use caution when completing Attestation, as it can only be completed one time per submission window.**

9.1 ATTESTATION AVAILABLE

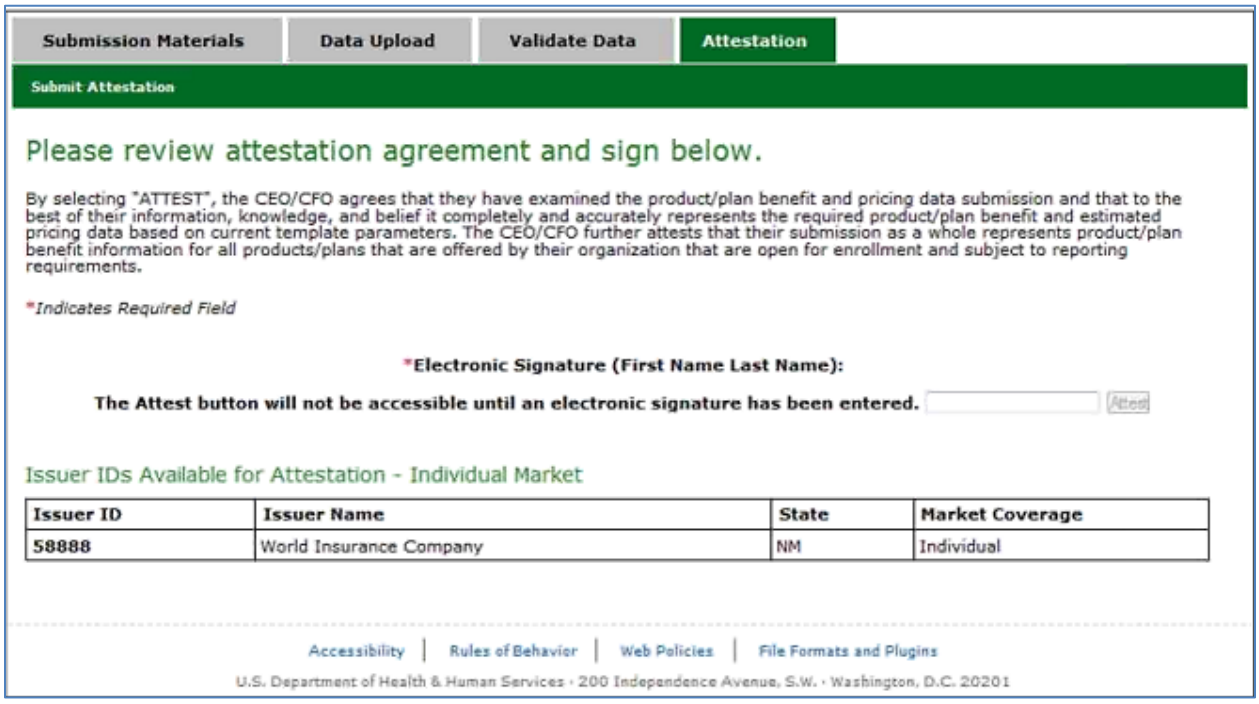
Attestation becomes available when all Issuers associated to a CEO/CFO from both markets have been submitted successfully or have indicated they have no data to submit. In order to attest to the accuracy of Plan data, the Attester must fill in the Electronic Signature box and select the Attest button.

There is a single Attestation page and a single Attestation button for the User. The Attester must attest to all plans for both markets concurrently as information for each Issuer associated to the User is displayed on the Attestation page and grouped by market type. This includes the status information if the Issuer is not available for Attestation or a list of the Issuers that the User is attesting for when Attestation is available.

There will are manual Attestation forms available upon request for when an Attester wishes to only attest to a single market. The request for the manual Attestation form will need to be sent to insuranceoversight@hhs.gov with a description of what market the request is for.

By selecting ***Attest***, the CEO/CFO agrees that they have examined the product/plan benefit and pricing data submission and that to the best of their information, knowledge, and belief it completely and accurately represents the required product/plan benefit and estimated pricing data based on current template parameters. The CEO/CFO further attests that their submission as a whole represents product/plan benefit information for all products/plans that are offered by their organization that are open for enrollment and subject to reporting requirements. Please refer to Exhibit 9-1.

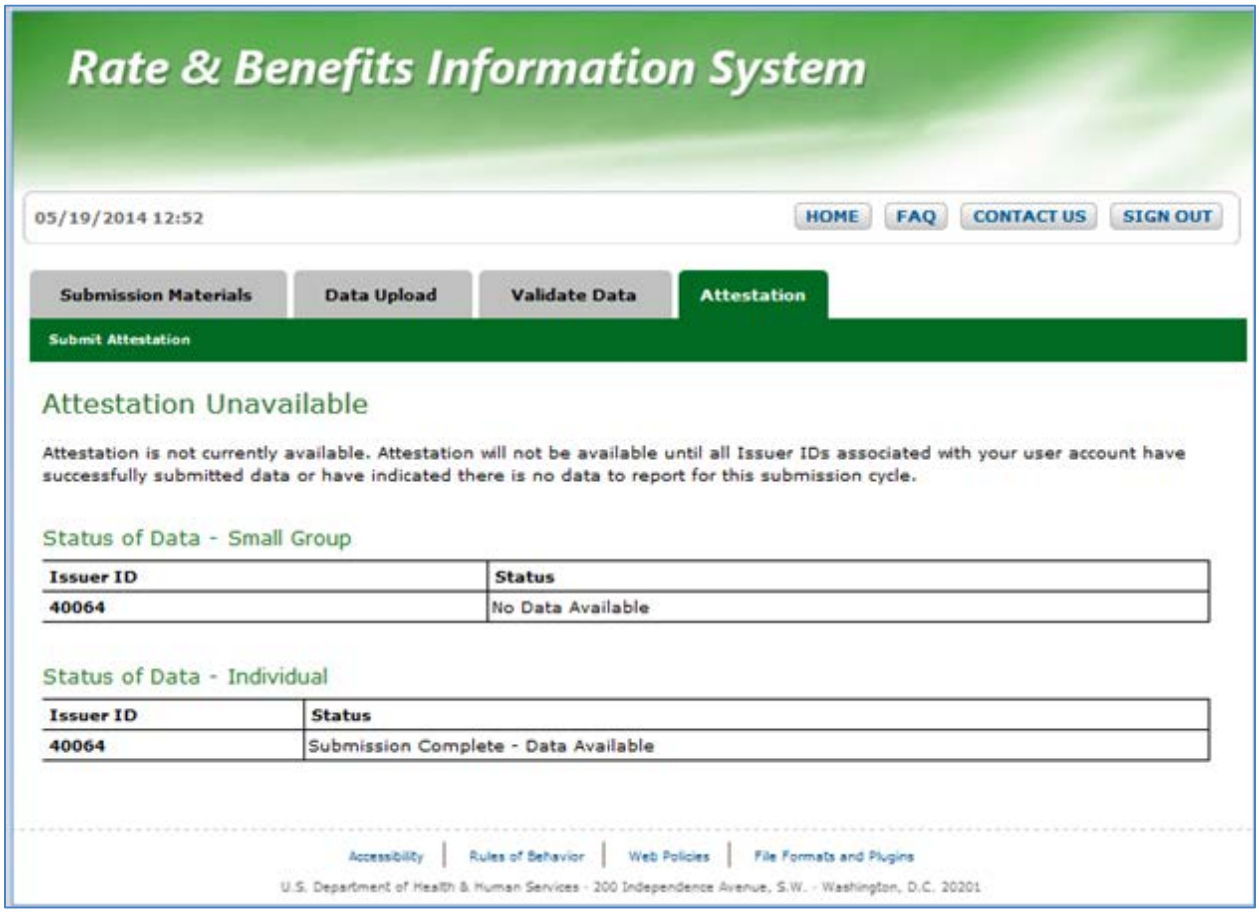
Exhibit 9-1: Attestation



9.2 ATTESTATION UNAVAILABLE

Data Attestation is unavailable when an Issuer has not completed submission for all Issuer IDs associated with their User ID. Please refer to Exhibit 9-2. Issuers must submit data for every Issuer ID they are associated with before Attestation will become available. To upload data, Users should navigate to the Data Upload tab. In the event that there is no data to report for the current submission window for one or more Issuer IDs associated with the User ID, Users may indicate under the Validate Data Tab that no data will be submitted. Please see Section 8.1.1.3 for further instructions.

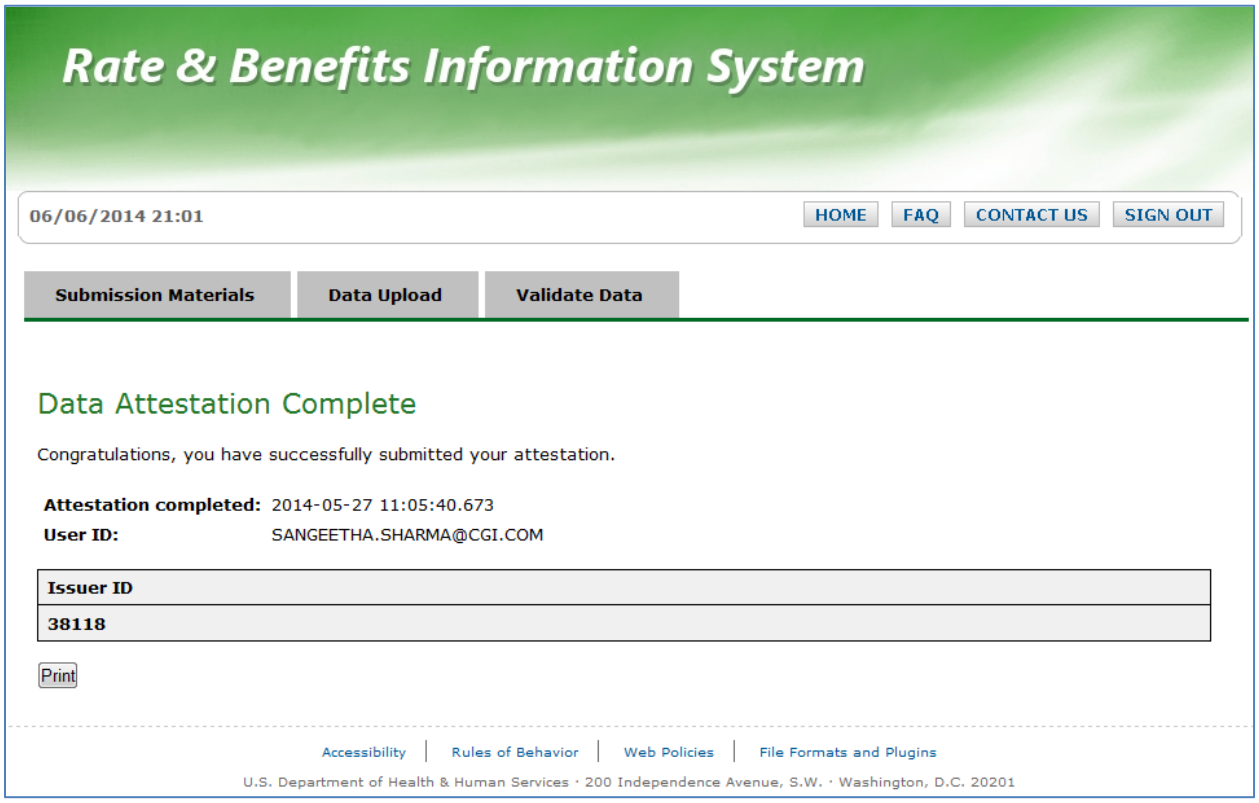
Exhibit 9-2: Attestation Unavailable



9.3 ATTESTATION COMPLETE

Once Attestation has been completed, the Users will be redirected to the Attestation Complete page displayed in Exhibit 9-3.

Exhibit 9-3: Attestation Complete



The Data Attestation, Data Submission, and Data Validation contacts will all receive a copy of the Attestation Complete email notification. The email will provide the following information:

- Issuer ID
- Issuer Name
- Market Type
- Message confirming that Attestation is complete for the Issuer
- Date Attestation is complete
- Time Attestation is complete

9.4 MANUAL ATTESTATION

If an electronic Attestation cannot be completed, Issuer may request a paper Attestation form for either the Small Group or Individual market. This manual Attestation request must be approved by CCIIO before Issuers will be granted access to the form. If Issuers are granted approval to manually attest, they will be provided with a form for the CEO/CFO to sign. This form will need to be scanned and emailed back to insuranceoversight@hhs.gov.

10 RESUBMISSION

The resubmission process is a time for the Issuer to change or update any data currently in the RBIS system. The Issuer can also add new data or correct any previously failed data during the submission process. If information is updated in the HIOS system, an email will be generated informing the User that a new Pre-populated template will be available. After an Issuer has re-submitted their data, the templates will go through both Template Validations and overall Plan Cross-Check Validations. Template-specific System Validations will be performed prior to the Cross-Check Validations.

Plans that are displayed in RBIS during the resubmission process are:

- Plans currently in production
- Previously submitted plans that were validated successfully but not attested
- Plans newly submitted to RBIS
- New plans in HIOS that will be available only in the Pre-Populated templates.

10.1 RESUBMISSION REQUIREMENTS

Issuers may submit any updates or changes, or correct failed submissions from the previous refresh via the resubmission process. If a plan failed in the previous submission because it was "Not Attested" the Issuer will need to resubmit or the plan will be removed from RBIS.

Plans currently in production can only be updated and cannot be removed from the Validate Data tab through submission. If no updates are needed, then the Issuer may just remove them from the template.

If no changes or updates need to be made, then resubmission is not necessary. The plan will still require Validation and Attestation in order to be displayed on Healthcare.gov. The Issuer will need to indicate there is no data to submit and then Attestation will become available. Validation and Attestation are required in order to be displayed on Healthcare.gov.

10.2 RESUBMISSION VALIDATION REQUIREMENTS

All plans will require Validation and Attestation even if there are no updates from the previous submission. The Issuer will need to confirm there is no data to submit, and then validate and attest. All plans in RBIS will have a default Validation status of "No". All submissions must successfully pass System Validation.

