Qualified Health Plan
Issuer Application Instructions

2018

April 13, 2017

Version 1

Section 2D: Plans & Benefits

1. Introduction

In the Plans & Benefits section, issuers will enter data about their plans and list covered benefits with any quantitative limits or exclusions. They will also provide cost sharing and basic plan variation information for each plan that is being submitted, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. These pieces of information will be included through two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet. These instructions apply to QHP and SADP issuers.

2. Data Requirements

To complete this section, the issuer will need the following:

1. Completed Network ID (QHP & SADP), Service Area (QHP & SADP), and Formulary Excel Templates (QHP only);
2. Applicable plan URLs; and
3. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2018
◆ There is a new *Level of Coverage* option called “Expanded Bronze.” This metal level’s AV has a de minimis range of 56 percent to 65 percent and should be used for plans that either cover and pay for at least one major service—other than preventive services—before the deductible, or meet the requirements to be a high deductible health plan. “Expanded Bronze” will appear as the *Level of Coverage* on the Benefits Package and Cost Share Variances worksheets; however, the plan will show as just “Bronze” to consumers. ◆ The cost sharing drop down “$X copay with deductible” will now take the place of the option “$X copay before deductible” that was shown in previous years. This cost sharing option means the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible. ◆ There are now three sets of Simple Choice plan options that vary by state. Set 2 is for DE, IA, KY, LA, MO, MT, and NH; Set 3 is for NJ; and Set 1 is for all the other states. Each issuer should use the Simple Choice plans applicable to its specific state.

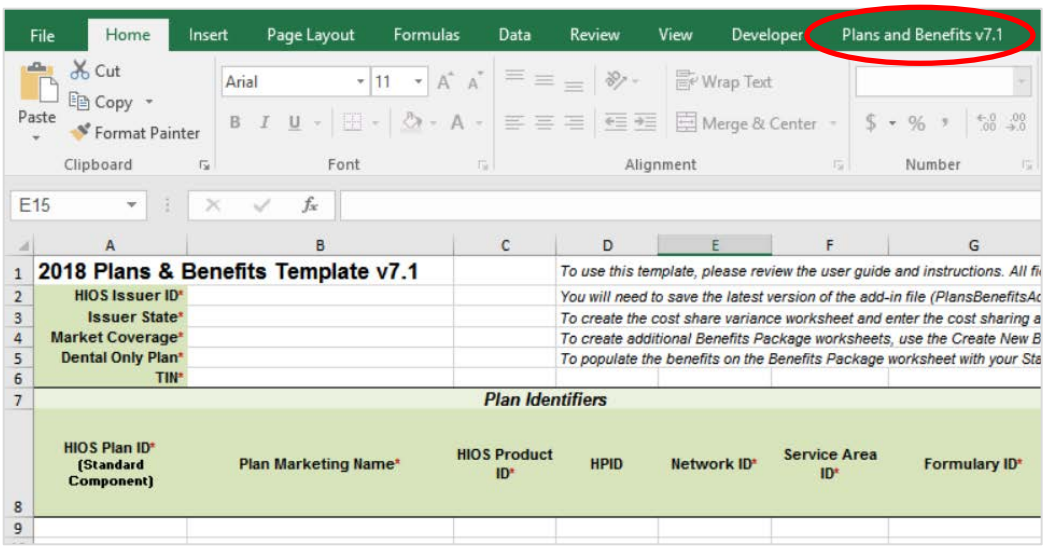
Tips for the Plans & Benefits Section

- Download the most recent versions of the 2018 Plans & Benefits Template, Add-In file, Actuarial Value Calculator (AVC), and Simple Choice Plan Add-In file.
- Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template for the macros to run properly.
- All data elements that CMS anticipates displaying to individual market consumers on Plan Compare are **identified by a number symbol (#)** next to the field name.
- All data fields required for SADP issuers are **identified by an asterisk (*)** next to the field name. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variance worksheet, see Sections 4.11, 4.20–4.22, 4.24, 4.26, and 4.27.
- All data fields used by the AVC are **identified by a caret (^)** next to the field name. See the Appendix for additional AVC instructions.
- The issuer should complete the Network, Service Area, and Prescription Drug Templates (QHPs only) and save them to its computer before filling out the Plans & Benefits Template. This template requires issuers to assign a network, service area, and formulary ID to each plan on the basis of the IDs already created in these three templates.
- Complete a separate Benefits Package worksheet for each unique benefits package the issuer wishes to offer. To create additional benefits packages, click the Create New Benefits Package button on the menu bar under the Plans & Benefits ribbon. The *HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan,* and *TIN* fields are auto-populated.
- Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost sharing reduction plan variation the issuer wishes to offer.
- The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays. See Appendix 1 for how these values relate to AV.
- When a cell is grayed out, it is locked and cannot be edited. The Benefits and Service Area Module will not process data entered into the cell before it was grayed out.

4. Detailed Section Instructions

When opening the Plans & Benefits Template, if the issuer is asked to enable macros, use the **Options** button on the Security Warning toolbar, and select **Enable this content**. If the macros are not enabled before the data are entered, the template will not recognize those data fields and they will have to be reentered. Once the issuer does this, the **Plans & Benefits** and **Simple Choice Plan** ribbons should appear (Figure 2D-1) as tabs on the file's toolbar. **Note**: The **Simple Choice Plan** Add-In will not automatically load into the Plans & Benefits Template and must be opened before the ribbon will appear.

Figure 2D-4. Plans & Benefits Ribbon

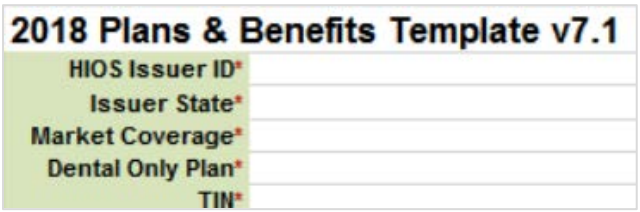


Before proceeding, the issuer should confirm that it has downloaded the latest versions of the Plans & Benefits Template and both Add-In files from the Centers for Consumer Information and Insurance Oversight (CCIIO) website (https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits).

4.1 General Information

The fields in the upper-left portion of the Benefits Package worksheet contain basic information about the issuer and the types of plans to be entered into the template (Figure 2D-2). This information must be entered in the first Benefits Package worksheet; it will then auto-populate any additional Benefits Package worksheets generated by the issuer.

