Title: Revised Benchmark Benefits Instructions

Subtitle: Instructions for using state-specific information to accurately reflect Individual Market and Small Group Market EHB and state-required benefits on the Plans and Benefits Template.

Purpose: This document provides issuers with instructions for correcting the Benefits Package Worksheet of the Plans and Benefits Template using the included state-specific worksheets (e.g., AK, HI, PA).

Version: 1

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Background

To help issuers, this document lists important state- and CMS-identified corrections to the benefit data auto-populated by the 2015 Add-In file on the Benefits Package Worksheet of the Plans and Benefits Template. Benefits that have incorrectly auto-populated benefit data for the Small Group Market are indicated in the "*Small Group Market Add-In Changes*" columns of the state-specific spreadsheets (e.g., AK, AL, etc.) in this document.

Issuers should use the step-by-step instructions below when entering the benefit coverage information for each set of plans offered in the Small Group Market in the Benefits Package Worksheet of the Plan and Benefits Template. These instructions explain how an issuer should complete the benefit coverage information for the benefits that auto-populated inaccurately.

1 Identify the benefits that have incorrectly auto-populated data in the Benefits Package Worksheet

Select the appropriate state-specific spreadsheet.

Review the "*Small Group Market Add-In Changes*" columns of the spreadsheet to identify the benefits indicated to have corrections in how the benefit data autopopulated. These benefits are also highlighted in yellow to facilitate identification.

Review the *"Benefit Information"* or *"General Information"* fields that have changed for these benefits, which are indicated in the *"Fields Changed"* column (e.g., EHB, State-Required Benefit), and compare them to the auto-populated data in the Benefits Package Worksheet of the Plans and Benefits Template.

Small Group Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	Is this a correction to the data populated by the Add-In file on the state Benefit Package?	Benefits	EHB	State-Required Benefit	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Benefit Explanation
	No	Primary Care Visit to Treat an Injury or Illness	Yes		Covered						
	No	Specialist Visit	Yes		Covered						
	No	Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes		Covered						
	No	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes		Covered						
	No	Outpatient Surgery Physician/Surgical Services	Yes		Covered						
	No	Hospice Services	Yes		Covered						
EHB	Yes	Non-Emergency Care When Traveling Outside the U.S.									

2	**Select the appropriate scenario based on the corrections identified in the state-specific spreadsheet**		
	Select the appropriate scenario below (A, B, or C) for each benefit indicated to have a correction to the data populated by the Add-In File in the state-specific spreadsheet.		
	Scenario A	**The state-specific worksheet DOES identify a given benefit as an *EHB* and/or *State Required Benefit* and the benefit DOES NOT appear on the Plans and Benefits Template (*"Fields Changed"* = "Added Benefit"):**	
		Cover	**If you intend to cover the benefit,** add the benefit using the "Add Benefit" button on the menu bar under the Plans and Benefits ribbon, select "Covered" in the "*Is this Benefit Covered?*" field, and select "Additional EHB" as the "*EHB Variance Reason.*"
		Do Not Cover	**If you do <u>not</u> intend to cover the benefit and instead want to substitute with actuarially equivalent coverage of another benefit in the same EHB category,** add the benefit using the "Add Benefit" button on the menu bar under the Plans & Benefits ribbon, select "Not Covered" in the "*Is this Benefit Covered?*" field, and select "Substituted" as the "*EHB Variance Reason.*" *[* For the "new" benefit that is taking the place of this one, select "Additional EHB Benefit" as the "*EHB Variance Reason."]* **If you do <u>not</u> intend to cover a pediatric dental benefit and there is a stand-alone dental plan available,** add the pediatric dental benefit using the "Add Benefit" button on the menu bar, select "Not Covered," and select "Dental Only Plan Available" as the "*EHB Variance Reason.*"
	Scenario B	**The state-specific spreadsheet DOES identify a given benefit as an *EHB* and/or *State Required Benefit* and the benefit DOES appear on the Plans & Benefits Template, but the *"Is this Benefit Covered?"* field is BLANK:**	
		Cover	**If you intend to cover the benefit,** add "Covered" in the "*Is this Benefit Covered?*" field and select "Additional EHB Benefit" as the "*EHB Variance Reason.*"
		Do Not Cover	**If you do <u>not</u> intend to cover the benefit and instead intend to substitute with actuarially equivalent coverage of another benefit in the same EHB category,** select "Not Covered" in the "*Is this Benefit Covered?*" field and select "Substituted" as the *EHB Variance Reason.* [For the "new" benefit that is taking the place of this one, select "Additional EHB Benefit" as the *"EHB Variance Reason."]* **If you do <u>not</u> intend to cover a pediatric dental benefit and there is a stand-alone dental plan available,** select "Not Covered" and select "Dental Only Plan Available" as the "*EHB Variance Reason.*"
	Scenario C	**The state-specific worksheet DOES NOT identify a given benefit as an *EHB* and/or *State Required Benefit* and the Plans & Benefits Template DOES populate the benefit as "Covered" in the *Is this Benefit Covered?* field:**	
		Cover	**If you intend to cover the benefit,** leave "Covered" in the "*Is this Benefit Covered?*" field and select "Above EHB" as the "*EHB Variance Reason.*"
		Do Not Cover	**If you do <u>not</u> intend to cover the benefit**, change "Covered" to "Not Covered" in the "*Is this Benefit Covered?*" field and select "Above EHB" as the "*EHB Variance Reason.*"