10.3 HEALTHCARE.GOV REFRESH

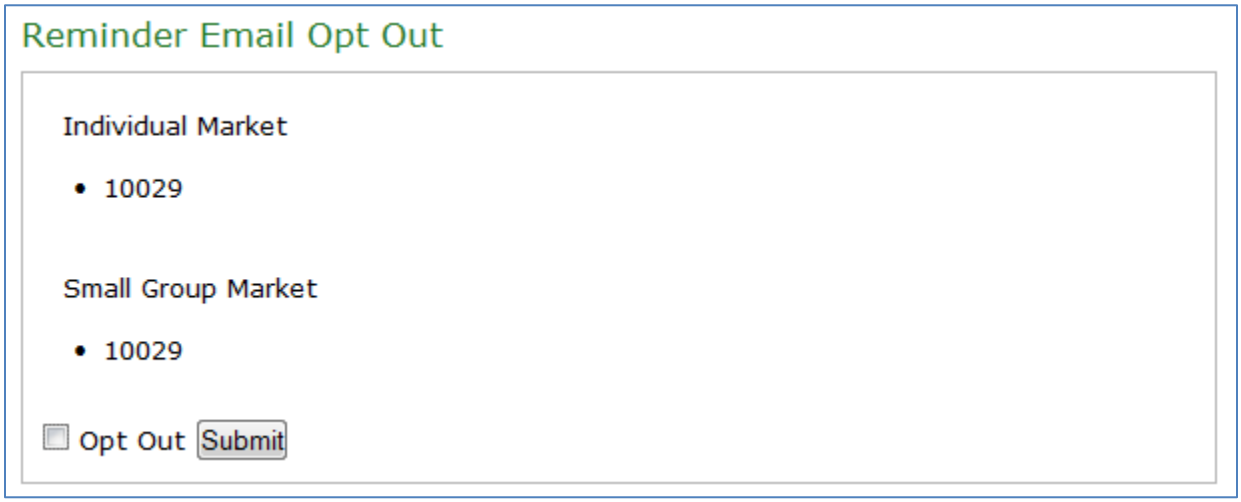
Information will be updated every two weeks on Healthcare.gov during the submission window. A status update email will be sent every two weeks, on the week contrary to the refresh, for the first six weeks of the submission window and will be sent weekly thereafter. These status emails will be sent to the Primary Data Submitters with all Validators and all other Submitters cc'd. One email with all the associated Issuer IDs will be sent per Primary Data Submitter. The emails will be sent for the appropriate market type based upon the associations of the Primary Data Submitter. The following information will be included in the emails:

- Submission status

    - Successful
    - Unsuccessful
- Validation status
    - All plans have been validated
    - At least one plan has been rejected or not yet validated
- Attestation status
    - Complete
    - Incomplete

If all Issuers associated to the Primary Data Submitter have been submitted successfully and have had all of their products validated and attested, no email will be sent. Users will be able to turn off email reminders via a checkbox on the RBIS home page. This opt-out selection will only apply to the email reminders and not to any other system generated emails. Refer to Exhibit 10-1.

Exhibit 10-1: Email Opt-Out Checkbox



All plans that have been validated and attested will be displayed on Healthcare.gov.

10.3.1 Interim Refresh.

This is a scheduled process. Additional ad-hoc requests may still occur.

- No plans currently in production will be removed
- Only data that meet the gate check criteria will be moved to production:
    - Validated
    - Attested
    - Open in HIOS
    - Not Suppressed in HIOS
    - Not CCIIO suppressed
    - Not Expired

All Issuer and Product data for plans that meet the criteria will move to Healthcare.gov.

10.3.2 Final Refresh

This will occur at the end of the submission window.

11 APPENDICES

11.1 APPENDIX A – TEMPLATE DATA VALIDATIONS

To trigger the Validation Process:

1. When the Submitter has completed the data entry or updates, it is recommended to save the document before starting the Validation Process.
    a. For Excel 2003 version, select on the Excel ***Save*** icon. There is no need to rename the document at this point.
    b. For Excel 2007 version, select on the Microsoft Office button  , select Save As, and ensure the file version is set to 2003 version.
    c. For Excel 2010, Select File, Save As and save the file as an Excel Macro-Enabled Workbook.

    There is no need to rename the document at this point.

2. Click on the ***Validate*** button.

Upon triggering the Validation Process, a message box will pop up indicating which cells did not pass Validation along with a brief description of why the cell did not pass Validation. Once the Validation rules are corrected, the Validate process will display a message indicating the Validation was successful.

Once the template has passed Validation, the Excel file must be finalized. In order to do finalize the Excel file, select the ***Finalize*** button. This will create an .xml file that is suitable for submission in the RBIS system.

11.2 APPENDIX B - EMAIL ERROR MESSAGES

11.2.1 Plans Benefits Template

The table below in Exhibit 11-1 describes all possible error messages produced if the Plans Benefits Template does not pass System Validations.

Exhibit 11-1: Plans Benefits Template Email Error Messages

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Benefits Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The Issuer ID does not exist in HIOS. Please submit Issuer data in HIOS before submitting	6002

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
			in RBIS.	
System Validation	Benefits Template	Product ID :<Product ID>	Invalid Product ID - Product ID does not exist in HIOS. Product ID must exist in HIOS before data can be submitted to RBIS.	6004
System Validation	Benefits Template	Market Coverage :<Market Coverage>	Invalid Market Coverage - This template was submitted under a market type that does not match the market type indicated in Market Coverage.	6017
System Validation	Benefits Template	Product ID :<Product ID>	Invalid Product ID – This product was submitted under a market type that does not match the market type listed for the product in HIOS.	6005
System Validation	Benefits Template	Product ID :<Product ID>	Invalid Product ID - This product is closed in HIOS.	6006
System Validation	Benefits Template	Product ID :<Product ID>	Invalid Product ID - This product is suppressed in HIOS.	6007
System Validation	Benefits Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - User that submitted this template does not have permissions to submit data for this issuer.	6003
System Validation	Benefits Template	Product ID :<Product ID>	Invalid Product ID - The Product ID entered is not valid for the Issuer ID entered.	6009
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Plan ID - The Plan ID entered is not valid for the Product ID entered.	6010
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Plan ID - This plan ID does not exist in the database. Please use only the Plan IDs that were provided to you. If you need additional Plan IDs please contact the Exchange Operations Service Center (XOSC).	6008
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered in Plan Effective Date field is either Invalid or Null. This is a mandatory field and requires valid data.	6011
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Format - The data entered in Plan Expiration Date field is either Invalid or Null. This is a mandatory field and requires valid data.	6012
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Date - The Plan Expiration Date must greater than the Plan Effective Date	6013
System Validation	Benefits Template	Product ID :<Product	Null value - You cannot leave the Issuer ID field blank.	6014

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
		Smart ID>		
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered in one of the EHB fields is not valid. Please verify the data and resubmit.	6040
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data received for one of the State Mandate fields is not valid. Please verify the data and resubmit.	6043
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data submitted has to include one Gold and one Silver Plan for a Plan type of QHP or Both. Please verify the data and resubmit.	6046
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered for the Limited Cost Sharing Plan Variation - Est Advanced Payment is not compatible with the value in Level of Coverage. Please verify and resubmit.	6049
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data -The data entered in Limit Quantity is not compatible with the value entered in Quantitative limit on Service.	6052
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered in Limit Unit is not compatible with the value entered in Quantitative limit on Service.	6055
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value you entered in Specialists Requiring a Referral is incompatible with the value you entered in Is a Referral required to see a specialist.	6058
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered for the Network ID is not in the proper format. Please refer to the template for proper format.	6064
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Network ID - The data entered for the Service Area ID not in the proper format. Please refer to the template for proper format.	6066
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered for the Formulary ID not in the proper format. Please refer to the template for proper format.	6069
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data entered in one or more of the Header fields is not valid. Please refer to the template for correct for instructions.	6072

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Value - The data entered for one or more of the Plan attributes fields is not valid. Please check the template for correct value options.	6078
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Value - The data entered for one of the AV Calculator Additional Benefit Design fields is not valid. Please check the template for correct value options.	6081
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Value - The data entered for one of the Geographic Coverage fields is not valid. Please check the template for correct value options.	6084
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Value- The data entered for one of the General Information fields is not valid. Please check the template for the correct value options.	6087
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Child Only Plan ID - The Plan ID entered in Child Only Plan ID field, should be included as a Plan in this Benefits Package.	6090
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Value - The Child Only Plan ID field cannot be blank when the value in Child only Offering field is "Allows Adult Only".	6093
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Header information blank.	6099
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Plan Identifiers blank.	6102
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Plan Attributes blank.	6103
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Plan Dates blank.	6105
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Geographical Coverage blank.	6108
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of General Information.	6114
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Deductible and Out of Pocket Exceptions blank.	6116
System Validation	Benefits Template	Plan ID :<Plan ID>	Null value - You cannot leave any of the required fields of Cost Share	6117

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
			Reduction Information blank.	
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The data you submitted in one or more of the Cost share Reduction Information is not valid. Please verify the template and resubmit.	6118
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Template - The Template submitted is a Dental Template. Please verify the template and resubmit.	6154
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in Issuer Actuarial Value is not compatible with the value entered in Unique Plan Design.	6157
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in 1st Tier Utilization and 2nd Tier Utilization are not compatible with the value entered in Multiple In Network Tiers.	6159
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in one of the Maximum Out of Pocket for Medical EHB Benefits is not compatible with the data entered in Medical & Drug Maximum Out of Pocket Integrated?.	6160
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in one of the Maximum Out of Pocket for Drug EHB Benefits is not compatible with the data entered in Medical & Drug Maximum Out of Pocket Integrated?.	6163
System Validation	Benefits Template	Plan ID :<Plan ID>, Plan ID:<Plan ID>	Invalid Data - The value entered in one of the Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) is not compatible with the data entered in Medical & Drug Maximum Out of Pocket Integrated?.	6164
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in one of the Medical EHB Deductible is not compatible with the data entered in Medical & Drug Deductibles Integrated?.	6165
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in one of the Drug EHB Deductible is not compatible with the data entered in Medical & Drug Deductibles Integrated?.	6167

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Benefits Template	Plan ID :<Plan ID>	Invalid Data - The value entered in one of the Combined Medical & Drug EHB Deductible is not compatible with the data entered in Medical & Drug Deductibles Integrated?.	6169

11.2.2 Service Area Template

The table below in Exhibit 11-2 describes all possible error messages produced if a Service Area template does not pass System Validations.

Exhibit 11-2: Service Area Template Email Error Messages

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Service Area Template	File Name: <File Name>	Invalid Template type - Template does not match the selected Template type. Template submitted is not a Service Area Template.	4001
System Validation	Service Area Template	File Name: <File Name>	Invalid Template - The Template submitted is not the correct version of the template. Please download the latest version of the Templates from RBIS - Submission Materials page.	4002
System Validation	Service Area Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The issuer's market coverage type does not match the market coverage type the template was submitted for.	4011
System Validation	Service Area Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The Issuer ID does not exist in HIOS. Please submit Issuer data in HIOS before submitting in RBIS.	4003
System Validation	Service Area Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - User that submitted this template does not have permissions to submit data for this issuer.	4004
System Validation	Service Area Template	Issuer ID: <Issuer ID>	Invalid Issuer State - The Issuer State selected is not valid for the Issuer.	4005
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Invalid Format - The Service Area ID entered is not in the valid format.	4006
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Invalid State - The State value entered is not valid.	4007
System Validation	Service Area Template	Service Area ID :<Service Area	Invalid County Name - One or more county names associated with service	4008

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
		ID>	area are invalid.	
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Invalid Partial County - The Partial County entered is not valid.	4009
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Invalid Format - The Service Area Zip Code(s) entered is not in the correct format.	4010
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Null value - You cannot leave the Service Area Name field blank.	4014
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Invalid Zip Code(s) - The Service Area Zip Code(s) entered is not valid for the State and County selected.	4020
System Validation	Service Area Template	Service Area ID :<Service Area ID>	Null value - You cannot leave the Partial County Justification field blank.	4019
System Validation	Service Area Template	Issuer ID: <Issuer ID>	Null value - You cannot leave the HIOS Issuer ID field blank.	4021

11.2.3 Rates Template

The table below in Exhibit 11-3 describes all possible error messages produced if a Rates template does not pass System Validations.

Exhibit 11-3: Rates Template Email Error Messages

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Rates Template	File Name: <File Name>	Invalid Template type - Template does not match the selected Template type. Template submitted is not a Rates Template.	7001
System Validation	Rates Template	File Name: <File Name>	Invalid Template - The Template submitted is not the correct version of the template. Please download the latest version of the Templates from RBIS - Submission Materials page.	7031
System Validation	Rates Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The issuer's market coverage type does not match the market coverage type the template was submitted for.	7043
System Validation	Rates Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The Issuer ID does not exist in HIOS. Please submit Issuer data in HIOS before submitting in RBIS.	7002

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Rates Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - User that submitted this template does not have permissions to submit data for this issuer.	7003
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Plan ID - The Plan ID entered does not belong to the issuer specified in the template header.	7044
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Format - The Plan ID entered is not in the correct format.	7009
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Plan ID - This Plan ID has not been established. Please use only the Plan IDs that were provided to you. If you need additional Plan IDs please contact the Exchange Operations Service Center (XOSC).	7010
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Plan ID: This plan was submitted under a market type that does not match the market type listed for the plan in HIOS.	7045
System Validation	Rates Template	Rate Expiration Date :<Rate Expiration Date>	Invalid Date - The Rate Expiration Date must be greater than or equal to the Rate Effective Date	7011
System Validation	Rates Template	Rate Effective Date :<Rate Effective Date>	Invalid Format - The Rate Effective Date must be in the appropriate date format.	7012
System Validation	Rates Template	Rate Expiration Date :<Rate Expiration Date>	Invalid Format - The Rate Expiration Date must be in the appropriate date format.	7013
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Tobacco Type - The Tobacco Type entered is not Valid	7030
System Validation	Rates Template	Federal TIN: <Federal TIN>	Invalid Federal TIN - The Federal TIN entered is not Valid.	7014
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Rating Area ID - The Rating Area ID entered is not Valid.	7015
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Age - The Age entered is not Valid.	7016
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Individual Rate - Individual Rate must be a number greater than or equal to 0.	7018
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Individual Rate - Individual Rate for an age band greater than 22 cannot be more than 3x the Individual Rate for age 21.	7040
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Tobacco Individual Rate - Tobacco Individual Rate must be a number greater than or equal to 0.	7020

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Tobacco Individual Rate - Tobacco Individual Rate cannot be more than 1.5x the Individual Rate.	7041
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Tobacco Individual Rate - Tobacco Individual Rate for an age band greater than 22 cannot be more than 3x the Tobacco Individual Rate for age 21.	7042
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Couple Rate - Couple Rate must be a number greater than or equal to 0.	7023
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Primary Subscriber and One Dependent Rate - Primary Subscriber and One Dependent Rate must be a number greater than or equal to 0.	7026
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Primary Subscriber and Two Dependents - Primary Subscriber and Two Dependents Rate must be a number greater than or equal to 0.	7029
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Primary Subscriber and Three or More Dependents - Primary Subscriber and Three or More Dependents must be a number greater than or equal to 0.	7036
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Couple and One Dependent - Couple and One Dependent must be a number greater than or equal to 0.	7037
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Couple and Two Dependents - Couple and Two Dependents must be a number greater than or equal to 0.	7038
System Validation	Rates Template	Plan ID :<Plan ID>	Invalid Couple and Three or More Dependents - Couple and Three or More Dependents must be a number greater than or equal to 0.	7039
System Validation	Rates Template	Plan ID :<Plan ID>	Null value - You cannot leave the Issuer ID field blank.	7022

11.2.4 Business Rules Template

The table below in Exhibit 11-4 describes all possible error messages produced if a Business Rules Template does not pass System Validations.