Figure 2D-5. Plans & Benefits Template



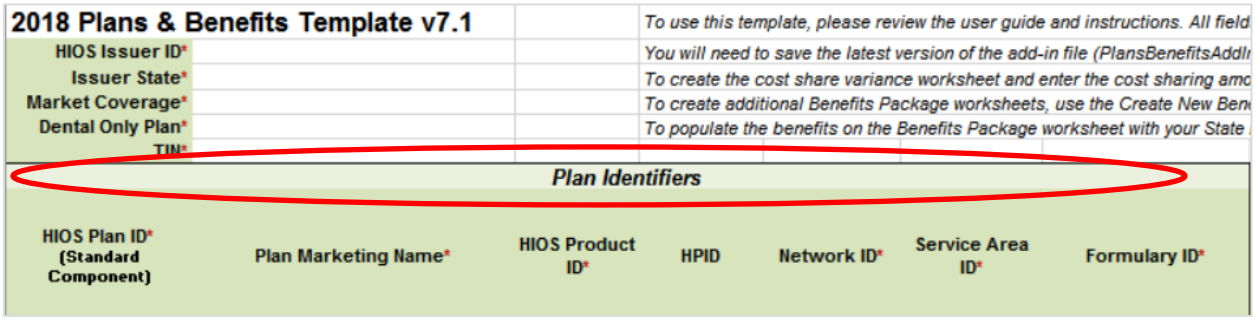
General Plans & Benefit Information	*Steps*
HIOS Issuer ID *	Enter the five-digit HIOS Issuer ID.
Issuer State *	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage *	Select the market coverage. Choose from the following options: ◆ **Individual**—if the plans are offered on the individual market. ◆ **SHOP (Small Group)**—if the plans are offered on the small group market.
Dental Only Plan *	Indicate whether the plans contained in the template are dental only plans. Choose from the following: ◆ **Yes**—if this is a dental only package. When "**Yes**" is selected, the template grays out areas that do not apply to SADPs and prevents the field from accepting data entry. ◆ **No**—if this is not a dental only package.
TIN *	Enter the issuer's 9-digit (xx-xxxxxxx) Tax Identification Number (TIN).

4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data on each plan, including its Plan ID and the network, service area, and formulary (QHPs only) it uses (Figure 2D-3). Complete this section for each standard plan the issuer plans to offer as part of this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage (low or high level of coverage for SADP), and a benefits package is a group of plans that covers the same set of benefits. Each plan in a benefits package may have different cost sharing values, which are entered in the corresponding Cost Share Variances worksheet. Enter each standard plan in the Benefits Package worksheet, and the template automatically creates the necessary plan variations in the Cost Share Variances worksheet.

If the issuer runs out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans & Benefits** ribbon. Each benefits package may have up to 50 plans. If there are more than 50 plans associated with the same benefits package, a new benefits package with the identical benefits package structure must be created.

Figure 2D-6. Plan Identifiers Section

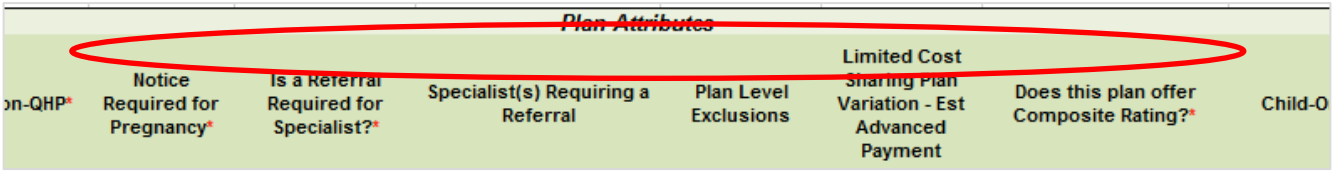


Plan Identifiers	Steps
HIOS Plan ID (Standard Component) *#	Enter the 14-character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name *#	Enter the plan marketing name at the standard plan level.
HIOS Product ID *	Enter the 10-character, HIOS-generated Product ID number.
HPID *	Enter the 10-digit national Health Plan Identifier (HPID).
Network ID *	Click the **Import Network IDs** button on the menu bar under the **Plans & Benefits** ribbon, and select the completed Network Template Excel file to import a list of values from the Network Template; then select the appropriate one from the drop-down menu. (The Excel version of the Network ID Template must be completed and saved before importing the Network IDs.)
Service Area ID *	Click the **Import Service Area IDs** button on the menu bar under the **Plans & Benefits** ribbon, and select the completed Service Area Template Excel file to import a list of values from the Service Area Template; then select the appropriate one from the drop-down menu. (The Excel version of the Service Area Template must be completed and saved before importing the Service Area IDs.)
Formulary ID	Click the **Import Formulary IDs** button on the menu bar under the **Plans & Benefits** ribbon, and select the completed Prescription Drug Template Excel file to import a list of values from the Prescription Drug Template; then select the appropriate one from the drop-down menu. (The Excel version of the Prescription Drug Template must be completed and saved before importing the Formulary IDs.)

4.3 Plan Attributes

This section includes fields for inputting more specific data for each plan, including its type, its metal level, and other plan-level requirements (Figure 2D-4).

Figure 2D-4. Specific Data Fields for Plan Attributes



Plan Attributes	Steps
New/Existing Plan? *	Indicate whether this is a new or existing plan. Choose from the following options:

Plan Attributes	Steps
	◆ **New**—if this is a new plan that was not offered last year. This includes a plan that was offered last year but is not considered to be the "same plan" as described in 45 CFR 144.103. These plans should use new Plan IDs that were not used for the 2017 plan year. ◆ **Existing**—if this plan was offered last year and the plan is considered to be the "same plan" as described in 45 CFR 144.103. These plans should use the same Plan ID that was used for the 2017 plan year.
Plan Type *#	Select the plan type that best corresponds to plan definitions provided in state law or regulations in the issuer's state. Plan type selections must be consistent with the issuer's state form-filing submissions. Choose from the following product network types: ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point-of-service) ◆ EPO (exclusive provider organization)
Level of Coverage ^*#	Select the metal level of the plan on the basis of its AV. A de minimis variation of -4/+2 percentage points is allowed for standard metal-level plans. Please note that, pursuant to 45 CFR 156.200(c), QHP issuers must offer at least one QHP in the silver coverage level and one QHP in the gold coverage level in each county they cover through the Marketplace, as described in Section 1302(d)(1) of the ACA. Choose from the following: ◆ **Bronze**—AV of 60 percent. ◆ **Expanded Bronze—**AV of 56 percent to 65 percent. This is a new option for PY2018 with an expanded AV de minimis range. A plan may use this option if it either covers and pays for at least one major service, other than preventive services, before the deductible, or meets the requirements to be a high deductible health plan within the meaning of 26 U.S.C. 223(c)(2). ◆ **Silver**—AV of 70 percent. ◆ **Gold**—AV of 80 percent. ◆ **Platinum**—AV of 90 percent. ◆ **Catastrophic**—offered to certain qualified individuals and families; it does not meet a specific AV but must comply with several requirements, including the MOOP and deductible limits. For SADP issuers, choose from the following: ◆ **Low**—AV of 70 percent. ◆ **High**—AV of 85 percent.
Design Type*	Indicate whether this plan will follow a Simple Choice plan design. An issuer may have up to five unique plans in each metal level that follow the Simple Choice plan design for that metal level. This designation is selected at the plan level but must be applied to all associated plan variations. For example, if the issuer selects "Design Type 1" for a silver plan, all of the corresponding silver plan variations must follow the cost sharing structure for their respective CSR Simple Choice plan designs. For more information on the Simple Choice plan design and populating plans' cost sharing using the **Simple Choice Plan** Add-In, see Section 5.12. Choose from the following: ◆ **Not Applicable**—if this plan does not follow a Simple Choice plan design. ◆ **Design Type 1**—if this plan will be the first Simple Choice plan design for a metal level. ◆ **Design Type 2**—if this plan will be the second Simple Choice plan design for a metal level. ◆ **Design Type 3**—if this plan will be the third Simple Choice plan design for a metal level.