3	**Populate the "*General Information*" fields when completing the Plans and Benefits Template**

Provide benefit coverage information for each set of plans in the Benefits Package Worksheet of the Plan and Benefits Template.

For benefits indicated to have corrections in how the benefit data auto-populated:
Complete the "*Is this Benefit Covered?*" and the *"EHB Variance Reason"* fields according to the scenario selected in Step 2.

For benefits NOT indicated to have any corrections:
Complete the *"General Information"* fields according to Chapter 10: *Instructions for the Plans and Benefits Application Section* in the QHP Template Instructions, Sections 4.10 and 4.11.

Benefit Information			***General Information***							
Benefits	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**	**EHB Variance Reason**
Primary Care Visit to Treat an Injury or Illness										
Specialist Visit										
Other Practitioner Office Visit (Nurse, Physician Assistant)										

Individual Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	**Is this a correction to the data populated by the Add-In file on the state Benefit Package?**	**Benefits**	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**
	No	**Primary Care Visit to Treat an Injury or Illness**	Yes		Covered						
	No	**Specialist Visit**	Yes		Covered						
	No	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Yes		Covered						
	No	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Yes		Covered						
	No	**Outpatient Surgery Physician/Surgical Services**	Yes		Covered						
	No	**Hospice Services**	Yes		Covered						
	No	**Non-Emergency Care When Traveling Outside the U.S.**									
	No	**Routine Dental Services (Adult)**									
	No	**Infertility Treatment**									
	No	**Long-Term/Custodial Nursing Home Care**									
	No	**Private-Duty Nursing**	Yes		Covered						
EHB	Yes	**Routine Eye Exam (Adult)**									
	No	**Urgent Care Centers or Facilities**	Yes		Covered						
	No	**Home Health Care Services**	Yes		Covered	Yes	28	Hours per Week			
	No	**Emergency Room Services**	Yes		Covered						
	No	**Emergency Transportation/Ambulance**	Yes		Covered						
	No	**Inpatient Hospital Services (e.g., Hospital Stay)**	Yes		Covered						
	No	**Inpatient Physician and Surgical Services**	Yes		Covered						
	No	**Bariatric Surgery**									
	No	**Cosmetic Surgery**									
	No	**Skilled Nursing Facility**	Yes		Covered	Yes	100	Days per Year			
	No	**Prenatal and Postnatal Care**	Yes	Yes	Covered						
	No	**Delivery and All Inpatient Services for Maternity Care**	Yes	Yes	Covered						
State-Required Benefit	Yes	**Mental/Behavioral Health Outpatient Services**	Yes	Yes	Covered						
State-Required Benefit	Yes	**Mental/Behavioral Health Inpatient Services**	Yes	Yes	Covered						
	No	**Substance Abuse Disorder Outpatient Services**	Yes		Covered						
	No	**Substance Abuse Disorder Inpatient Services**	Yes		Covered						
	No	**Generic Drugs**	Yes		Covered						
	No	**Preferred Brand Drugs**	Yes		Covered						
	No	**Non-Preferred Brand Drugs**	Yes		Covered						
	No	**Specialty Drugs**	Yes		Covered						