Exhibit 11-4: Business Rules Template Email Error Messages

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Business Rules Template	File Name: <File Name>	Invalid Template type - Template does not match the selected Template type. Template submitted is not a Business Rules Template.	8001
System Validation	Business Rules Template	File Name: <File Name>	Invalid Template - The Template submitted is not the correct version of the template. Please download the latest version of the Templates from RBIS - Submission Materials page.	1113
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The Issuer ID does not exist in HIOS. Please submit Issuer data in HIOS before submitting in RBIS.	8002
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - User that submitted this template does not have permissions to submit data for this issuer.	8003
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Null value - You cannot leave the Issuer ID field blank.	8004
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Null value - You cannot leave the TIN field blank.	8005
System Validation	Business Rules Template	TIN: <TIN>	Invalid value - TIN field contains an invalid value.	8008
System Validation	Business Rules Template	Plan ID: Plan ID>	Invalid value - Enter either a Product ID or Plan ID, not both.	8009
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - Product ID and Plan ID must be blank on the first row.	8010
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - What are the maximum number of children used to quote a children-only contract? field blank, select from list.	8011
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid Issuer ID - The issuer's market coverage type does not match the market coverage type the template was submitted for.	8012
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - Is there a maximum age for a dependent? field blank, select from list.	8013
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - Are domestic partners treated the same as secondary subscribers? field blank, select from list.	8014
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - Are same-sex partners treated the same as secondary subscribers? field blank, select from list.	8015
System Validation	Business Rules Template	Plan ID: <Plan ID>	Invalid value - Plan ID does not contain a valid value.	8016

Type of Validation	Template type	Issuer Error Key ID	Issuer Error Type name	Error Code
System Validation	Business Rules Template	Plan ID: <Plan ID>	Invalid Plan ID - This plan was submitted under a market type that does not match the market type listed for the plan in HIOS.	8017
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - How is tobacco status determined for subscribers and dependents? field blank, select from list.	8018
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber? field blank, select from list.	8019
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - How is age determined for rating and eligibility purposes? field blank, select from list.	8020
System Validation	Business Rules Template	Product ID :<Product ID>	Invalid Product ID - Product ID does not exist in HIOS. Product ID must exist in HIOS before data can be submitted to RBIS.	8021
System Validation	Business Rules Template	Product ID :<Product ID>	Invalid Product ID - This product was submitted under a market type that does not match the market type listed for the product in HIOS.	8022
System Validation	Business Rules Template	Product ID :<Product ID>	Invalid Product ID - This product is closed in HIOS.	8023
System Validation	Business Rules Template	Product ID :<Product ID>	Invalid Product ID - This product is suppressed in HIOS.	8024
System Validation	Business Rules Template	Product ID :<Product ID>	Invalid Product ID - The Product ID entered is not valid for the Issuer ID entered.	8025
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - How are rates for contracts covering two or more enrollees calculated? field blank, select from list.	8027
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - What are the maximum number of under age (under 21) dependents used to quote a two parent family? field blank, select from list.	8030
System Validation	Business Rules Template	Issuer ID: <Issuer ID>	Invalid value - What are the maximum number of under age (under 21) dependents used to quote a single parent family? field blank, select from list.	8031

11.2.5 Cross-Check Validations

The table below in Exhibit 11-5 describes all error messages produced when a template does not pass Cross-Check System Validations.

Exhibit 11-5: Cross-Check Email Error Messages

Type of Validation	Issuer Error Key ID	Issuer Error Type name	Error Code
Cross Check Validation	Plan ID :<Plan ID>	Incomplete Plan - This Plan ID was listed in the Rates Template, however no Benefit information was received in the Plans Benefits Template. All plans must have benefits information for the submission to be valid.	9005
Cross Check Validation	Plan ID :<Plan ID>	Incomplete Plan - This Plan ID was listed in the Plans Benefits Template, however no Rates information was received in the Rates Template. Each plan must have at least one rate to be valid.	9006
Cross Check Validation	Plan ID :<Plan ID>	Incomplete Plan - This Service Area ID was listed in the Plans Benefits Template, however no Service Area information was received in the Service Area Template..	9007
Cross Check Validation	Issuer ID: <Issuer ID>	Incomplete Plan – Business rules do not exist for this Issuer.	9008

11.3 APPENDIX C - FILE TYPE INSTRUCTIONS

The following file formats are accepted for data upload into the Rate and Benefits Information System (RBIS):

- XML
- ZIP

11.3.1 XML

All files must be 50 MB or smaller. Before saving the finalized document, users should ensure that all required fields have been filled in correctly.

11.3.2 ZIP

All files must be 50 MB or smaller. If Users have difficulty with the file size, zipped or compressed files take up less storage space and may be utilized instead. User can combine several files into a single compressed folder, making it easier to upload into RBIS. It is important to note that **Users may only have one Template type per ZIP file**. For example, Users may upload multiple Benefits template in one ZIP file, but they cannot upload a Benefits template with a Rates template into the same ZIP file.

11.3.3 Saving documents in .ZIP format

Before saving the finalized document as a ZIP file, Users should ensure that all required fields have been filled in correctly.

To compress a file or folder using Windows:

1. Locate the file(s) or folder(s) that you want to compress.

2. Select the file(s) or folder(s) and right-click, point to Send To, and then select Compressed (zipped) Folder.

    a. A new compressed folder is created. To rename it, right-click the folder, select Rename, and then type the new name.

To compress files and folders using Mac OS:

1. Select the item or items you want to compress.

2. Choose File and select Compress.

    a. If you compress a single item, the compressed file has the name of the original item with a .zip extension. If you compress multiple items at once, the compressed file is called Archive.zip.

    b. When you open a compressed file, it is replaced by a folder containing uncompressed copies of the original items. As the item is being uncompressed, the Archive Utility appears in the Dock. If you want to change where the uncompressed files appear or automatically delete the .zip files, select Archive Utility, and select Archive Utility > Preferences.

11.4 APPENDIX D - TEMPLATE DATA FIELD DEFINITIONS

11.4.1 Plans Benefits Template

The following table in Exhibit 11-6 is the Plans Benefits Template Data Dictionary. The table includes definitions for the fields found in each column of the template.

Exhibit 11-6: Plans Benefits Template Data Dictionary

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
HIOS Issuer ID	Five digit number that identifies the Issuer.	Yes	Numeric	5	Exists in Issuer Organization and Issuer Request tables.
Issuer State	Two character abbreviation for the state code.	Yes	Drop-down	N/A	Values for 50 US states plus 9 codes for US territories
Market Coverage	Indicates whether the benefit package template is for Individual or Small Group offerings.	Yes	Drop-down	N/A	1 – Individual 2 – SHOP (Small Group)

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Dental Only Plan	Indicates if the plans offered in the benefit package are for stand alone dental only (not medical).	Yes	Drop-down	N/A	1 – Yes 2 – No
TIN	Tax Identification Number (TIN) for the tax entity.	Yes	Numeric	9	N/A
HIOS Plan ID (Standard Component)	HIOS generated fourteen digit number that identifies the plan.	Yes	Varchar	14	N/A
Plan Marketing Name	Name of the plan given by the Issuer.	Yes	Varchar	256	N/A
HIOS Product ID	Ten digit alphanumeric that identifies a product.	Yes	Varchar	10	Exists in Insurance Product table.
HPID	The National Health Plan Identifier associated with the plan.	No	Numeric	10	
Network ID	The Network ID associated with the plan.	Yes	Drop-down	6	Exists in values imported from Network template
Service Area ID	The Service Area associated with the plan.	Yes	Drop-down	6	Exists in values imported from Service Area template
Formulary ID	The Formulary ID associated with the plan.	Yes	Drop-down	6	Exists in values imported from Prescription Drug template
New/Existing Plan?	Indicates whether the plan is new (newly approved or under review by a state) or existing (with subscribers already enrolled).	Yes	Drop-down	N/A	1 – New 2 – Existing
Plan Type	Network design for the product (e.g., PPO, HMO, etc.).	Yes	Drop-down	N/A	• INDEMNITY • PPO • POS • EPO • HMO
Level of Coverage	Coverage level for a specific plan The list of values for this field changes if the user indicates this is a Dental-only plan.	Yes	Drop-down	N/A	Platinum Gold Silver Bronze Catastrophic

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Unique Plan Design	Indicates whether if the plan design is not compatible with the Actuarial Value Calculator.	Yes	Drop-down	N/A	1 – Yes 2 – No
QHP/Non QHP	Indicates if the plan is offered on exchange, off exchange or both.	Yes	Drop-down	N/A	1 – On Exchange 2 – Off Exchange 3 - Both
Notice Required for Pregnancy	Indicates whether notice is required for pregnancy.	Yes	Drop-down	N/A	1 – Yes 2 – No
Is a Referral Required for Specialist?	Indicates whether a referral is required to see a specialist.	Yes	Drop-down	N/A	1 – Yes 2 – No
Specialist(s) Requiring a Referral	Enter the specialist by service and indicate whether the specialist or service is In or Out-of-Network -- for example, "Specialist (IN), Diagnostic X-Ray (OON)" -- separated by commas.	Required if "Is Referral Required for Specialist" is Yes	Varchar		N/A
Plan Level Exclusions	List of any plan level exclusions.	No	Varchar		N/A
Limited Cost Sharing Plan Variation – Est Advance Payment	Estimated amount of cost-sharing reductions for eligible enrollees to be provided in the form of an advance payment to the issuer. This amount is estimated by the issuer. Applies to Indian plan variations described in Section 156.420(b)(2).	No	Numeric		N/A
HSA-Eligible	Plan meets all of the requirements to be an HSA-qualified high deductible health plan.	Yes	Varchar	N/A	• 1- Yes • 2- No
HSA/HRA Employer Contribution	Indicates whether employer contributes funds to HSA/HRA account.	Required if Market type is SHOP (Small Group)	Drop-down		• 1- Yes • 2- No

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
HSA/HRA Employer Contribution Amount	Whole dollar amount an employer contributes to employee HSA/HRA accounts.	Required if "HSA/HRA Employer Contribution" is Yes	Numeric		N/A
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; one option must be selected consistent with requirements at 45 CFR 156.200. Not applicable if the plan's coverage level is catastrophic.	Yes	Drop-down	N/A	Allows Adult and Child-Only Allows Adult-Onlyl Allows Child-Only
Child Only Plan ID	If child-only is not allowed in plan the user must list the plan ID of the child-only plan equivalent.	Required if "Child-Only Offering" is Allows Adult-Only	Varchar	14	N/A
Wellness Program Offered	Indicates whether the plan offers wellness programs according to Section 2705 of the Public Health Service Act.	Yes	Drop-down	N/A	1 – Yes 2 - No
Disease Management Programs Offered	A list of disease management programs offered by the plan.	No	Drop-down	N/A	Asthma Heart disease Depression Diabetes High blood pressure and high cholesterol Low back pain Pain management Pregnancy
EHB Apportionment for Pediatric Dental	Dollar amount of the EHB apportionment to allocate to pediatric dental costs.	Required if "Dental Only Plan" is Yes	Numeric	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Guaranteed vs. Estimated Rate	Indicates if the rate for this standalone dental plan is a guaranteed rate or an estimated rate (estimated rates will require enrollees to contact the issuer to determine a final rate).	Required if "Dental Only Plan" is Yes	Drop-down	N/A	1 – Guaranteed Rate 2 – Estimated Rate
Maximum Coinsurance for Specialty Drugs	The maximum coinsurance amount a policy holder will pay for a prescription for a specialty drug. If you have a maximum coinsurance for specialty high–cost drugs, enter the maximum dollar value. If no maximum coinsurance, leave field as the default value, which is "N/A". This is a maximum dollar amount a policy holder can pay for their coinsurance responsibility on specialty RX claims. If this field is N/A they will be responsible for their entire portion (X%) of the claim during the coinsurance phase.	No	Numeric		N/A
Maximum Number of Days for Charging an Inpatient Copay?	The maximum number of days (1 – 10) on which a policy holder can be charged a co-payment for an inpatient stay, if the insurance plan charges inpatient stays by day. Select this option to limit the number of days on which a patient can be charged a copay for an inpatient stay. If this option does not apply, leave field as the default value, which is "N/A".	No	Integer (1 to 10)		N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?	The number of fully covered visits (1 – 10) after which the primary care cost sharing (co-payment and/or coinsurance) begins. Select this option if you begin primary care cost sharing (copay, deductible, coinsurance) after a certain number of (fully covered) visits have occurred. If this option does not apply, leave field as the default value, which is "N/A".	No	Integer (1 to 10)		N/A
Plan Effective Date	Effective date of the plan.	Yes	Date		N/A
Plan Expiration Date	Date that a plan becomes closed and no longer accepts new enrollments.	No	Date		N/A
Out of Country Coverage	Indicates whether care obtained outside the country is covered under the plan.	Yes	Drop-down	N/A	1 – Yes 2 - No
Out of Country Coverage Description	A short description of whether care obtained outside the country is covered under the plan.	Required if "Out of Country Coverage" is Yes	Varchar		N/A
Out of Service Area Coverage	Indicates whether care obtained outside the service area is covered under the plan.	Yes	Drop-down	N/A	1 – Yes 2 - No
Out of Service Area Coverage Description	A short description of whether care obtained outside the service area is covered under the plan.	Required if "Out of Service Area Coverage" is Yes	Varchar		N/A
National Network	Indicates whether a national network is available.	Yes	Drop-down	N/A	1 – Yes 2 - No

Field Name	Definition	Required?	Data Type	Field Length Max	List of 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.	No	URL	N/A	N/A
URL for Enrollment Payment	URL for the location on the plan website where the enrollee will effectuate payment.	No	URL	N/A	N/A
Plan Brochure	URL for the location of the plan brochure.	No	URL	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Benefits	Description of benefits relevant to the plan. The Refresh EHB macro will add EHB data and any state mandated benefits based on market and state.	N/A	N/A	N/A	Primary Care Visit to Treat an Injury or Illness Specialist Visit Other Practitioner Office Visit (Nurse, Physician Assistant) Outpatient Facility Fee (e.g., Ambulatory Surgery Center) Outpatient Surgery Physician/Surgical Services Hospice Services Non-Emergency Care When Traveling Outside the U. S. Routine Dental Services (Adults) Infertility Treatment Long-Term/Custodial Nursing Home Care Private-Duty Nursing Routine Eye Exam (Adult) Urgent Care Centers of Facilities Home Health Care Services Emergency Room Services Emergency Transportation/Ambulance Inpatient Hospital Services (E.g., Hospital Stay) Inpatient Physician and Surgical Services Bariatric Surgery Cosmetic Surgery Skilled Nursing Facility Prenatal and Postnatal Care