Plan Attributes	Steps
	◆ **Design Type 4**—if this plan will be the fourth Simple Choice plan design for a metal level. ◆ **Design Type 5**—if this plan will be the fifth Simple Choice plan design for a metal level. An issuer may offer up to five plans with the Simple Choice plan design at each of the bronze, silver, and gold metal levels. The plans must meet meaningful difference requirements under 45 CFR 156.298 but may differ with respect to other features, such as product type (e.g., HMO vs. PPO), provider network, drug formulary, or additional benefits covered (e.g., adult dental). SADPs and SHOP plans should select **Not Applicable** for this field.
Unique Plan Design	Indicate whether the plan design is unique, meaning it cannot use the standard AVC developed and made available for HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix 1. Choose from the following options: ◆ **Yes**—if the unique plan design features cause the use of the AVC to yield an AV result that materially differs from that of the other approved methods described in 45 CFR 156.135(b). This indicates that the plan is not compatible with the AVC. If **Yes** is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification (see Supporting Document section). The signed and dated actuarial certification certifies that a member of the American Academy of Actuaries performed the calculation, which complies with all applicable federal and state laws and actuarial standards of practice. ◆ **No**—if the plan design is not unique.
QHP/Non-QHP*	Indicate whether the plan will be offered only outside the Exchange or whether the plan will be offered through and outside the Exchange. (An Exchange is also known as a Marketplace.) Choose from the following options: ◆ **On the Exchange**—under the guaranteed availability requirements in 45 CFR 147.104, a plan offered through the Marketplace generally must be available to individuals and employers (as applicable) in the state who apply for the plan outside the Marketplace. Issuers that offer a plan through the Marketplace should select the "Both" option below unless an exception to guaranteed availability applies. ◆ **Off the Exchange**—if the plan will be offered only outside the Marketplace. This includes non-QHPs as well as plans that are substantially the same as a QHP offered through the Marketplace for purposes of the risk corridor program (see 45 CFR 153.500 for more details). ◆ **Both**—if the plan will be offered both through and outside the Marketplace. A plan that is offered both through and outside the Marketplace must have the same premium, provider network, cost sharing structure, service area, and benefits, regardless of whether it is offered through or outside of the Marketplace. Selecting this option creates two separate plan variations in the Cost Share Variance worksheet when the worksheet is created: one on-Marketplace plan and one off-Marketplace plan.
Notice Required for Pregnancy	Indicate whether the plan has to be notified (by a member or a doctor) before pregnancy benefits are covered. Choose from the following options: ◆ **Yes**—if a notice is required. ◆ **No**—if a notice is not required.
Is a Referral Required for a Specialist? #	Indicate whether a referral is required to see a specialist. Choose from the following options: ◆ **Yes**—if a referral is required to see a specialist. ◆ **No**—if a referral is not required to see a specialist.
Specialist(s) Requiring a Referral #	(Required if "Yes" is entered for *Is a Referral Required for a Specialist?*). Enter the types of specialists that require a referral.
Plan Level Exclusions*	Enter any plan exclusions.

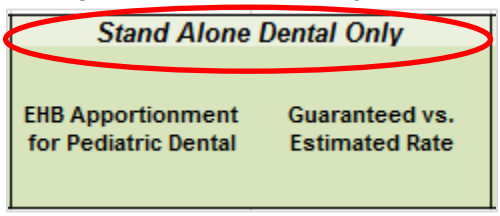
Plan Attributes	Steps
Limited Cost Sharing Plan Variation—Est Advance Payment	This data element is not necessary this year because, as specified in the annual 2015 HHS Notice of Benefit and Payment Parameters, beginning with the 2015 plan year, Marketplaces will calculate the advance payment amounts for CSRs for limited cost sharing plan variations. Therefore, leave this field blank.
Does this plan offer Composite Rating?	The ability for issuers and employers to use the composite premium field to indicate whether the plans' premiums will be available based on the average enrollee premium amounts has been deferred for 2018. Please leave the field populated to "No." ◆ **Yes**—if the plan offers composite rating. (For 2018, do not select this option.) ◆ **No**—if the plan does not offer composite rating.
Child-Only Offering *	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (offered only to individuals who, as of the beginning of the plan year, have not attained the age of 21 for QHP and 19 for SADP); one option must be selected consistent with the requirements at 45 CFR 156.200. This does not apply if the plan's level of coverage is catastrophic. Please note that FF-SHOP and the State Partnership SHOP (SP-SHOP) do not accommodate child-only plans for both medical and SADPs. Enrollment in FF-SHOP and SP-SHOP must include an employee enrollment. Choose from the following options: ◆ **Allows Adult and Child-Only**—if the plan allows adult and child-only enrollment and is offered at a child-only rate. ◆ **Allows Adult-Only**—if the plan does not allow child-only enrollment. This does not mean that only adults can enroll but that these plans require an adult as the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Since child-only plans are required if "Allows Adult-Only" is selected, as a work-around for FF-SHOP and SP-SHOP plans, issuers should designate these plans as "Allows Adult and Child-Only" and note in the *Plan Level Exclusions* field that the plan excludes child-only enrollment. (Does not apply to SADPs because they must have the option of being offered to child-only subscribers. Do not select this option unless the SADP is offered in the FF-SHOP or SP-SHOP.) ◆ **Allows Child-Only**—if the plan is a child-only plan that allows only child subscribers. (Do not select this option for SADP plans offered in the FF-SHOP and SP SHOP. ◆
Child-Only Plan ID	(Required if "Allows Adult-Only" is entered for *Child-Only Offering* for plans that are not catastrophic). Enter the corresponding 14-character Plan ID if this plan does not allow child-only enrollment. The entered Plan ID must correspond to a plan in which *Child-Only Offering* is equal to "Allows Adult and Child-Only" or "Allows Child-Only." The corresponding plan must have the same *Level of Coverage* as the plan for which the issuer is entering data.
Tobacco Wellness Program Offered	Indicate whether, as required to rate for tobacco use in the small group market, the plan offers a wellness program designed to prevent or reduce tobacco use that meets the standards of Section 2705 of the Public Health Service (PHS) Act. (This is unrelated to whether the plan provides benefits for recommended preventive services, including tobacco use counseling and interventions, under Section 2713 of the PHS Act.) Choose from the following options: ◆ **Yes**—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. ◆ **No**—if the plan does not offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter **No** if either of the following applies: ▪ The plan is offered in the individual market, or ▪ The plan is offered in the small group market and does not rate for tobacco use.