Individual Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	**Is this a correction to the data populated by the Add-In file on the state Benefit Package?**	**Benefits**	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**
State-Required Benefit, Benefit Explanation	Yes	**Outpatient Rehabilitation Services**	Yes	Yes	Covered						Limits apply, see state mandates for Rehabilitative Speech Therapy, Rehabilitative Occupational Therapy, and Rehabilitative Physical Therapy
State-Required Benefit	Yes	**Habilitation Services**	Yes	Yes	Covered						
	No	**Chiropractic Care**									
	No	**Durable Medical Equipment**	Yes	Yes	Covered						
	No	**Hearing Aids**	Yes	Yes	Covered						
	No	**Imaging (CT/PET Scans, MRIs)**	Yes		Covered						
	No	**Preventive Care/Screening/Immunization**	Yes	Yes	Covered						
	No	**Routine Foot Care**									
	No	**Acupuncture**									
	No	**Weight Loss Programs**									
	No	**Routine Eye Exam for Children**	Yes		Covered	Yes	1	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Eye Glasses for Children**									
	No	**Dental Check-Up for Children**	Yes		Covered	Yes	1	Visit(s) per 6 Months			
	No	**Rehabilitative Speech Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Occupational and Rehabilitative Physical Therapy**									
EHB	Yes	**Well Baby Visits and Care**	Yes		Covered						
	No	**Laboratory Outpatient and Professional Services**	Yes		Covered						
	No	**X-rays and Diagnostic Imaging**	Yes		Covered						
	No	**Basic Dental Care – Child**	Yes		Covered						
	No	**Orthodontia – Child**									
	No	**Major Dental Care – Child**									
	No	**Basic Dental Care – Adult**									
	No	**Orthodontia – Adult**									
	No	**Major Dental Care – Adult**									
	No	**Abortion for Which Public Funding is Prohibited**									
	No	**Transplant**	Yes		Covered						
	No	**Accidental Dental**									
EHB	Yes	**Dialysis**	Yes		Covered						
	No	**Allergy Testing**	Yes		Covered						
	No	**Chemotherapy**	Yes		Covered						
	No	**Radiation**	Yes		Covered						

Individual Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	**Is this a correction to the data populated by the Add-In file on the state Benefit Package?**	**Benefits**	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**
EHB	Yes	**Diabetes Education**	Yes		Covered						
	No	**Prosthetic Devices**	Yes		Covered						
	No	**Infusion Therapy**	Yes		Covered						
	No	**Treatment for Temporomandibular Joint Disorders**									
	No	**Nutritional Counseling**	Yes		Covered						
EHB	Yes	**Reconstructive Surgery**	Yes		Covered						
EHB	Yes	**Clinical Trials**	Yes	Yes	Covered						
EHB	Yes	**Diabetes Care Management**	Yes	Yes	Covered						
EHB	Yes	**Inherited Metabolic Disorder - PKU**	Yes	Yes	Covered						
EHB	Yes	**Off Label Prescription Drugs**	Yes	Yes	Covered						
EHB	Yes	**Dental Anesthesia**	Yes	Yes	Covered						
EHB	Yes	**Prescription Drugs Other**	Yes	Yes	Covered						
EHB	Yes	**Congenital Anomaly, including Cleft Lip/Palate**	Yes	Yes	Covered						
EHB	Yes	**Early Intervention Services**	Yes	Yes	Covered						
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Occupational Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Physical Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			

Small Group Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	**Is this a correction to the data populated by the Add-In file on the state Benefit Package?**	**Benefits**	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**
	No	**Primary Care Visit to Treat an Injury or Illness**	Yes		Covered						
	No	**Specialist Visit**	Yes		Covered						
	No	**Other Practitioner Office Visit (Nurse, Physician Assistant)**	Yes		Covered						
	No	**Outpatient Facility Fee (e.g., Ambulatory Surgery Center)**	Yes		Covered						
	No	**Outpatient Surgery Physician/Surgical Services**	Yes		Covered						
	No	**Hospice Services**	Yes		Covered						
	No	**Non-Emergency Care When Traveling Outside the U.S.**									
	No	**Routine Dental Services (Adult)**									
	No	**Infertility Treatment**									
	No	**Long-Term/Custodial Nursing Home Care**									
	No	**Private-Duty Nursing**	Yes		Covered						
EHB	Yes	**Routine Eye Exam (Adult)**									
	No	**Urgent Care Centers or Facilities**	Yes		Covered						
	No	**Home Health Care Services**	Yes		Covered	Yes	28	Hours per Week			
	No	**Emergency Room Services**	Yes		Covered						
	No	**Emergency Transportation/Ambulance**	Yes		Covered						
	No	**Inpatient Hospital Services (e.g., Hospital Stay)**	Yes		Covered						
	No	**Inpatient Physician and Surgical Services**	Yes		Covered						
	No	**Bariatric Surgery**									
	No	**Cosmetic Surgery**									
	No	**Skilled Nursing Facility**	Yes		Covered	Yes	100	Days per Year			
	No	**Prenatal and Postnatal Care**	Yes	Yes	Covered						
	No	**Delivery and All Inpatient Services for Maternity Care**	Yes	Yes	Covered						
	No	**Mental/Behavioral Health Outpatient Services**	Yes	Yes	Covered						
	No	**Mental/Behavioral Health Inpatient Services**	Yes	Yes	Covered						
	No	**Substance Abuse Disorder Outpatient Services**	Yes		Covered						
	No	**Substance Abuse Disorder Inpatient Services**	Yes		Covered						
	No	**Generic Drugs**	Yes		Covered						
	No	**Preferred Brand Drugs**	Yes		Covered						
	No	**Non-Preferred Brand Drugs**	Yes		Covered						
	No	**Specialty Drugs**	Yes		Covered						