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
					(*Values continued*) Delivery and All Inpatient Services for Maternity Care Mental/Behavioral Health Outpatient Services Mental/Behavioral Health Inpatient Services Substance Abuse Disorder Outpatient Services Substance Abuse Disorder Inpatient Services Generic Dugs Preferred Brand Drugs Non-Preferred Brand Drugs Specialty Drugs Outpatient Rehabilitation Services Habilitation Services Chiropractic Care Durable Medical Equipment Hearing Aids Imaging (CT/PET Scans, MRIs) Preventive Care/Screening/Immunization Routine Foot Care Acupuncture Weight Loss Programs Routine Eye Exam for Children Eye Glasses for Children Dental Check-Up for Children Rehabilitative Speech Therapy

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
					(*Values continued*) Rehabilitative Occupational and Rehabilitative Physical Therapy Well Baby Visits and Care Laboratory Outpatient and Professional Services X-rays and Diagnostic Imaging Basic Dental Care – Child Orthodontia – Child Major Dental Care – Child Basic Dental Care – Adult Orthodontia – Adult Major Dental Care – Adult Abortion for Which Public Funding is Prohibited Transplant Accidental Dental Dialysis Allergy Testing Chemotherapy Radiation Diabetes Education Prosthetic Devices Infusion Therapy Treatment for Temporormandibular Joint Disorders Nutritional Counseling Reconstructive Surgery [Custom Benefits]
EHB	Indicates whether the benefit is considered EHB.	N/A	N/A	N/A	1 – Yes 2 – No

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
State Mandate	Indicates whether the benefit is a state mandated benefit.	N/A	N/A	N/A	1 – Yes 2 – No
Is this Benefit Covered?	Indicates whether the benefit is covered by the plan.	No	Drop-down	N/A	1 – Covered 2 – Not Covered (or blank)
Quantitative Limit on Service	Indicates if there is quantitative limit on the benefit.	No	Drop-down	N/A	1 – Yes 2 – No (or blank)
Limit Quantity	If there are limits on this benefit, the numerical limit. (e.g., day or visit limits for essential health benefits, dollar limits on services other than essential health benefits).	Required if "Quantitative Limit on Service" is Yes	Integer	N/A	N/A
Limit Unit	Allows users to select from two drop-down boxes to create a combined Limit Unit of "something per something". Any combination is allowed.	Required if "Quantitative Limit on Service" is Yes	Drop-down Popup	N/A	**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

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Minimum Stay	The minimum required stay, where applicable, expressed in hours.	No	Integer		N/A
Exclusions	A listing of any services or diagnoses that are excluded from coverage.	No	Varchar		N/A
Explanation (text field)	Contains optional explanations and notes from the plan.	No	Varchar		N/A
EHB Variance Reason	Displays the reason that the benefit varies from EHB.	Required if "EHB" is Yes or "State Mandate" is Yes and data does not match benchmark	Drop-down	N/A	Above EHB Substituted Substantially Equal Using Alternate Benchmark Other Law/Regulation Additional EHB Benefit Dental Only Plan Available
Subject to Deductible (Tier 1)	Indicates whether the benefit is subject to deductible for Tier 1.	Required if the benefit is covered by the plan	Drop-down	N/A	1 – Yes 2 – No
Subject to Deductible (Tier 2)	Indicates whether the benefit is subject to deductible for Tier 2.	Required if the benefit is covered by the plan	Drop-down	N/A	1 – Yes 2 – No
Excluded from In Network MOOP	Indicates whether the benefit is excluded from the in network maximum out of pocket total.	Required if the benefit is covered by the plan	Drop-down	N/A	1 – Yes 2 – No
Excluded from Out of Nework MOOP	Indicates whether the benefit is excluded from the out of network maximum out of pocket total.	Required if the benefit is covered by the plan	Drop-down	N/A	1 – Yes 2 – No

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
HIOS Plan ID (Standard Component + Variant)	Copied over from the benefits package sheet. Suffixes automatically added depending on the plan variation. CSR variants apply to Individual Market Exchange plans only. CSR variants do not apply to Catastrophic or Stand Alone Dental plans.	Yes	Varchar	N/A	N/A
Plan Marketing Name	Copied over from the benefits package sheet.	Yes	Varchar	N/A	N/A
Level of Coverage (Metal Level)	Pre-populated with metal level from designated plan. Copied over from the benefits package sheet.	Yes	Varchar	N/A	N/A
CSR Variation Type	Will auto-populate correct variance based on market, on/off exchange, and metal level. CSR variants apply to Individual Market Exchange plans only. CSR variants do not apply to Catastrophic or Stand Alone Dental plans. See CSR Matrix sheet.	Yes	Varchar	N/A	Variant Suffixes: 00 = non-exchange variant 01 = exchange variant (not CSR) 02 = Zero Cost Sharing Plan Variation 03 = Limited Cost Sharing Plan Variation 04 = 73% AV Level Silver Plan CSR 05 = 87% AV Level Silver Plan CSR 06 = 94% AV Level Silver Plan CSR
Issuer Actuarial Value	If unique plan design, the user will give the AV value. Required if unique plan design = YES Must be blank if unique plan design = NO.	Situational	Percentage	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
AV Calculator Output Number	The Actuary Value of this plan as calculated by the AV Calculator. User will check AV Calc button to populate the field. Blank when metal level = Catastrophic. Blank when plan type = Stand Alone Dental. AV calculator will return an error when AV is more than 2% greater than or less than the AV for the metal level for bronze, silver, gold, and platinum plans with Unique Plan Design value = NO. For plan variant ID 02 (Zero Cost) must be equal to 100. For plan variant ID 03 (Limited Cost) must be equal to standard variant id 01 For plan variant ID 04 (Silver 73), AV must be at least 2% greater than value for variant ID 01. For Plan variant ID 04, AV must be based on silver metal level and must be no more than 1% greater than or less than 73. For Plan variant ID 05, AV must be based on gold metal level and must be no more than 1% greater than or less than 87. For Plan variant ID 06, AV must be based on platinum level and must be no more than 1% greater than or less than 94.	Yes	Percentage	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Medical & Drug Deductibles Integrated?	If Medical and Drug Deductibles are Integrated select YES, if they are separated select NO. When answered on standard plan variant, prepopulates for all variants of a plan. Will grey/lock fields that are not required based on this answer.	Yes	Drop-down	N/A	1- Yes 2 - No
Medical & Drug Maximum Out of Pocket Integrated?	If Medical and Drug Maximum out of Pockets are Integrated select YES, if they are separated select NO. When answered on standard plan variant, prepopulates for all variants of a plan. Will grey/lock fields that are not required based on this answer.	Yes	Drop-down	N/A	1- Yes 2 – No
Multiple In Network Tiers?	Does plan use multiple in-network provider tiers? When answered on standard plan variant, prepopulates for all variants of a plan. Will grey/lock fields that are not required based on this answer.	Yes	Drop-down	N/A	1- Yes 2 – No
1st Tier Utilization	What is the expected percentage of utilization for tier 1? Required If Do You Have Multiple in-network provider tiers = YES Default = 100% if Do You Have Multiple In-Network provider tiers = NO. Prepopulate for all variants of a plan based on 01 variant.	Yes	Percentage	N/A	1- Yes 2 – No

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
2nd Tier Utilization	What is the expected percentage of utilization for tier 2? Required If Do You Have Multiple in-network provider tiers = YES Default = 100 minus value in 1st Tier Utilization Prepopulate for all variants of a plan.	Situational	Percentage	N/A	N/A
Having a Baby - Deductible	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Having a Baby - Copayment	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Having a Baby - Coinsurance	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Having a Baby - Limit	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers	No	Dollar	N/A	N/A
Having Diabetes - Deductible	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Having Diabetes - Copayment	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Having Diabetes - Coinsurance	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Having Diabetes - Limit	SBC information is not for calculation in AV or direct cost sharing amounts. It is for example purposes only, to be fed into the SBC template as examples for shoppers.	No	Dollar	N/A	N/A
Maximum Out of Pocket for Medical EHB Benefits – In Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits In Network Individual dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical EHB Benefits – In Network - Family	The Maximum Out of Pocket for Medical EHB Benefits In Network Family dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Medical EHB Benefits – In Network (Tier 2) - Individual	The Maximum Out of Pocket for Medical EHB Benefits In Network Tier 2 - Individual dollar amount. Required if MOOP Integrated = NO AND Multiple In Network Tiers is YES. Must be blank if Multiple In Network Tiers is No. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical EHB Benefits – In Network (Tier 2) - Family	The Maximum Out of Pocket for Medical EHB Benefits In Network Tier 2 - Family dollar amount. Required if MOOP Integrated = NO AND Multiple In Network Tiers is YES. Must be blank if Multiple In Network Tiers is No. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical EHB Benefits – Out of Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits Out of Network Individual dollar amount. Required if MOOP Integrated = NO Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical EHB Benefits – Out of Network - Family	The Maximum Out of Pocket for Medical EHB Benefits Out of Network Family dollar amount. Required if MOOP Integrated = NO Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Medical EHB Benefits – Combined In/Out of Network - Individual	The Maximum Out of Pocket for Medical EHB Benefits Combined In/Out of Network - Individual dollar amount. Required if MOOP Integrated = NO Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical EHB Benefits – Combined In/Out of Network - Family	The Maximum Out of Pocket for Medical EHB Benefits Combined In/Out of Network - Family dollar amount. Required if MOOP Integrated = NO Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – In Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits In Network Individual dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – In Network - Family	The Maximum Out of Pocket for Drug EHB Benefits In Network Family dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Drug EHB Benefits – In Network (Tier 2) - Individual	The Maximum Out of Pocket for Drug EHB Benefits In Network Tier 2 - Individual dollar amount. Required if MOOP Integrated = NO AND Multiple In Network Tiers = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – In Network (Tier 2) - Family	The Maximum Out of Pocket for Drug EHB Benefits In Network Tier 2 - Family dollar amount. Required if MOOP Integrated = NO AND Multiple In Network Tiers = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – Out of Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits Out of Network Individual dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – Out of Network - Family	The Maximum Out of Pocket for Drug EHB Benefits Out of Network Family dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Drug EHB Benefits – Combined In/Out of Network - Individual	The Maximum Out of Pocket for Drug EHB Benefits Combined In/Out of Network - Individual dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Drug EHB Benefits – Combined In/Out of Network - Family	The Maximum Out of Pocket for Drug EHB Benefits Combined In/Out of Network - Family dollar amount. Required if MOOP Integrated = NO. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network – Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Individual dollar amount. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network – Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Family dollar amount. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network (Tier 2) – Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Individual dollar amount. Required if MOOP Integrated = YES AND Multiple In Network Tiers = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network (Tier 2) – Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) In Network Tier 2 - Family dollar amount. Required if MOOP Integrated = YES AND Multiple In Network Tiers = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Out of Network – Individual	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Out of Network Individual dollar amount. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Out of Network – Family	The Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) Out of Network Family dollar amount. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – 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. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $6400.	Situational	Drop-down	N/A	$X Not Applicable
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – 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. Required if MOOP Integrated = YES. Pre-pop to zero for variant ID = 02. Warning message if value greater than $12,800.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – In Network – Individual	The Medical EHB Deductible - In Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – In Network – Family	The Medical EHB Deductible - In Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Medical EHB Deductible – In Network – Default Coinsurance	The Medical EHB default Coinsurance for In Network. Required if Deductible Integrated = NO.	Situational	Percentage	N/A	N/A
Medical EHB Deductible – In Network (Tier 2) – Individual	The Medical EHB Deductible - In Network Tier 2 - Individual dollar amount. Required if Deductibles Integrated = NO AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – In Network (Tier 2) – Family	The Medical EHB Deductible - In Network Tier 2 - Family dollar amount. Required if Deductibles Integrated = NO AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – In Network (Tier 2) – Default Coinsurance	The Medical EHB Default Coinsurance for In Network Tier 2. Required if Deductible Integrated = NO AND Multiple In Network Tiers = YES.	Situational	Percentage	N/A	N/A
Medical EHB Deductible – Out of Network – Individual	The Medical EHB Deductible - Out of Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Medical EHB Deductible – Out of Network – Family	The Medical EHB Deductible - Out of Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – Combined In/Out of Network – Individual	The Medical EHB Deductible - Combined In/Out of Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Medical EHB Deductible – Combined In/Out of Network – Family	The Medical EHB Deductible - Combined In/Out of Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – In Network – Individual	Dollar amount. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – In Network – Family	Dollar amount. If Market = Small Group then warning message if greater than or equal to $4000 .Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Custom Deductible Sub-Groups – In Network (Tier 2) – Individual	Dollar amount. Required if Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – In Network (Tier 2) – Family	Dollar amount. Required if Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – Out of Network – Individual	Dollar amount. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – Out of Network – Family	Dollar amount. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – Combined In/Out of Network – Individual	Dollar amount. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Custom Deductible Sub-Groups – Combined In/Out of Network – Family	Dollar amount. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Drug EHB Deductible – In Network – Individual	The Drug EHB Deductible - In Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – In Network – Family	The Drug EHB Deductible - In Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – In Network – Default Coinsurance	The Drug EHB default Coinsurance for In Network. Required if Deductible Integrated = NO.	Situational	Percentage	N/A	N/A
Drug EHB Deductible – In Network (Tier 2) – Individual	The Drug EHB Deductible - In Network Tier 2 - Individual dollar amount. Required if Deductibles Integrated = NO AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – In Network (Tier 2) – Family	The Drug EHB Deductible - In Network Tier 2 - Family dollar amount. Required if Deductibles Integrated = NO AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Drug EHB Deductible – In Network (Tier 2) – Default Coinsurance	The Drug EHB Default Coinsurance for In Network Tier 2. Required if Deductible Integrated = NO AND Multiple In Network Tiers = YES.	Situational	Percentage	N/A	N/A
Drug EHB Deductible – Out of Network – Individual	The Drug EHB Deductible - Out of Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – Out of Network – Family	The Drug EHB Deductible - Out of Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – Combined In/Out of Network – Individual	The Drug EHB Deductible - Combined In/Out of Network - Individual dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Drug EHB Deductible – Combined In/Out of Network – Family	The Drug EHB Deductible - Combined In/Out of Network - Family dollar amount. Required if Deductibles Integrated = NO. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Combined Medical & Drug EHB Deductible – In Network – Individual	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – In Network – Family	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – In Network – Default Coinsurance	Percentage. Required if Deductible Integrated = YES.	Situational	Percentage	N/A	N/A
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Individual	Dollar amount. Required if Deductibles Integrated = YES AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Family	Dollar amount. Required if Deductibles Integrated = YES AND Multiple In Network Tiers = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Default Coinsurance	Percentage. Required if Deductible Integrated = YES AND Multiple In Network Tiers = YES.	Situational	Percentage	N/A	N/A