Plan Attributes	Steps
Disease Management Programs Offered[#]	Indicate whether the plan offers disease management programs. Choose one or more of the following options: ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure & High Cholesterol ◆ Low Back Pain ◆ Pain Management ◆ Pregnancy ◆ Weight Loss Programs
EHB Percent of Total Premium	Enter the percentage of the total premium that is associated with EHB services in each plan (including administrative expenses and profit associated with those services). This is required for all plans on the individual and SHOP markets except for catastrophic plans. This value will be used to calculate advanced premium tax credits and is required to match the value entered in the Unified Rate Review Template (URRT), except for catastrophic plans. For detailed instructions for completing this field, refer to the URRT instructions. Please note that if abortion services are included in the benefits package of the EHB benchmark plan, the portion of the premium related to these services is to be handled using two different methods in accordance with the criteria described below: ◆ If the plan is a QHP offered in the FFM or SBM, the percentage of the premium associated with abortion services should not be included in the EHB percentage (even though these services may be in the EHB benchmark package). The EHB percentage will be used in the calculation of subsidy amounts. Because subsidy payments may not be provided for costs associated with abortion services, they must be excluded from the EHB proportion. ◆ If the plan is not a QHP offered in the FFM or SBM, but rather is only offered in the outside market, the percentage of the premium associated with abortion services should be included in the EHB percentage. If abortion services are not included in the EHB benchmark package, any covered abortion services should be reflected in either the state-mandated benefits portion or the other benefits portion regardless of whether the plan is sold inside or outside of the Marketplace.

4.4 Stand-Alone Dental Only

The fields in this section apply to SADPs only (Figure D-5).

Figure 2D-5. SADPs Only Fields

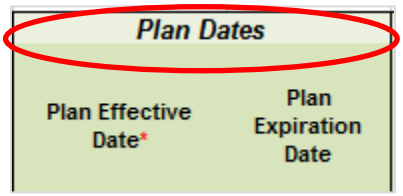


Stand-Alone Dental Only	*Steps*
EHB Apportionment for Pediatric Dental *	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age banded, use the EHB percent that applies to the pediatric rates. If the rates are family tiered, use the EHB percent of the individual rate assuming a child enrollment. This percentage is used to determine the amount of the advance payment of the premium tax credit required under 45 CFR 155.340(e)(2). Issuers must also submit the "Stand-Alone Dental Plans—Description of EHB Allocation" form as a supporting document.
Guaranteed vs. Estimated Rate *	This indicates whether the rate for this SADP is a guaranteed rate or an estimated rate. CMS calculates the rates a consumer sees using the Rates Table and the Business Rules Template. By indicating the rate is a "Guaranteed Rate," the issuer commits to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers' geographic location, age, and other permissible rating factors provided for in the Rates Table and Business Rules Templates. Estimated rates require enrollees to contact the issuer to determine a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported. Please note that FF-SHOP and SP-SHOP SADPs offered on the Marketplace does not accommodate estimated rates, and they must have guaranteed rates in order to be offered on the Marketplace. Select whether this plan offers guaranteed or estimated rates: ◆ **Guaranteed Rate**—if the plan offers a guaranteed rate. ◆ **Estimated Rate**—if the plan offers an estimated rate.

4.5 Plan Dates

This section contains fields for the effective date and expiration date for each plan. The FFM and FF-SHOP rating engine uses the effective dates in the Rates Table Template, not the Plans & Benefits Template (Figure 2D-6).

Figure 2D-6. Plan Dates

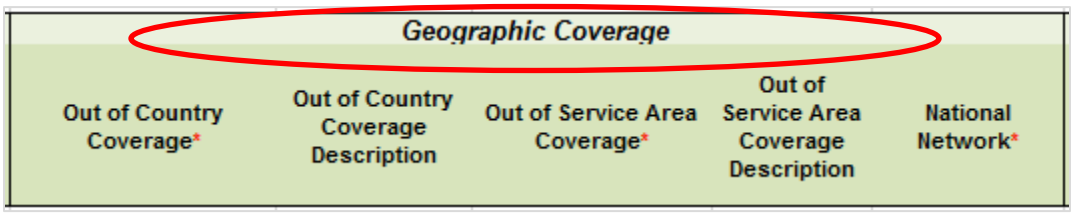


Plan Dates	Steps
Plan Effective Date *	This should be the effective date for the upcoming 2018 plan year—even for existing plans offered on-Marketplace in 2017. Enter the effective date of the plan using the mm/dd/yyyy format. This must be January 1, 2018, for all plans that will be offered through the FFM and FF-SHOP.
Plan Expiration Date *	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (it must be December 31, 2018, for the individual market). In the context of FF-SHOP, the plan is effective for a 12-month plan year. The plan expiration date is 12 months after the original employer coverage effective date.

4.6 Geographic Coverage

This section contains fields detailing coverage offered in other geographic locations. Issuers should only select **Yes** for these data elements if the plan offers the entire package of benefits for the geographic unit. Issuers should not select **Yes** if the plan covers only emergency services for the geographic unit (Figure 2D-7).

Figure 2D-7. Geographic Coverage Fields

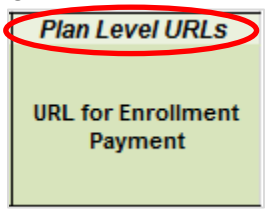


Geographic Coverage	Steps
Out of Country Coverage *	Indicate whether care obtained outside the country is covered under the plan. Choose from the following options: ◆ **Yes**—if the plan covers care obtained out of the country. ◆ **No**—if the plan does not cover care obtained out of the country.
Out of Country Coverage Description *	(Required if "Yes" is selected for *Out of Country Coverage*). Enter a short description of the care obtained outside the country that the plan covers.
Out of Service Area Coverage *	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options: ◆ **Yes**—if the plan covers care obtained outside the plan service area. ◆ **No**—if the plan does not cover care obtained outside the plan service area.
Out of Service Area Coverage Description *	(Required if "Yes" is entered for *Out of Service Area Coverage*). Enter a short description of the care obtained outside the service area that is covered under the plan.
National Network *#	Indicate whether a national network is available. Choose from the following: ◆ **Yes**—if a national network is available. ◆ **No**—if a national network is not available.