Small Group Market Add-In Changes		*Benefit Information*			*General Information*						
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State-Required Benefit, Benefit Explanation	Yes	**Outpatient Rehabilitation Services**	Yes	Yes	Covered						Limits apply, see state mandates for Rehabilitative Speech Therapy, Rehabilitative Occupational Therapy, and Rehabilitative Physical Therapy
	No	**Habilitation Services**	Yes	Yes	Covered						
	No	**Chiropractic Care**									
	No	**Durable Medical Equipment**	Yes	Yes	Covered						
	No	**Hearing Aids**	Yes	Yes	Covered						
	No	**Imaging (CT/PET Scans, MRIs)**	Yes		Covered						
	No	**Preventive Care/Screening/Immunization**	Yes	Yes	Covered						
	No	**Routine Foot Care**									
	No	**Acupuncture**									
	No	**Weight Loss Programs**									
	No	**Routine Eye Exam for Children**	Yes		Covered	Yes	1	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Eye Glasses for Children**									
	No	**Dental Check-Up for Children**	Yes		Covered	Yes	1	Visit(s) per 6 Months			
	No	**Rehabilitative Speech Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Occupational and Rehabilitative Physical Therapy**									
EHB	Yes	**Well Baby Visits and Care**	Yes		Covered						
	No	**Laboratory Outpatient and Professional Services**	Yes		Covered						
	No	**X-rays and Diagnostic Imaging**	Yes		Covered						
	No	**Basic Dental Care – Child**	Yes		Covered						
	No	**Orthodontia – Child**									
	No	**Major Dental Care – Child**									
	No	**Basic Dental Care – Adult**									
	No	**Orthodontia – Adult**									
	No	**Major Dental Care – Adult**									
	No	**Abortion for Which Public Funding is Prohibited**									
	No	**Transplant**	Yes		Covered						
	No	**Accidental Dental**									
EHB	Yes	**Dialysis**	Yes		Covered						
	No	**Allergy Testing**	Yes		Covered						
	No	**Chemotherapy**	Yes		Covered						
	No	**Radiation**	Yes		Covered						

Small Group Market Add-In Changes		*Benefit Information*			*General Information*						
Fields Changed	**Is this a correction to the data populated by the Add-In file on the state Benefit Package?**	**Benefits**	**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**	**Limit Unit**	**Minimum Stay**	**Exclusions**	**Benefit Explanation**
EHB	Yes	**Diabetes Education**	Yes		Covered						
	No	**Prosthetic Devices**	Yes		Covered						
	No	**Infusion Therapy**	Yes		Covered						
	No	**Treatment for Temporomandibular Joint Disorders**									
	No	**Nutritional Counseling**	Yes		Covered						
EHB	Yes	**Reconstructive Surgery**	Yes		Covered						
EHB	Yes	**Clinical Trials**	Yes	Yes	Covered						
EHB	Yes	**Diabetes Care Management**	Yes	Yes	Covered						
EHB	Yes	**Inherited Metabolic Disorder - PKU**	Yes	Yes	Covered						
EHB	Yes	**Off Label Prescription Drugs**	Yes	Yes	Covered						
EHB	Yes	**Dental Anesthesia**	Yes	Yes	Covered						
State-Required Benefit	Yes	**Mental Health Other**									
EHB	Yes	**Prescription Drugs Other**	Yes	Yes	Covered						
EHB	Yes	**Congenital Anomaly, including Cleft Lip/Palate**	Yes	Yes	Covered						
EHB	Yes	**Early Intervention Services**	Yes	Yes	Covered						
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Occupational Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			
EHB, Limit Quantity, Limit Unit	Yes	**Rehabilitative Physical Therapy**	Yes	Yes	Covered	Yes	20	Visit(s) per Year			