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Combined Medical & Drug EHB Deductible – Out of Network – Individual	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – Out of Network – Family	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – Combined In/Out of Network – Individual	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $2000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Combined Medical & Drug EHB Deductible – Combined In/Out of Network – Family	Dollar amount. Required if Deductibles Integrated = YES. If Market = Small Group then warning message if greater than or equal to $4000. Pre-pop to zero for variant ID = 02.	Situational	Drop-down	N/A	$X Not Applicable
Covered Benefits Cost Sharing – Copay – In Network (Tier 1)	Dollar amount. If an in-network copayment is charged, enter the amount here. If no copayment is charged, leave blank. Prepopulate to zero for Variant ID = 02.	Yes	Drop-down	N/A	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible
Covered Benefits Cost Sharing – Copay – In Network (Tier 2)	Dollar amount. If an in-network copayment is charged, enter the amount here. If no copayment is charged, leave blank. Only if Multiple In Network Tiers is Yes. Prepopulate to zero for Variant ID = 02.	Situational	Drop-down	N/A	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible

Field Name	Definition	Required?	Data Type	Field Length Max	List of Values
Covered Benefits Cost Sharing – Copay – Out of Network	Dollar amount. If an out of network copayment is charged, enter the amount here. If no copayment is charged, leave blank. Prepopulate to zero for Variant ID = 02.	Yes	Drop-down	N/A	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible
Covered Benefits Cost Sharing – Copay – In Network (Charge per day or stay?)	Options are day or stay, only applicable to Skilled Nursing and Inpatient Hospital. If the benefit is Skilled Nursing Facility or Inpatient Hospital - then these values replace the default copayment options.	Situational	Drop-down	N/A	$X Copay per Day $X Copay per Stay
Covered Benefits Cost Sharing – Coinsurance – In Network (Tier 1)	Percentage amount. If an in-network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank. Prepopulate to zero for Variant ID = 02.	Yes	Drop-down	N/A	No Charge No Charge after deductible X%, X% after deductible
Covered Benefits Cost Sharing – Coinsurance – In Network (Tier 2)	Percentage amount. If an in-network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank. Only if Multiple In Network Tiers is Yes. Prepopulate to zero for Variant ID = 02.	Situational	Drop-down	N/A	No Charge No Charge after deductible X%, X% after deductible
Covered Benefits Cost Sharing – Coinsurance – Out of Network	Percentage amount. If an out of network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank. Prepopulate to zero for Variant ID = 02.	Yes	Drop-down	N/A	No Charge No Charge after deductible X%, X% after deductible

11.4.2 Service Area Template

The following table in Exhibit 11-7 is the Service Area Template Data Dictionary. The table includes definitions for the fields found in each column of the template.

Exhibit 11-7: Service Area Template Data Dictionary

Field Name	Description	Required ?	Data Type	Field Length Max	List of Values
Issuer State	State abbreviation.	Yes	Dropdown	2	50 state abbreviations plus 9 territories
HIOS Issuer ID	Five digit number that identifies the Issuer.	Yes	Numeric	5	N/A
Service Area ID	An ID automatically generated by the system to identify each geographic service area in which the issuer intends to offer one or more QHPs.	Yes	Varchar	6	This will value based upon the creation of IDs
Service Area Name	The name associated with a specific Service Area ID.	Yes	Varchar	N/A	
State	Indicator that denotes whether the service area encompasses the entire state.	Yes	Dropdown	N/A	1 – Yes 2 - No
County Name	Name of county found in a geographic service area. One service area may contain multiple counties.	Required if State is No	Dropdown	N/A	N/A
Partial County	An indicator of whether a service area contains any partial counties.	Required if State is No	Dropdown	N/A	1 – Yes 2 - No
Service Area Zip Code(s)	For any partial counties included in a service area, each Zip code from that county included in the service area.	Required if Partial County is Yes	Numeric	5	N/A
Partial County Justification	Free text to justify request to serve a partial county.	Required if Partial County is Yes	Varchar	N/A	N/A

11.4.3 Rates Template

The following table in Exhibit 11-8 is the Rates Template Data Dictionary. The table includes definitions for the fields found in each column of the template.

Exhibit 11-8: Rates Template Data Dictionary

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
HIOS Issuer ID	Five digit number that identifies the Issuer.	Yes	Numeric	5	Exists in Issuer Organization and Issuer Request tables.
Federal TIN	A Tax Identification Number (TIN) is used to identify a tax entity.	Yes	Numeric	9	N/A
Rate Effective Date	Date when a rate goes into effect for a plan.	Yes	Date	10	N/A
Rate Expiration Date	Date when a rate is no longer available for a plan.	Yes	Date	10	N/A
Plan ID	A specific value conveying an understanding of identification of an insurance plan within the state.	Yes	Varchar	14	Exists in Issuer Insurance Plan table.
Exchange Rate Area ID	Identifies a specific geographic rate area as defined by a State.	Yes	Dropdown	N/A	Rating Area 1 to 150
Tobacco	Identifies if the rate is for a tobacco user.	Yes	Dropdown	N/A	• Tobacco User/Non Tobacco User • No Preference
Age	Subscriber age bands used to identify a product	Yes	Dropdown	N/A	• 0-20 • Separate values for 21-64 • 65 and over
Individual Rate	Insurance rate for an individual on a plan (non tobacco user or no tobacco preference).	Yes	Numeric	N/A	
Individual Tobacco Rate	Insurance rate for a tobacco using individual on a plan.	No	Numeric	N/A	

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
Couple	A couple rate based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse).	No	Numeric	N/A	N/A
Primary Subscriber and One Dependent	A family rate for a single parent with one dependent.	No	Numeric	N/A	N/A
Primary Subscriber and Two Dependents	A family rate for a single parent with two dependents.	No	Numeric	N/A	N/A
Primary Subscriber and Three or More Dependents	A family rate for a single parent with three or more dependents.	No	Numeric	N/A	N/A
Couple and One Dependent	A family rate for a couple with one dependent.	No	Numeric	N/A	N/A
Couple and Two Dependents	A family rate for a couple with two dependents.	No	Numeric	N/A	N/A
Couple and Three or More Dependents	A family rate for a couple with three dependents.	No	Numeric	N/A	N/A

11.4.4 Business Rules Template

The following table in Exhibit 11-9 is the Business Rules Template Data Dictionary. The table includes definitions for the fields found in each column of the template.

Exhibit 11-9: Business Rules Template Data Dictionary

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
HIOS Issuer ID	Five digit number that identifies the Issuer.	Yes	Numeric	5	Exists in Issuer Organization and Issuer Request tables.
Federal TIN	A Tax Identification Number (TIN) is used to identify a tax entity.	Yes	Numeric	9	
Product ID	A specific value identifying an insurance product within the RBIS system.	No	Varchar	10	Exists in Insurance Product table.
Plan ID (Standard Component)	A specific value conveying an understanding of identification of an insurance plan within the state.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Varchar	14	Exists in Issuer Insurance Plan table
How are rates for contracts covering two or more enrollees calculated?	Determines if a returned rate is the sum of individual rates or if a group rate is available.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Dropdown	N/A	• 1 - There are rates specifically for couples and for families (not just addition of individual rates) • 2 - A different rate (specifically for parties of two or more) for each member is added together
What are the maximum number of under age (under 21) dependents used to quote a two parent family?	For a two parent family, group rates are based on the number of dependents up to the maximum amount stated.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Varchar	N/A	• 1 • 2 • 3 or more

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
What are the maximum number of under age (under 21) dependents used to quote a single parent family?	For a single parent family, group rates are based on the number of dependents up to the maximum amount stated.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Varchar	N/A	• 1 • 2 • 3 or more
Is there a maximum age for a dependent?	A specific value conveying the maximum age for a dependent.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Drop-down Pop-up	N/A	• Yes – Enter Age greater than 20 [ ] • Not Applicable
What are the maximum number of children used to quote a children-only contract?	Defines how many children rates are added up to determine the overall rate if more than one child is eligible for a child only policy.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Drop-down	N/A	• 1 • 2 • 3 or more
Are domestic partners treated the same as secondary subscribers?	Defines the rules for treating a domestic partner when determining if a couple is eligible for a rate.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Dropdown	N/A	• 1 - Yes • 2 – No
Are same-sex partners treated the same as secondary subscribers?	Defines the rules for treating a same sex partner when determining if a couple is eligible for a rate.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Dropdown	N/A	• 1 - Yes • 2 – No
How is age determined for rating and eligibility purposes?	Defines the rules for determining the eligibility of a subscriber based on their age in	Required on first row (Issuer Rule). Otherwise enter if	Drop-down	N/A	• 1 - Age on effective date • 2 - Age on January 1st of the effective date year

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
	relation to rate effective dates.	different from Product or Issuer rule.			• 3 - Age on insurance date (age on birthday nearest the effective date) • 4 – Age on January 1st or July 1st
How is tobacco status determined for subscribers and dependents?	Defines the rules for determining whether a subscriber or dependent are considered tobacco users.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Drop-down Popup	N/A	• 1 – No Tobacco user for a least [ ] months • 2 – Not Applicable
What relationship between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	Identifies relationships between primary and dependent are allowed. If the relationship is allowed it will identify if the dependent is required to live in the same household as the primary subscriber.	Required on first row (Issuer Rule). Otherwise enter if different from Product or Issuer rule.	Popup with radio buttons	N/A	Spouse - Yes/No Father or Mother - Yes/No Grandfather or Grandmother - Yes/No Grandson or Granddaughter - Yes/No Uncle or Aunt - Yes/No Nephew or Niece - Yes/No Cousin - Yes/No Adopted Child - Yes/No Foster Child - Yes/No Son-in-law or daughter-in-law - Yes/No Brother-in-law or sister-in-law - Yes/No Mother-in-law or father-in-law - Yes/No Brother or sister - Yes/No Ward - Yes/No Stepparent - Yes/No Stepson or stepdaughter - Yes/No

Field Name	Description	Required?	Data Type	Field Length	Template List of Values
					Self - Yes/No Child - Yes/No Sponsored dependent - Yes/No Dependent of a Minor Dependent - Yes/No Ex-spouse - Yes/No Guardian - Yes/No Court Appointed Guardian - Yes/No Collateral Dependent - Yes/No Life Partner - Yes/No Annuitant - Yes/No Trustee - Yes/No Other Relationship - Yes/No Other Relative - Yes/No

11.5 APPENDIX E - BUSINESS RULES AND RATES TEMPLATE INTEGRATION

HealthCare.gov is used to assist consumers in identifying affordable and comprehensive health insurance coverage options that are available in their state. The information displayed on HealthCare.gov should include, but is not limited to, information on eligibility, availability, premium rates, and benefit descriptions by plan and within an appropriate geographic context.

The purpose of this section is to illustrate how the various data input from consumers on Healthcare.gov combined with Issuer data submissions in the Rates and Benefits Information System generate the estimated premium rates that are output and displayed to a consumer on Healthcare.gov. The following three components are involved:

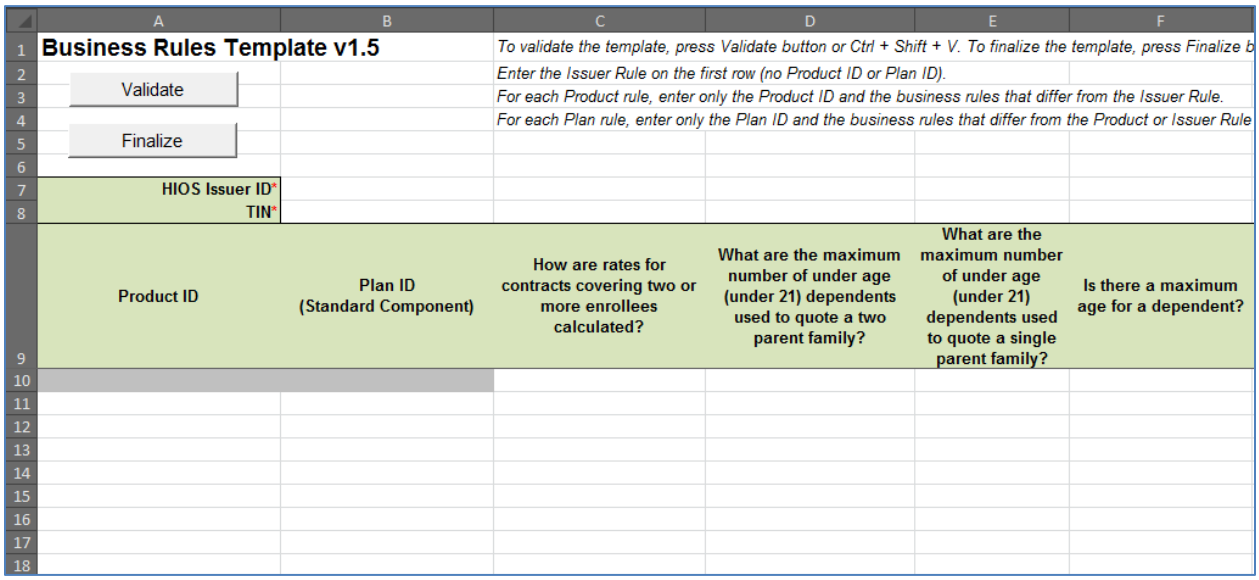
- **Consumer Input on Healthcare.gov** – The data that a consumer inputs on Healthcare.gov plays a factor in determining which benefit plans that the consumer is eligible for.
- **Business Rules Template** – This template allows Issuers to submit the answers to questions that will eventually affect how the rates for their benefit plans are calculated.
- **Rates Template** - The Rates Template allows Issuers to submit plan rate data as well as other determining factors such as subscriber type and smoking habits.

The combination of all three components outlined above is what determines the benefit plans and associated rates that are displayed to a consumer when they perform a search for available healthcare plans that they are eligible for on Healthcare.gov.

11.5.1 Business Rules Template Guidelines

Please refer to Exhibit 11-10 below.

Exhibit 11-10: Business Rules Template



	A	B	C	D	E	F
1	**Business Rules Template v1.5**		*To validate the template, press Validate button or Ctrl + Shift + V. To finalize the template, press Finalize b*			
2			*Enter the Issuer Rule on the first row (no Product ID or Plan ID).*			
3	Validate		*For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.*			
4			*For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule*			
5	Finalize					
6						
7	HIOS Issuer ID*					
8	TIN*					
9	**Product ID**	**Plan ID (Standard Component)**	**How are rates for contracts covering two or more enrollees calculated?**	**What are the maximum number of under age (under 21) dependents used to quote a two parent family?**	**What are the maximum number of under age (under 21) dependents used to quote a single parent family?**	**Is there a maximum age for a dependent?**
10						
11						
12						
13						
14						
15						
16						
17						
18						

1. **Download the Business Rules Template**
    a. For further instructions on how to download the Business Rules Template for submission, see *Section 5.2*.

2. **Complete the Business Rules Template**
    a. Complete the Business Rules Template using the table above in Exhibit 11-9 as a guide to the data collected on the Business Rules template.
    b. For further step by step instructions on how to complete the Business Rules Template, see *Section 11.6*.