4.7 URLs

This section contains a field pertaining to URL information on plans (Figure 2D-8).

Figure 2D-8. URL Fields



URLs	Steps
URL for Enrollment Payment *	Enter the website location for enrollment payment information. Only submit a URL if it is a working payment site capable of collecting a consumer's first-month premium and it complies with the latest payment redirect business service description. URLs must start with "http://" or "https://" to work properly for the consumer. This is optional for SADPs.

4.8 Benefit Information

After completing the sections of the template discussed above, issuers will complete the Benefit Information section of the template to indicate the scope of benefits covered in their plans (Figure 2D-9).

Figure 2D-9. Benefits Information Template

Benefit Information				
Benefits	EHB	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity
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				
Routine Dental Services (Adult)				
Infertility Treatment				
Long-Term/Custodial Nursing Home Care				
Private-Duty Nursing				

Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. If this benefits package has multi-state plans using an alternate benchmark, click **Yes** to the pop-up. Otherwise, click **No**. The Plans & Benefits Add-In file has been updated to accurately reflect the current EHB benchmark data. Scroll down the worksheet to the Benefit Information section. The following fields may auto-populate, depending on the state, market type, and EHB benchmark:

- EHB
- Is this Benefit Covered?
- Quantitative Limit on Service
- Limit Quantity
- Limit Unit
- Exclusions
- Benefit Explanation

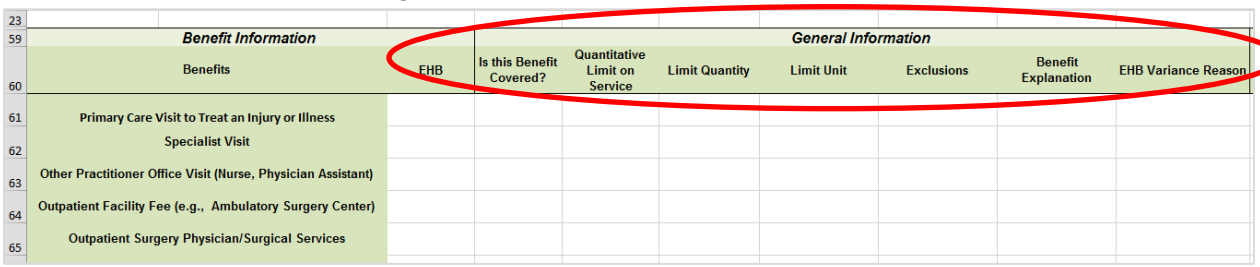
To add a benefit not listed on the template, click the **Add Benefit** button on the menu bar under the **Plans & Benefits** ribbon.

- Look through the drop-down menu to see whether the benefit already exists as an option, and select it if it does. If the benefit is not on this menu, click the **Custom** button and type in the benefit name. The benefit name may not be identical to any other benefit's name.
- A row for this benefit then appears below the last row in the Benefit Information section.
- If a benefit is mistakenly added, it cannot be deleted, but an issuer may do one of the following:
  - Select **Not Covered** under the *Is this Benefit Covered?* column (described below).
  - Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. This deletes the added benefit, but the issuer also loses any other data entered in the Benefit Information, General Information, or Out of Pocket Exceptions sections.
- If the benefit added is not found in the state's benchmark, and the issuer is not substituting for an EHB found in the state's benchmark, select **Not EHB** as the *EHB Variance Reason*.
- If the benefit added is not found in the state's benchmark, but the issuer is substituting for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the *EHB Variance Reason*.
- If the benefit added is a state-required benefit enacted after December 2011, select **Not EHB** as the *EHB Variance Reason*.
- For more information on how to select the correct EHB Variance Reason, see Section 5.6.
- A benefits package should not have multiple benefits with identical names. In the event of multiple cost sharing schemas for a given benefit based on multiple limits, choose the cost sharing type that applies to the limits in *Limit Quantity* and *Limit Unit* for each of the network types.

4.9 General Information

This section contains fields that give more information on each benefit in the benefits package, such as whether it is covered, whether it has any limits, and any applicable exclusions or benefit explanations (Figure 2D-10).

Figure 2D-10. General Information Fields



General Information	Steps
EHB *	This field is auto-populated for all benefits listed in the template that are covered by the state EHB benchmark plan for the market coverage. Issuers cannot edit this field. **Note**: Issuers should carefully review the benefits covered by their applicable EHB benchmark plan as identified on CMS's "Information on Essential Health Benefits (EHB) Benchmark Plans" webpage at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html. On the basis of their review of the applicable EHB benchmark plan documents, issuers may need to update the Benefits Package worksheet with any changes required to accurately reflect their coverage of EHB benchmark benefits. See the *EHB Variance Reason* field instructions below for more information on updating the Benefit Package worksheet.

General Information	Steps
Is this Benefit Covered? *	This field is auto-populated with **Covered** for benefits identified in the template as EHB. If the *Is this Benefit Covered?* data element is changed to **Not Covered**, the issuer must substitute another benefit in its place and provide the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution (see the *EHB Variance Reason* data field and Supporting Document section). If a benefit is marked as **Not Covered**, it does not appear on the Cost Share Variances worksheet and the remaining fields for this benefit may be left blank. Choose from the following options: ◆ **Covered**—if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar coverage or in combination with a cost sharing mechanism (e.g., copays, coinsurance, or deductibles). ◆ **Not Covered**—if this benefit is not covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service? *	(Required if **Covered** is entered for *Is this Benefit Covered?*). This field is auto-populated for benefits identified in the template as EHBs. If this data element is changed, an EHB variance reason must be provided and associated supporting documents. For any benefits not identified as EHBs, choose from the following options: ◆ **Yes**—if this benefit has quantitative limits. ◆ **No**—if this benefit does not have quantitative limits. **Note**: Pursuant to 45 CFR 156.115(a)(5)(iii), for plan years beginning on or after January 1, 2017, issuers may not impose combined limits on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Plans & Benefits Template Benefit Package worksheet, issuers must provide a separate limit for those benefits.
Limit Quantity *#	(Required if **Yes** is entered for *Quantitative Limit on Service?*). This field is auto-populated for benefits in the template identified as EHBs. If the issuer changes this data element, it must provide an *EHB Variance Reason*. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., a limit of two specialist visits per year, enter “2” here).
Limit Unit *#	(Required if **Yes** is entered for *Quantitative Limit on Service?*). This field is auto-populated for benefits in the template identified as EHBs. If data are changed for this element, select the *EHB Variance Reason* of **Substantially Equal**. For any benefits not identified as EHBs, using the drop-down menus, enter the units being restricted per interval to show the quantitative limits that are placed on this benefit (e.g., if the plans have a limit of two specialist visits per year, enter **Visits per year** here). Choose from the following options: ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year ◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits

General Information	Steps
	◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollar per year ◆ Dollar per visit ◆ Days per admission ◆ Procedures per episode. If a benefit has limit units that do not align with the list above, the limit does not auto-populate in the *Limit Unit* field but does auto-populate in the *Benefit Explanation* field (e.g., a limit of one hearing aid per ear every 48 months for subscribers up to age 18). If a benefit has quantitative limits that span several types of services, they do not auto-populate. See the EHB benchmarks on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). The message "Quantitative limit units apply, see EHB benchmark" appears in the *Benefit Explanation* field (e.g., Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services). If a benefit has multiple limit units, they do not auto-populate. Put the limit quantity and limit unit that should be displayed on the Plan Compare function of the FFM website in these columns, and put all other quantitative limits in the *Benefit Explanation* field (e.g., Outpatient Rehabilitative Services—90 days per year in the *Limit Quantity* and *Limit Unit* columns; two treatments per year in the benefit explanation). The message "Quantitative limit units apply, see EHB benchmark" may appear in the *Benefit Explanation* field for a benefit that does not have quantitative limits in the "Benefits and Limits" section of the EHB benchmark on the CCIIO website (http://www.cciio.cms.gov/resources/data/ehb.html). This message appears because certain benefits, identified in the *Other Benefits* section of the EHB benchmark Benefit Template, may have quantitative limits, which may not apply to all services in the higher-level benefit category.
Exclusions *#	Enter any benefit-level exclusions. ◆ If particular services or diagnoses are subject to exclusions (covered under some circumstances but not others), list those specific exclusions. ◆ If no services or diagnoses are excluded, leave this field blank.
Benefit Explanation *#	Enter any benefit explanations. ◆ Examples of benefit explanations include additional quantitative limits, links to additional plan documents, child-specific MOOP or deductible limits, detailed descriptions of services provided, and alternate cost-sharing structures if they depend on provider type or place of service.
EHB Variance Reason *	(Required if the issuer changed the fields *Is this Benefit Covered?*, *Limit Units*, or *Limit Quantity* or if the benchmark has an unallowable limit or exclusion under the ACA). Select from the following *EHB Variance Reasons* if this benefit differs from the state's benchmark: ◆ **Not EHB**—if this benefit is not an EHB.

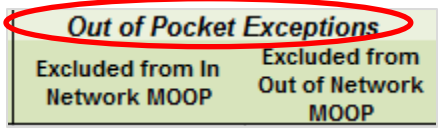
General Information	Steps
	▪ If the issuer has added a new benefit and it is not found in the state's benchmark, the *EHB* field will be blank and the issuer should set the *EHB Variance Reason* to **Not EHB**. This benefit is not considered an EHB. ▪ If a benefit auto-populated as **Yes** in the *EHB* column, but the issuer has received guidance from CMS or the state indicating that it should not be considered an EHB, set the *EHB Variance Reason* to **Not EHB**. This benefit is not considered an EHB. ◆ **Substituted—**if a benefit is included in the state's benchmark, the *EHB* field auto-populates as **Yes**. If substituting a different benefit for an EHB, set the *EHB Variance Reason* field to **Substituted** and the *Is this Benefit Covered?* field to **Not Covered**. The benefit that takes its place must be designated as **Additional EHB Benefit**, and the issuer must provide the "EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification" document to support the actuarial equivalence of the substitution. ◆ **Substantially Equal—**if the *Limit Quantity* for a benefit differs from the limit quantity in the EHB benchmark, but is still substantially equal to the EHB benchmark, select **Substantially Equal** as the *Variance Reason*. Also, if the *Limit Unit* for a benefit differs from the limit unit in the EHB benchmark, but is still substantially equal to the EHB benchmark, select **Substantially Equal** as the *Variance Reason*. For example, if the benchmark lists a limit of 40 hours per month, and the plan defines a day as 8 hours and lists a limit of 5 days per month, the issuer should use that variance reason. ◆ **Using Alternate Benchmark—**multi-state plans use an alternate benchmark. Issuers should select this EHB variance reason for any benefit that has **Yes** for EHB but is not an EHB in the alternate benchmark. ◆ **Other Law/Regulation**—if a benefit is required by a state or federal law or regulation that was enacted on or before December 31, 2011, and the benefit is not represented in the state's EHB benchmark plan. (State-required benefits that were enacted after December 31, 2011, are not EHBs, and for those the issuer should use **Not EHB** as the variance reason instead.) For example, a benefit may not appear as an EHB because the benchmark plan is a small group plan and coverage is only state-required in the individual market. When an issuer is filling out the template for an individual market plan, coverage of the benefit must be changed from blank to **Covered** using the EHB variance reason "Other Law/Regulation." ◆ **Additional EHB Benefit**—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list by state. For example, non-preferred brand drug benefits may appear as not being covered in the auto-populated table when they actually are. In this case, change the benefit to **Covered,** and choose **Additional EHB Benefit** as the EHB variance reason. This benefit is considered an EHB, and cost sharing values for the plan variations should be entered accordingly. ◆ **Dental Only Plan Available—**if a dental benefit auto-populates as **Covered**, but the issuer is not covering a benefit because it is a dental EHB covered by a separate dental only plan, set the *EHB Variance Reason* to **Dental Only Plan Available**. For example, an issuer may offer SADPs to cover pediatric dental benefits, so they will not need to cover pediatric dental as part of the medical plans. The issuer would select **Not Covered** and select **Dental Only Plan Available** as the EHB variance reason for benefits, such as *Dental Check-Up for Children*, *Basic Dental Care—Child*, *Orthodontia—Child*, and *Major Dental Care—Child* if the benefits are designated as a **Covered** EHB. (This option is not applicable to SADPs) **Note**: Because EHB benchmark plan benefits are based on plans that were sold in 2012 or 2014, some of the benchmark plan designs may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, issuers may need to conform plan benefits, including coverage and limitations, to comply with these requirements and limitations. Therefore, issuers should carefully review the information available on the CMS

General Information	Steps
	"Information on Essential Health Benefits (EHB) Benchmark Plans" webpage (https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html). If more than one EHB variance reason applies, select the option related to EHB designation instead of the one related to limits. For example, if an issuer adds a new benefit that is an EHB and also changes its limits, the EHB variance reason that should be selected is "Additional EHB Benefit" instead of "Substantially Equal." It is important that the issuer enter the correct *EHB Variance Reason* because it has implications for nondiscrimination and EHB reviews as well as cost sharing requirements for EHBs and non-EHBs related to cost sharing reduction plan variations.