11.5.2 Age Calculation for Eligibility and Quote determination

The subscriber's age is used for determining:

- Eligibility for a specific Issuer, Product, or Plan.
- Rate lookup for specific User type for a specific plan.

There are three factors that influence the age calculation:

1. The subscribers date of birth
2. The insurance effective date
3. One of the following, Issuer specified, rules to determine the age on a specific date:
    a. Age on effective date
    b. Age on January 1st of the effective date year
    c. Age on insurance date (age on birthday nearest the effective date)

d. Age on January 1st or July 1st

These factors can be reduced to the question: “Given a subscriber, how old is he/she on a specific date?”

Age related eligibility rules are provided in months, while rates are specified for age bands in years. Therefore, we will first calculate the age in months and convert the result into years as needed.

For a specific subscriber born on date “DOB” the following algorithm is used to determine the age in months on a specific date “IED”:

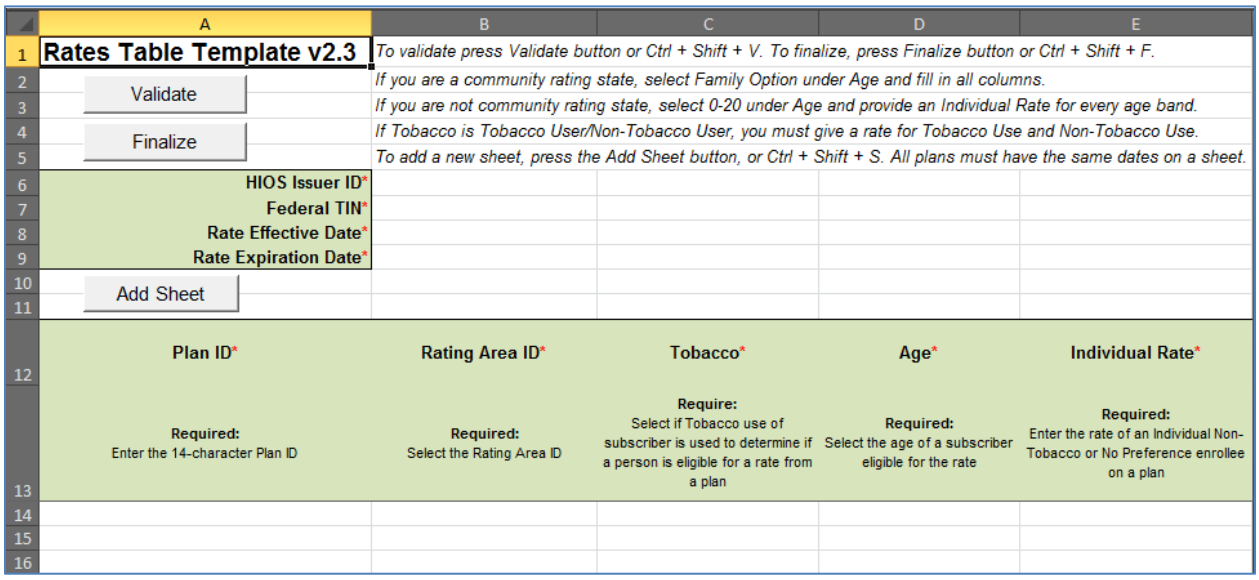
1. Determine “age in years” as DOB.year – IED.year
2. If the birthday did not yet come up as at IED, then subtract one year from the “age in years” and determine the “months that have passed since the last birthday” as 12 - DOB.month + IED.month
3. Else determine the “months that have passed since the last birthday” as IED.month – DOB.month
4. If the day of the month of IED is before the day of the month of the DOB, then subtract one month from the “months that have passed since the last birthday”
5. The resulting age in months is the determined as 12 * “age in years” + “months that have passed since the last birthday”

The age in years is then calculated from the age in months by dividing the age in months by 12, ignoring the fractional portion of the result (which is the same as “age in years” from the above calculation).

11.5.3 Rates Template Guidelines

Please refer to Exhibit 11-11.

Exhibit 11-11: Rates Template



	A	B	C	D	E
1	**Rates Table Template v2.3**	*To validate press Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*			
2	Validate	*If you are a community rating state, select Family Option under Age and fill in all columns.*			
3		*If you are not community rating state, select 0-20 under Age and provide an Individual Rate for every age band.*			
4	Finalize	*If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.*			
5		*To add a new sheet, press the Add Sheet button, or Ctrl + Shift + S. All plans must have the same dates on a sheet.*			
6	**HIOS Issuer ID***				
7	**Federal TIN***				
8	**Rate Effective Date***				
9	**Rate Expiration Date***				
10	Add Sheet				
11					
12	**Plan ID***	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
13	**Required:** Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Require:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
14					
15					
16					

1. **Download the Rates Template**
    a. Download the Rates Template. For further instructions on how to download the Rates Template for submission, see *Section 8.*
2. **Complete the Rates Template**
    a. Complete the following required fields for each plan on the worksheet labeled "Rates Template."
        i. HIOS Issuer ID
        ii. Federal TIN
        iii. Rate Effective Date
        iv. Rate Expiration Date
        v. Plan ID
        vi. Rating Area ID
        vii. Tobacco
        viii. Age
        ix. Individual Rate

Exhibit 11-12: Rates Template Subscriber Types

Template Subscriber Type	Definition
Primary Subscriber	Primary enrollee on a plan used to determine which rate(s) to return when individual rates are used.
Secondary Subscriber	A joint enrollee (e.g. a Spouse) on a plan used to determine which rate(s) to return when individual rates are used.
Dependent	A joint enrollee (e.g. a child or other family member not the spouse) on a plan used to determine which rate(s) to return when individual rates are used.
Couple	A couple rate based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse).
Primary Subscriber and One Dependent	A family rate for a single parent with one dependent.
Primary Subscriber and Two Dependents	A family rate for a single parent with two dependents.
Primary Subscriber and Three or More Dependents	A family rate for a single parent with three or more dependents.
Couple and One Dependent	A family rate for a couple with one dependent.
Couple and Two Dependents	A family rate for a couple with two dependents.
Couple and Three or More Dependents	A family rate for a couple with three or more dependents.

a. Subscriber Type Mappings - The tables below in Exhibit 11-13 provide subscriber type mappings for Issuers based on the method in which they calculate plan rates.

i. **Individual Rates** - The following table displays subscriber type mappings for when rates are calculated individually by adding up the sum of individual rates.

Exhibit 11-13: Subscriber Type Mapping for Individual Rate Calculations

Scenario	Template Subscriber Type
Single Person	Primary Subscriber
Child	Dependent
One Child Only	Primary Subscriber

Scenario	Template Subscriber Type
Two Children Only	Primary Subscriber + Primary Subscriber
Three Children Only	Primary Subscriber + Primary Subscriber + Primary Subscriber
Husband + Wife	Primary Subscriber + Secondary Subscriber
Husband + Wife + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Husband + Wife + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Husband + Wife + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent
Single Parent + One Child	Primary Subscriber + Dependent
Single Parent + Two Children	Primary Subscriber + Dependent + Dependent
Single Parent + Three or more Children	Primary Subscriber + Dependent + Dependent + Dependent
Domestic Partner + Domestic Partner	Primary Subscriber + Secondary Subscriber
Domestic Partner + Domestic Partner + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Domestic Partner + Domestic Partner + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Domestic Partner + Domestic Partner + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent
Same Sex Partner + Same Sex Partner	Primary Subscriber + Secondary Subscriber
Same Sex Partner + Same Sex Partner + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Same Sex Partner + Same Sex Partner + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Same Sex Partner + Same Sex Partner + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent

ii. Group Rates – When determining group rates, the relationships between the primary subscriber and dependent(s) specified on Business Rules template must also be considered. Issuers can define specific permissible relaltionship types and whether the dependent must live with the primary subscriber (for each relationship type). Exhibit 11-14 below contains a list of the possible relationship types of which an issuer can support for a particular product/plan.

Exhibit 11-14: Permissible Relationship Types (from the Business Rules template)

Relationship Types for Group Rates
Spouse
Father or Mother
Grandfather or Grandmother
Grandson or Granddaughter

Relationship Types for Group Rates
Uncle or Aunt
Nephew or Niece
Cousin
Adopted Child
Foster Child
Son-in-Law or Daughter-in-Law
Brother-in-Law or Sister-in-Law
Father-in-Law or Mother-in-Law
Brother or Sister
Ward
Stepparent
Stepson or Stepdaughter
Self
Child
Sponsored Dependent
Dependent or a Minor Dependent
Ex-Spouse
Guardian
Court Appointed Guardian
Collateral Dependent
Life Partner
Annuitant
Trustee
Other Relationship
Other Relative

iii. The following table in Exhibit 11-15 displays subscriber type mappings for when group rates are applied to a family of two or more enrollees.

Exhibit 11-15: Subscriber Type Mapping for Group Rate Calculations

Scenario	Template Subscriber Type	Limitations/Exceptions
Single Person	Primary Subscriber	
Child	Dependent	
One Child Only	Primary Subscriber	
Two Children Only	Primary Subscriber + Primary Subscriber	
Three Children Only	Primary Subscriber + Primary Subscriber + Primary Subscriber	

Scenario	Template Subscriber Type	Limitations/Exceptions
Husband + Wife	Couple	
Husband + Wife + One Child	Couple and One Dependent	
Husband + Wife + Two Children	Couple and Two Dependents	
Husband + Wife + Three (or more) Children	Couple and Three or More Dependents	
Single Parent + One Child	Primary Subscriber and One Dependent	
Single Parent + Two Children	Primary Subscriber and Two Dependents	
Single Parent + Three (or more) Children	Primary Subscriber and Three or More Dependents	
Domestic Partner + Domestic Partner	Couple	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + One Child	Couple and One Dependent	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + Two Children	Couple and Two Dependents	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + Three (or more) Children	Couple and Three or More Dependents	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner	Couple	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner + One Child	Couple and One Dependent	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner + Two Children	Couple and Two Dependents	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner + Three (or more) Children	Couple and Three or more Dependents	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.

11.5.4 Sample Rate Calculations

Example Scenario 1 – Husband, Wife and 2 Children

Please refer to Exhibit 11 -16 and Exhibit 11 -17.

Exhibit 11-16: Example Scenario 1 - Individual Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Husband	38	Tobacco use within 3 months*	Individual	80
Wife	36	Non-tobacco	Individual	50
Child	12	Non-tobacco	Individual	25
Child	14	Non-tobacco	Individual	25

* For this example, assume the business rules classify a person using tobacco within the last six months as a tobacco user subject to tobacco user rates.

Exhibit 11-17: Example Scenario 1 – Individual Rate Results

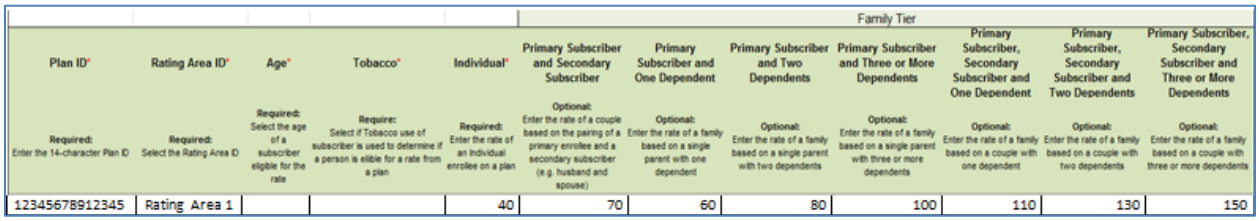
					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an Individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1	38	Tobacco User	80							
12345678912345	Rating Area 1	36	Non-Tobacco User	50							
12345678912345	Rating Area 1	0-20	Non-Tobacco User	25							

Three rows are populated: The first row displays the husband, 38 years old, a tobacco user with a rate of $80.00. The second row displays the wife, 36 years old, who is a non-tobacco user with a rate of $50.00. The third rows displays the rate for the two children (both under 20 years of age) of $25.00 per person. The total rate would be the sum of $80 + $50 +$25 + $25 = $180.

Exhibit 11-18: Example Scenario 1 - Group Rate Calculation

Enrollees	Template Subscriber Type	Sample Output Rate
Husband, Wife and two Children	Primary Subscriber, Secondary Subscriber and Two Dependents	130

Exhibit 11-19: Example Scenario 1 – Group Rate Results



					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1			40	70	60	80	100	110	130	150

One row is populated. The rate listed is $130.00 covering the field primary subscriber, secondary subscriber and two dependents.

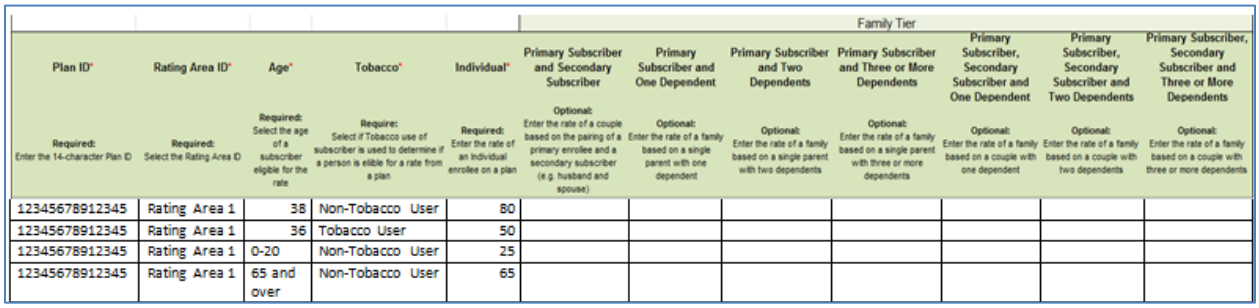
Example Scenario 2 – Husband, Wife, two Children and Grandmother

Exhibit 11-20: Example Scenario 2 - Individual Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Husband	38	Non-tobacco	Individual	80
Wife	36	Tobacco use within 2 months*	Individual	50
Child	12	Non-tobacco	Individual	25
Child	14	Non-tobacco	Individual	25
Grandmother	65	Non-tobacco	Individual	65

* For this example, assume the business rules classify a person using tobacco within the last six months as a tobacco user subject to tobacco user rates.

Exhibit 11-3: Example Scenario 2 – Individual Rate Results



					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1	38	Non-Tobacco User	80							
12345678912345	Rating Area 1	36	Tobacco User	50							
12345678912345	Rating Area 1	0-20	Non-Tobacco User	25							
12345678912345	Rating Area 1	65 and over	Non-Tobacco User	65							

Four rows are populated: The first row displays the husband, 38 years old, who is a non-tobacco user with a rate of $80.00. The second row displays the wife, 36 years old, who is a tobacco user with a rate of $65.00. The third row displays the rate for the two children (both under 20 years of age) of $25.00 per person. The fourth row displays the grandmother, 65 years old, who is a non-smoker with a rate of $65.00 per person. The total rate would be the sum of $80 + $50 +$25 + $25 + $65 = $245.