4.10 Out-of-Pocket Exceptions

This section is for indicating whether each benefit is excluded from the MOOP. All plans in a benefits package must have the same MOOP structure and exclude the same benefits from the MOOP. To create plans with a different MOOP structure, issuers must create a new benefits package and then a new Cost Share Variances worksheet (Figure 2D-11).

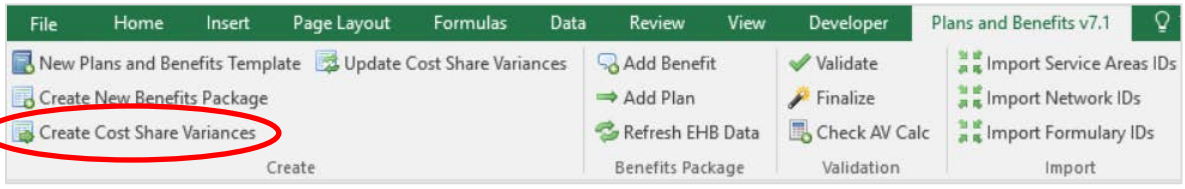
Figure 2D-11. Out of Pocket Exceptions



Out-of-Pocket Exceptions	Steps
Excluded from In-Network MOOP *	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following options: ◆ **Yes**—if this benefit is excluded from the in-network MOOP. ◆ **No**—if this benefit is not excluded from the in-network MOOP.
Excluded from Out-of-Network MOOP *	Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following options: ◆ **Yes**—if this benefit is excluded from the out-of-network MOOP. ◆ **No**—if this benefit is not excluded from the out-of-network MOOP.
◆ If the plans only have a combined (no separate in-network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP.* ◆ If *Is this Benefit Covered?* for a benefit is **Not Covered**, or blank, leave *Excluded from In Network MOOP* and *Excluded from Out of Network MOOP* blank. ◆ If the plans do not have an out-of-network MOOP, set *Excluded from Out of Network MOOP* equal to **Yes**.	

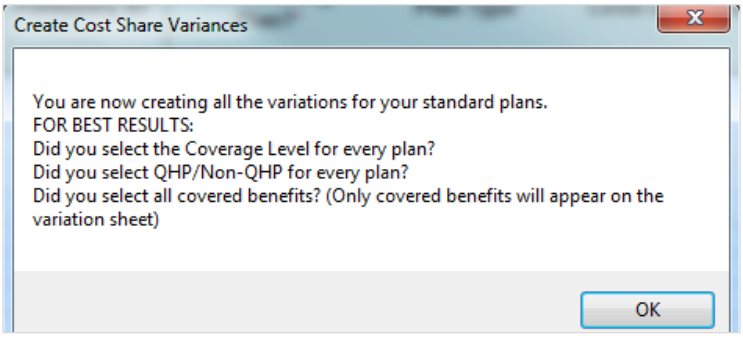
After the above benefit-related information is entered in the Benefits Package worksheet, click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-12). The Cost Share Variances worksheet is designed to collect more detailed cost sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

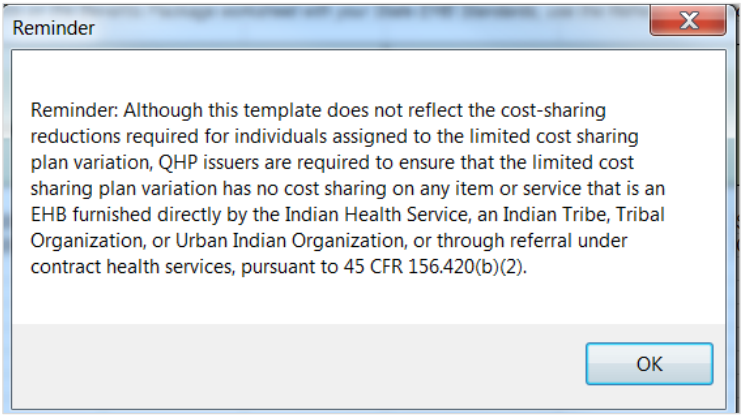
Figure 2D-12. Create Cost Share Variances Button



Click **OK** after reading the warnings (Figure 2D-13), and make any necessary changes.

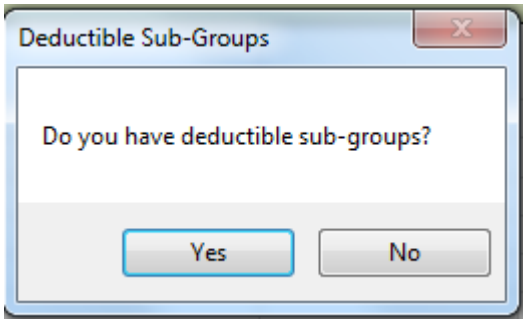
Figure 2D-13. Warning Pop-Up Boxes





The following questions pop up regarding deductible sub-groups (Figure 2D-14). Deductible sub-groups should be used to identify benefits or groupings of benefits that have their own deductibles. These deductible sub-groups are not separate deductibles outside any maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to have any deductible sub-groups.

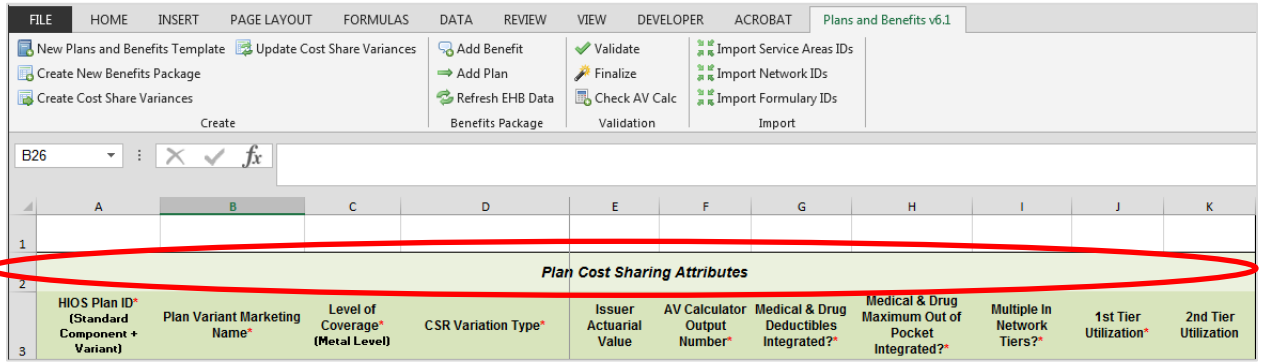
Figure 2D-14. Deductible Sub-Groups



1. Do you have any deductible sub-groups?
    a. **Yes**—if the plan contains deductible sub-groups.
    b. **No**—if the plan does not contain deductible sub-groups.
2. How many deductible sub-groups do you have? Enter the correct number, and click **OK**.
3. What is the name of this deductible sub-group? Enter the name of each sub-group, and click **OK** after each. You must use a different name for each sub-group.