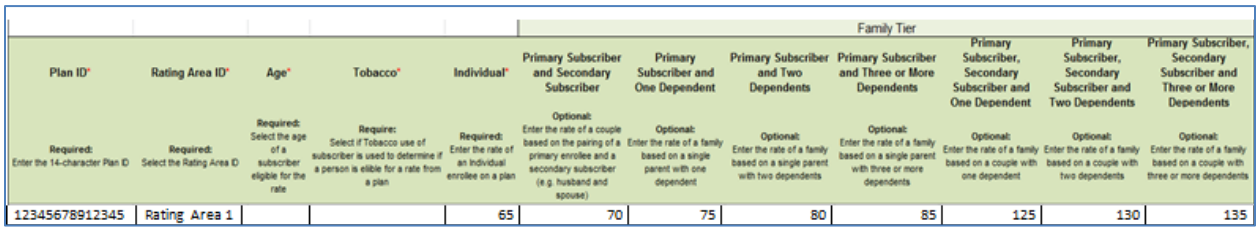
Exhibit 11-4: Example Scenario 2 - Group Rate Calculation

Enrollees	Template Subscriber Type	Sample Output Rates
Husband, Wife, 2 Children, and grandmother	N/A because grandmother is older than 21 and does not qualify as a dependent.	No plans will be returned for this family configuration

Instead, the family configuration will be returned as follows for group rate calculations:

Enrollees	Template Subscriber Type	Sample Output Rates
Husband, Wife, and 2 Children	Primary Subscriber, Secondary Subscriber, and two dependents	130
Grandmother	Individual	65

Exhibit 11-23: Example Scenario 2 – Group Rate Results



					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1			65	70	75	80	85	125	130	135

One row is populated. The rate listed is $130.00 covering the field primary subscriber, secondary subscriber and two dependents, plus the grandmother is listed as an individual (on a separate plan) with a rate of $65.00.

Example Scenario 3 – Four Children Only

For this scenario, the rate calculation would be the same for both individual and group rates. This is because there are no group rates for child only plans. For both cases, the overall rate is the sum of the individual rates for the children, using the three oldest for rate determination.

Exhibit 11-24: Example Scenario 3 – Individual and Group Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Child 1	20	Tobacco use within 4 months*	Individual	50
Child 2	18	Tobacco use within 1 month*	Individual	50
Child 3	16	Nonsmoker	Individual	25
Child 4	14	Nonsmoker	Individual	0 (Based upon business rules, only the three oldest children are taken into account)

* For this example, assume the business rules classify a person using tobacco within the last six months as a tobacco user subject to tobacco user rates.

Exhibit 11-25: Example Scenario 3 – Individual and Group Rate Results

					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1	0-20	Non-Tobacco User	25							
12345678912345	Rating Area 1	0-20	Tobacco User	50							

There are two rows populated. The first row displays child 3, 16 years old, who is a non-tobacco user with a rate of $25.00. The second row displays the rates for children 1 & 2, 20 and 18 years old respectively, who are tobacco users with a rate of $50.00 each. The total rate would be the sum of $50 + $50 +$25 = $125.

11.6 APPENDIX F – PLANS BENEFITS AND BUSINESS RULES TEMPLATE .XML CODES

In order to make the data upload process more efficient and standardized, an .xml conversion process occurs upon the finalization of the Plans Benefits and Business Rules Templates. When a User selects the Finalize button, the data that has been input into the template is translated into corresponding code values and converted into an .xml file. The translation of data into code values makes it easier for the system to read the input values in the database. The tables below represent how the template data fields map to the corresponding.xml codes and how the data will be displayed in the .xml file. These tables may be used to confirm that the data in the .xml file matches what was entered into the template. If any errors are found in the .xml file, make the corrections in the template and re-run the Finalize process. ***Note: It is not recommended that the .xml file is edited directly as this may impact the ability to troubleshoot any issues with the upload process.***

11.6.1 Plans Benefits Template Codes

Please refer to Exhibit 11-26 shown below.

Exhibit 11-26: Plans Benefits Template Codes

Template Field Name	List of Values	Value Displayed in .xml File
HIOS Issuer ID	Exists in Issuer Organization and Issuer Request tables.	Same value input by user on template
Issuer State	Abbreviations for 50 states plus 9 US territories	Same value input by user on template
Market Coverage	• Individual • SHOP (Small Group)	Same value input by user on template
Dental Only Plan	• Yes • No	Same value input by user on template
TIN	N/A	Same value input by user on template
HIOS Plan ID	N/A	Same value input by user on template
Plan Marketing Name	N/A	Same value input by user on template
HIOS Product ID	Exists in Insurance Product table.	Same value input by user on template
HPID	N/A	Same value input by user on template
Network ID	Exists in values imported from Network template	Same value input by user on template
Service Area ID	Exists in value imported from Service Area template	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Formulary ID	Exists in values imported form Prescription Drug template	Same value input by user on template
New/Existing Plan?	• New • Existing	New Existing
Plan Type	• Indemnity • PPO • POS • EPO • HMO • Other/Describe	11 - INDEMNITY 12 - HMO 13 - PPO 14 - EPO 15 - POS 16 - Other/Describe
Level of Coverage	Platinum Gold Silver Bronze Catastrophic	1- Platinum 2 - Gold 3 - Silver 4 - Bronze 5 - Catastrophic
Unique Plan Design?	• Yes • No	1 – Yes 2 – No
QHP/Non-QHP	• On Exchange • Off Exchange • Both	1 – On Exchange 2 – Off Exchange 3 - Both
Notice Required for Pregnancy	• Yes • No	1 - Yes 2- No
Is a Referral Required for Specialist?	• Yes • No	1 –Yes 2 – No
Specialist(s) Requiring a Referral	N/A	Same value input by user on template
Plan Level Exclusions	N/A	Same value input by user on template
Limited Cost Sharing Plan Variation – Est Advanced Payment	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
HSA-Eligible	• Yes • No	1 - Yes 2 – No
HSA/HRA Employer Contribution	• Yes • No	1 -Yes 2 - No
HSA/HRA Employer Contribution Amount	N/A	Same value input by user on template
Child-Only Offering	• Allows Adult and Child-Only • Allows Adult-Only • Allows Child-Only	1 – Allows Adult-Only and Child-Only 2 – Allows Adult-Only 3 – Allows Child-Only
Child Only Plan ID	N/A	Same value input by user on template
Wellness Program Offered	• Yes • No	1 - Yes 2 - No
Disease Management Programs Offered	• Asthma • Heart disease • Depression • Diabetes • High blood pressure and high cholesterol • Low back pain • Pain management • Pregnancy	1 – Asthma 2 – Heart Disease 3 – Depression 4 – Diabetes 9 – High Blood Pressure and High Cholesterol 10 – Low Back Pain 7 – Pain Management 8 - Pregnancy
EHB Apportionment for Pediatric Dental	N/A	Same value input by user on template
Guaranteed vs. Estimated Rate	• Guaranteed Rate • Estimated Rate	Guaranteed Estimated

Template Field Name	List of Values	Value Displayed in .xml File
Maximum Coinsurance for Specialty Drugs	N/A	Same value input by user on template
Maximum Number of Days for Charging an Inpatient Copay?	N/A	Same value input by user on template
Begin Primary Care Cost-Sharing After a Set Number of Visits?	N/A	Same value input by user on template
Plan Effective Date	N/A	Same value input by user on template
Plan Expiration Date	N/A	Same value input by user on template
Out of Country Coverage	• Yes • No	1- Yes 2 - No
Out of Country Coverage Description	N/A	Same value input by user on template
Out of Service Area Coverage	• Yes • No	1 - Yes 2 - No
Out of Service Area Coverage Description	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
National Network	• Yes • No	Yes No
URL for Summary Benefits & Coverage	N/A	Same value input by user on template
URL for Enrollment Payment	N/A	Same value input by user on template
Plan Brochure	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Benefits	• Primary Care Visit to Treat an Injury or Illness • Specialist Visit • Other Practitioner Office Visit (Nurse, Physician Assistant) • Outpatient Facility Fee (e.g., Ambulatory Surgery Center) • Outpatient Surgery Physician/Surgical Services • Hospice Services • Non-Emergency Care When Traveling Outside the U. S. • Routine Dental Services (Adults) • Infertility Treatment • Long-Term/Custodial Nursing Home Care • Private-Duty Nursing • Routine Eye Exam (Adult) • Urgent Care Centers or Facilities • Home Health Care Services • Emergency Room Services • Emergency Transportation/Ambulance • Inpatient Hospital Services (E.g., Hospital Stay) • Inpatient Physician and Surgical Services • Bariatric Surgery • Cosmetic Surgery • Skilled Nursing Facility • Prenatal and Postnatal Care	16 - Primary Care Visit to Treat an Injury or Illness 17 - Specialist Visit 1 - Other Practitioner Office Visit (Nurse, Physician Assistant) 20 - Outpatient Facility Fee (e.g., Ambulatory Surgery Center) 21 - Outpatient Surgery Physician/Surgical Services 37 - Hospice Services 45 - Non-Emergency Care When Traveling Outside the U.S. 42 - Routine Dental Services (Adult) 12 – Infertility Treatment 13 - Long-Term/Custodial Nursing Home Care 14 - Private-Duty Nursing 43 - Routine Eye Exam (Adult) 24 - Urgent Care Centers or Facilities 33 - Home Health Care Services 22 - Emergency Room Services 23 - Emergency Transportation/Ambulance 25 - Inpatient Hospital Services (e.g., Hospital Stay) 26 - Inpatient Physician and Surgical Services 9 - Bariatric Surgery 10 - Cosmetic Surgery 7 - Skilled Nursing Facility 31 - Prenatal and Postnatal Care

Template Field Name	List of Values	Value Displayed in .xml File
	(*Values continued*) • Delivery and All Inpatient Services for Maternity Care • Mental/Behavioral Health Outpatient Services • Mental/Behavioral Health Inpatient Services • Substance Abuse Disorder Outpatient Services • Substance Abuse Disorder Inpatient Services • Generic Drugs • Preferred Brand Drugs • Non-Preferred Brand Drugs • Specialty Drugs • Outpatient Rehabilitation Services • Habilitation Services • Chiropractic Care • Durable Medical Equipment • Hearing Aids • Imaging (CT/PET Scans, MRIs) • Preventive Care/Screening/Immunization • Routine Foot Care • Acupuncture • Weight Loss Programs • Routine Eye Exam for Children • Eye Glasses for Children • Dental Check-Up for Children • Rehabilitative Speech Therapy	32 - Delivery and All Inpatient Services for Maternity Care 27 - Mental/Behavioral Health Outpatient Services 28 - Mental/Behavioral Health Inpatient Services 29 - Substance Abuse Disorder Outpatient Services 30 - Substance Abuse Disorder Inpatient Services 2 – Generic Drugs 3 – Preferred Brand Drugs 4 – Non-Preferred Brand Drugs 5 – Specialty Drugs 34 - Outpatient Rehabilitation Services 35 - Habilitation Services 41 - Chiropractic Care 36 - Durable Medical Equipment 11 - Hearing Aids 19 - Imaging (CT/PET Scans, MRIs) 6 - Preventive Care/Screening/Immunization 44 - Routine Foot Care 8 – Acupuncture 15 - Weight Loss Programs 38 - Routine Eye Exam for Children 39 - Eye Glasses for Children 40 - Dental Check-Up for Children 8017 -Rehabilitative Speech Therapy

Template Field Name	List of Values	Value Displayed in .xml File
	(*Values continued*) • Rehabilitative Occupational and Rehabilitative Physical Therapy • Well Baby Visits and Care • Laboratory Outpatient and Professional Services • X-rays and Diagnostic Imaging • Basic Dental Care – Child • Orthodontia – Child • Major Dental Care – Child • Basic Dental Care – Adult • Orthodontia – Adult • Major Dental Care – Adult • Abortion for Which Public Funding is Prohibited • Transplant • Accidental Dental • Dialysis • Allergy Testing • Chemotherapy • Radiation • Diabetes Education • Prosthetic Devices • Infusion Therapy • Treatment for Temporormandibular Joint Disorders • Nutritional Counseling • Reconstructive Surgery	8016 - Rehabilitative Occupational and Rehabilitative Physical Therapy 8020 - Well Baby Visits and Care 8008 - Laboratory Outpatient and Professional Services 8021 - X-rays and Diagnostic Imaging 8003 - Basic Dental Care Child 67 - Orthodontia – Child 64 - Major Dental Care – Child 57 - Basic Dental Care – Adult 66 - Orthodontia – Adult 63 - Major Dental Care – Adult 8000 - Abortion for Which Public Funding is Prohibited 8018 – Transplant 8001 - Accidental Dental 8006 – Dialysis 8002 - Allergy Testing 8004 – Chemotherapy 8014 – Radiation 8005 - Diabetes Education 8013 - Prosthetic Devices 8007 - Infusion Therapy 8019 - Treatment for Temporomandibular Joint Disorders 8010 - Nutritional Counseling 8015 - Reconstructive Surgery
EHB	• Yes • No	1 - Yes 2 - No

Template Field Name	List of Values	Value Displayed in .xml File
State Mandate	• Yes • No	1 - Yes 2 - No
Is this Benefit Covered?	• Covered • Not Covered (or blank)	1 - Covered 2 - Not Covered
Quantitative Limit on Service	• Yes • No (or blank)	1- Yes 2 - No
Limit Quantity	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Limit Unit	**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	10 - Days per Month 100 - Months per Admission 101 - Months per Benefit Period 102 - Months per Episode 103 - Months per Lifetime 104 - Months per Month 105 - Months per Procedure 106 - Months per Stay 107 - Months per Transplant 108 - Months per Week 109 - Procedure(s) per 2 Years 11 - Days per Year 110 - Procedure(s) per 3 Years 111 - Procedure(s) per 6 Months 112 - Procedure(s) per Admission 113 - Procedure(s) per Benefit Period 114 - Procedure(s) per Procedure 115 - Procedure(s) per Stay 116 - Procedure(s) per Transplant 117 - Treatment(s) per 2 Years 118 - Treatment(s) per 3 Years 119 - Treatment(s) per 6 Months 12 - Months per Year 120 - Treatment(s) per Admission 121 - Treatment(s) per Benefit Period 122 - Treatment(s) per Episode 123 - Treatment(s) per Procedure 124 - Treatment(s) per Stay 125 - Treatment(s) per Transplant 126 - Visit(s) per 2 Years 127 - Visit(s) per 3 Years 128 - Visit(s) per 6 Months 129 - Visit(s) per Admission 13 - Visit(s) per Week 130 - Visit(s) per Benefit Period 131 - Visit(s) per Episode 132 - Visit(s) per Procedure 133 - Visit(s) per Stay 134 - Visit(s) per Transplant 14 - Visit(s) per Month 15 - Visit(s) per Year 16 - Visit(s) per Lifetime 17 - Treatment(s) per Week 18 - Treatment(s) per Month 19 - Treatment(s) per Year

Template Field Name	List of Values	Value Displayed in .xml File
		(**Values continued**) 2 - Days per Admission 20 - Treatment(s) per Lifetime 21 - Admission(s) per Lifetime 22 - Procedure(s) per Week 23 - Procedure(s) per Month 24 - Procedure(s) per Year 25 - Procedure(s) per Lifetime 26 – Other 27 - Admission(s) per 2 Years 28 - Admission(s) per 3 Years 29 - Admission(s) per 6 Months 3 - Procedure(s) per Episode 30 - Admission(s) per Admission 31 - Admission(s) per Benefit Period 32 - Admission(s) per Episode 33 - Admission(s) per Month 34 - Admission(s) per Procedure 35 - Admission(s) per Stay 36 - Admission(s) per Transplant 37 - Admission(s) per Week 38 - Admission(s) per Year 39 - Days per 2 Years 4 - Number of Occurrences 40 - Days per 3 Years 41 - Days per 6 Months 42 - Days per Benefit Period 43 - Days per Episode 44 - Days per Lifetime 45 - Days per Procedure 46 - Days per Stay 47 - Days per Transplant 48 - Dollars per 2 Years 49 - Dollars per 3 Years

Template Field Name	List of Values	Value Displayed in .xml File
		(**Values continued**) 5 - Occurrences per Episode 50 - Dollars per 6 Months 51 - Dollars per Admission 52 - Dollars per Benefit Period 53 - Dollars per Episode 54 - Dollars per Lifetime 55 - Dollars per Month 56 - Dollars per Procedure 57 - Dollars per Stay 58 - Dollars per Transplant 59 - Dollars per Week 6 - Hours per Week 60 - Dollars per Year 61 - Exam(s) per 2 Years 62 - Exam(s) per 3 Years 63 - Exam(s) per 6 Months 64 - Exam(s) per Admission 65 - Exam(s) per Benefit Period 66 - Exam(s) per Episode 67 - Exam(s) per Lifetime 68 - Exam(s) per Month 69 - Exam(s) per Procedure 7 - Hours per Month 70 - Exam(s) per Stay 71 - Exam(s) per Transplant 72 - Exam(s) per Week 73 - Exam(s) per Year 74 - Hours per 2 Years 75 - Hours per 3 Years 76 - Hours per 6 Months 77 - Hours per Admission 78 - Hours per Benefit Period 79 - Hours per Episode 8 - Hours per Year 80 - Hours per Lifetime 81 - Hours per Procedure 82 - Hours per Stay 83 - Hours per Transplant 84 - Item(s) per 2 Years 85 - Item(s) per 3 Years 86 - Item(s) per 6 Months 87 - Item(s) per Admission 88 - Item(s) per Benefit Period 89 - Item(s) per Episode

Template Field Name	List of Values	Value Displayed in .xml File
		(**Values continued**) 9 - Days per Week 90 - Item(s) per Lifetime 91 - Item(s) per Month 92 - Item(s) per Procedure 93 - Item(s) per Stay 94 - Item(s) per Transplant 95 - Item(s) per Week 96 - Item(s) per Year 97 - Months per 2 Years 98 - Months per 3 Years 99 - Months per 6 Months
Minimum Stay	N/A	Same value input by user on template
Exclusions	N/A	Same value input by user on template
Explanation (text field)	N/A	Same value input by user on template
EHB Variance Reason	• Above EHB • Substituted • Substantially Equal • Using Alternate Benchmark • Other Law/Regulation • Additional EHB Benefit • Dental Only Plan Available	1 - Above EHB 2 - Substituted 3 - Substantially Equal 4 - Using Alternate Benchmark 5 - Other Law/Regulation 6 - Additional EHB Benefit 7 - Dental Only Plan Available
Subject to Deductible (Tier 1)	• Yes • No (or blank)	1 - Yes 2 - No
Subject to Deductible (Tier 2)	• Yes • No (or blank)	1 - Yes 2 - No
Excluded from Newtork MOOP	• Yes • No (or blank)	1 - Yes 2 - No
Excluded from Out of Network MOOP	• Yes • No (or blank)	1 - Yes 2 - No

Template Field Name	List of Values	Value Displayed in .xml File
HIOS Plan ID (Standard Component + Variant)	N/A	Same value input by user on template
Plan Marketing Name	N/A	Same value input by user on template
Level of Coverage (Metal Level)	• Platinum • Gold • Silver • Bronze • Catastrophic	1 - Platinum 2 - Gold 3 - Silver 4 - Bronze 5 - Catastrophic
CSR Variation Type	**Variant Suffixes**: 00 = non-exchange variant 01 = exchange variant (not CSR) 02 = Zero Cost Sharing Plan Variation 03 = Limited Cost Sharing Plan Variation 04 = 73% AV Level Silver Plan CSR 05 = 87% AV Level Silver Plan CSR 06 = 94% AV Level Silver Plan CSR	0 - non-exchange variant 1 - exchange variant (not CSR) 2 - Zero Cost Sharing Plan Variation 3 - Limited Cost Sharing Plan Variation 4 - 73% AV Level Silver Plan CSR 5 - 87% AV Level Silver Plan CSR 6 - 94% AV Level Silver Plan CSR
Issuer Actuarial Value	N/A	Same value input by user on template
AV Calculator Output Number	N/A	Same value input by user on template
Medical & Drug Deductibles Integrated?	1- Yes 2 – No	Yes No
Medical & Drug Maximum Out of Pocket Integrated?	1- Yes 2 – No	Yes No
Multiple In Network Tiers?	1- Yes 2 – No	Yes No
1st Tier Utilization	1- Yes 2 – No	Yes No
2nd Tier Utilization	1- Yes 2 – No	Yes No
Having a Baby - Deductible	N/A	Same value input by user on template
Having a Baby - Copayment	N/A	Same value input by user on template
Having a Baby - Coinsurance	N/A	Same value input by user on template
Having a Baby - Limit	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Having Diabetes - Deductible	N/A	Same value input by user on template
Having Diabetes - Copayment	N/A	Same value input by user on template
Having Diabetes - Coinsurance	N/A	Same value input by user on template
Having Diabetes - Limit	N/A	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – In Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – In Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – In Network (Tier 2) - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – In Network (Tier 2) - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – Out of Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – Out of Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – Combined In/Out of Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical EHB Benefits – Combined In/Out of Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – In Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – In Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – In Network (Tier 2) - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – In Network (Tier 2) - Family	$X Not Applicable	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Maximum Out of Pocket for Drug EHB Benefits – Out of Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – Out of Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – Combined In/Out of Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Drug EHB Benefits – Combined In/Out of Network - Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network – Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network – Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network (Tier 2) – Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – In Network (Tier 2) – Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Out of Network – Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Out of Network – Family	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Combined In/Out of Network - Individual	$X Not Applicable	Same value input by user on template
Maximum Out of Pocket for Medical and Drug EHB Benefits (Total) – Combined In/Out of Network - Family	$X Not Applicable	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Medical EHB Deductible – In Network – Individual	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – In Network – Family	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – In Network – Default Coinsurance	N/A	Same value input by user on template
Medical EHB Deductible – In Network (Tier 2) – Individual	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – In Network (Tier 2) – Family	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – In Network (Tier 2) – Default Coinsurance	N/A	Same value input by user on template
Medical EHB Deductible – Out of Network – Individual	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – Out of Network – Family	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – Combined In/Out of Network – Individual	$X Not Applicable	Same value input by user on template
Medical EHB Deductible – Combined In/Out of Network – Family	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – In Network – Individual	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – In Network – Family	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – In Network (Tier 2) – Individual	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – In Network (Tier 2) – Family	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – Out of Network – Individual	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – Out of Network – Family	$X Not Applicable	Same value input by user on template
Custom Deductible Sub-Groups – Combined In/Out of Network – Individual	$X Not Applicable	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Custom Deductible Sub-Groups – Combined In/Out of Network – Family	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – In Network – Individual	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – In Network – Family	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – In Network – Default Coinsurance	N/A	Same value input by user on template
Drug EHB Deductible – In Network (Tier 2) – Individual	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – In Network (Tier 2) – Family	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – In Network (Tier 2) – Default Coinsurance	N/A	Same value input by user on template
Drug EHB Deductible – Out of Network – Individual	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – Out of Network – Family	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – Combined In/Out of Network – Individual	$X Not Applicable	Same value input by user on template
Drug EHB Deductible – Combined In/Out of Network – Family	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network – Individual	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network – Family	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network – Default Coinsurance	N/A	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Individual	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Family	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – In Network (Tier 2) – Default Coinsurance	N/A	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
Combined Medical & Drug EHB Deductible – Out of Network – Individual	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – Out of Network – Family	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – Combined In/Out of Network – Individual	$X Not Applicable	Same value input by user on template
Combined Medical & Drug EHB Deductible – Combined In/Out of Network – Family	$X Not Applicable	Same value input by user on template
Covered Benefits Cost Sharing – Copay – In Network (Tier 1)	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible	2 - No Charge 3 - No Charge after deductible 8 - $X, $X Copay after deductible 9 - $X Copay before deductible
Covered Benefits Cost Sharing – Copay – In Network (Tier 2)	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible	2 - No Charge 3 - No Charge after deductible 8 - $X, $X Copay after deductible 9 - $X Copay before deductible
Covered Benefits Cost Sharing – Copay – Out of Network	No Charge No Charge after deductible $X, $X Copay after deductible $X Copay before deductible	2 - No Charge 3 - No Charge after deductible 8 - $X, $X Copay after deductible 9 - $X Copay before deductible
Covered Benefits Cost Sharing – Copay – In Network (Charge per day or stay?)	$X Copay per Day $X Copay per Stay	Same value input by user on template
Covered Benefits Cost Sharing – Coinsurance – In Network (Tier 1)	No Charge No Charge after deductible X%, X% after deductible	2 - No Charge 3 - No Charge after deductible 5 – X%, X% Coinsurance after deductible
Covered Benefits Cost Sharing – Coinsurance – In Network (Tier 2)	No Charge No Charge after deductible X%, X% after deductible	2 - No Charge 3 - No Charge after deductible 5 – X%, X% Coinsurance after deductible
Covered Benefits Cost Sharing – Coinsurance – Out of Network	No Charge No Charge after deductible X%, X% after deductible	2 - No Charge 3 - No Charge after deductible 5 – X%, X% Coinsurance after deductible

11.6.2 Business Rules Codes

For the Business Rules Template, the .xml file will not display text for some fields and will only display corresponding codes. For example, in field 1 if the User selects"1 – There are rates specifically for couples and for families (not just addition of individual rates)" as an input for field 1, the value displayed in the .xml file will be "1". Please refer to Exhibit 11-27.

Exhibit 11-27: Business Rules Codes

Template Field Name	List of Values	Value Displayed in .xml File
HIOS Issuer ID	Exists in Issuer Organization and Issuer Request tables	Same value input by user on template
Federal TIN	N/A	Same value input by user on template
Product ID	Exists in Insurance Product table	Same value input by user on template
Plan ID (Standard Component)	Exists in Issuer Insurance Plan table	Same value input by user on template
How are rates for contracts covering two or more enrollees calculated?	1 - There are rates specifically for couples and for families (not just addition of individual rates) 2 - A different rate (specifically for parties of two or more) for each enrollee is added together	1 - There are rates specifically for couples and for families (not just addition of individual rates) 2 - A different rate (specifically for parties of two or more) for each enrollee is added together
What is the maximum number of under age (under 21) dependents used to quote a two parent family?	1 2 3 or more Not Applicable	1 - 1 2 - 2 3 - 3 or more 5 – Not Applicable
What is the maximum number of under age (under 21) dependents used to quote a single parent family?	1 2 3 or more Not Applicable	1 - 1 2 - 2 3 - 3 or more 5 – Not Applicable

Template Field Name	List of Values	Value Displayed in .xml File
Is there a maximum age for a dependent?	Enter age greater than 20 [ ] Not Applicable	Same value input by user on template
What are the maximum number of children use to quote a children-only contract?	1 2 3 or more Not Applicable	1 - 1 2 - 2 3 - 3 or more 5 – Not Applicable
Are domestic partners treated the same as secondary subscribers?	• Yes • No (or blank)	1 - Yes 2 - No
Are same-sex partners treated the same as secondary subscribers?	• Yes • No (or blank)	1 - Yes 2 - No
How is age determined for rating and eligibility purposes?	• 1 - Age on effective date • 2 - Age on January 1st of the effective date year • 3 - Age on insurance date (age on birthday nearest the effective date) • 4 – Age on January 1st or July 1st	1 - Age on effective date 4 - Age on January 1st of the effective date year 3 - Age on insurance date (age on birthday nearest the effective date) 2 – Age on January 1st or July 1st
How is tobacco status determined for subscribers and dependents?	• 1 – No Tobacco user for a least [ ] months • 2 – Not Applicable	Same value input by user on template

Template Field Name	List of Values	Value Displayed in .xml File
What relationship between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	• Spouse - Yes/No • Father or Mother - Yes/No • Grandfather or Grandmother - Yes/No • Grandson or Granddaughter - Yes/No • Uncle or Aunt - Yes/No • Nephew or Niece - Yes/No • Cousin - Yes/No • Adopted Child - Yes/No • Foster Child - Yes/No • Son-in-law or daughter-in-law - Yes/No • Brother-in-law or sister-in-law - Yes/No • Mother-in-law or father-in-law - Yes/No • Brother or sister - Yes/No • Ward - Yes/No • Stepparent - Yes/No • Stepson or stepdaughter - Yes/No • Self - Yes/No • Child - Yes/No • Sponsored dependent - Yes/No • Dependent of a Minor Dependent - Yes/No • Ex-spouse - Yes/No • Guardian - Yes/No • Court Appointed Guardian - Yes/No • Collateral Dependent - Yes/No • Life Partner - Yes/No • Annuitant - Yes/No • Trustee - Yes/No • Other Relationship - Yes/No • Other Relative - Yes/No	1 – Spouse 2 – Father or Mother 3 – Grandfather or Grandmother 4 - Grandson or Granddaughter 5 - Uncle or Aunt 6 - Nephew or Niece 7 – Cousin 8 – Adopted Child 9 – Foster Child 10 - Son-in-law or daughter-in-law 11 - Brother-in-law or sister-in-law 12 - Mother-in-law or father-in law 13 - Brother or sister 14 – Ward 15 - Stepparent 16 - Stepson or stepdaughter 17 – Self 18 – Child 19 – Sponsored dependent 20 – Dependent of a minor dependent 21 – Ex-spouse 22 – Guardian 23 – Court Appointed Guardian 24 – Collateral dependent 25 – Life Partner 26 – Annuitant 27 – Trustee 28 – Other Relationship 29 – Other Relative