A new worksheet, Cost Share Variances, is created for each Benefits Package worksheet (Figure 2D-15). Corresponding worksheets are labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2. The worksheet contains several auto-populated cells; verify that the information in each is accurate.

Figure 2D-15. Cost Share Variances Worksheet



For details on updating the Cost Share Variances worksheet after it has been created and incorporating changes made to the Benefits Package worksheet, see Section 5.4.

4.11 Plan Cost-Sharing Attributes

This section has fields with basic information on each plan and cost sharing reduction plan variation, such as its Plan ID, marketing name, and metal level. It also asks questions about the medical and drug integration for deductibles and MOOP to determine the appropriate columns to fill out later in the template.

Note: The Cost Share Variances worksheet is designed to collect more detailed cost sharing benefit design information for all plans and plan variations submitted by the issuer. However, cost-sharing reductions do not apply to SADPs.

Plan Cost Sharing Attributes	Steps
HIOS Plan ID *	The HIOS-generated number auto-populates for each cost sharing plan variation. ◆ Standard plans to be offered on the Marketplace have a Plan ID variant suffix of "-01," and standard plans to be offered outside the Marketplace have a Plan ID variant suffix of "-00." ◆ For the individual market, each standard plan (except for catastrophic) has two cost sharing reduction plan variations for American Indians and Alaska Natives: one with zero cost sharing and one with limited cost sharing. These are indicated with a Plan ID variant suffix of "-02" and "-03," respectively. ▪ In the zero cost sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs. ▪ In the limited cost sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian health care provider or from another provider if they have a referral from an Indian health care provider. ◆ Also in the individual market, each silver plan has three additional cost sharing reduction plan variations created: a 73 percent AV plan, an 87 percent AV plan, and a 94 percent AV plan. These are indicated with a Plan ID variant suffix of "-04," "-05," and "-06," respectively. ▪ These silver plan variations offer a discount that lowers the amount consumers have to pay out-of-pocket for deductibles, coinsurance, and copayments, and there is also a lower MOOP. Consumers qualify for these plans if their income is below a certain level.
Plan Variant Marketing Name *#	The name of the plan auto-populates for all standard plans and plan variations with the standard plan's plan marketing name. The field can be edited on this worksheet for each of the plan variations. The marketing name entered for each plan variation on this worksheet will be the one that displays to consumers. The field has a limit of 255 characters.
Level of Coverage ^*	The coverage level for the plan auto-populates for standard plans.
CSR Variation Type ^	The plan variation type auto-populates. This defines the plan variation as a standard on-Exchange plan, a standard off-Exchange plan, or one of the cost sharing reduction plan variations explained in this section.
Issuer Actuarial Value *	(Required if **Yes** is entered for *Unique Plan Design*). Enter the issuer-calculated AV. This applies to health plans that indicate they are a unique plan for AV purposes and SADP. SADP issuers must submit the "Stand-Alone Dental Plan Actuarial Value" supporting documentation certifying that their actuarial value was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methods.
AV Calculator Output Number	Clicking the **Check AV Calc** button on the **Plans & Benefits** ribbon and selecting the correct file populates this field with the AV for all plans on this worksheet with a non-unique plan design. All cost sharing information and benefits package information must be filled in before clicking this button. (For more information, see Appendix 1.)
Medical & Drug Deductibles Integrated? ^	Indicate whether the medical and drug deductible is integrated. An integrated deductible means that both medical and drug charges contribute to a total plan-level deductible. A separate deductible means medical and drug charges contribute to separate plan-level deductibles. Choose from the following options: ◆ **Yes**—if the medical and drug deductible is integrated. If **Yes** is entered, issuers should not enter information in the following sections: *Medical Deductible* and *Drug Benefits Deductible*. ◆ **No**—if the medical and drug deductible is not integrated. If **No** is entered, issuers should not enter information in the following section: *Combined Medical & Drug Deductible*.

Plan Cost Sharing Attributes	Steps
Medical & Drug Maximum Out of Pocket Integrated? ^	Indicate whether the medical and drug MOOP is integrated. An integrated MOOP means that both medical and drug charges contribute to a total plan-level MOOP. A separate MOOP means medical and drug charges contribute to separate plan-level MOOP values. Choose from the following options: ◆ **Yes**—if the medical and drug MOOP is integrated. If **Yes** is entered, issuers should not enter information in the following sections: *Maximum Out of Pocket for EHB Benefits* and *Maximum Out of Pocket for Drug Benefits.* ◆ **No**—if the medical and drug deductible MOOP is not integrated. If **No** is entered, issuers should not enter information in *Maximum Out of Pocket for EHB and Drug Benefits (Total).*
Multiple In Network Tiers? ^*	Indicate whether there are multiple in-network provider tiers, meaning that the plan applies to different levels of in-network cost sharing depending on the tier of the provider or facility. The value must be the same for all variations of a plan. Choose from the following options: ◆ **Yes**—if there are multiple in-network provider tiers. Enter Tier 1 information into the *In Network* and *In Network (Tier 1)* sections and Tier 2 information into the *In Network (Tier 2)* sections. ◆ **No**—if there are not multiple in-network provider tiers. Issuers will not be able to enter information into the *In Network (Tier 2)* sections, which will be grayed out and locked for editing.
1st Tier Utilization ^*	If the answer to *Multiple In Network Tiers?* is **Yes**, enter the *1st Tier Utilization* as a percentage here. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. If the answer to *Multiple In Network Tiers?* is **No**, the field auto-populates to "100%." (All plan variations must have the same 1st tier utilization as the standard plan.)
2nd Tier Utilization ^*	If the answer to *Multiple In Network Tiers?* is **Yes**, enter the *2nd Tier Utilization* as a percentage here. This cell will be grayed out and locked for editing if the answer to *Multiple In-Network Tiers?* is **No**. (All plan variations have the same 2nd tier utilization as the standard plan.)

4.12 Summary of Benefits and Coverage (SBC) Scenario

This section contains fields for basic information on three Summary of Benefits and Coverage (SBC) scenarios. This section is not applicable to SADPs. Additional information containing SBC scenario coverage examples and further resources for completing the scenarios can be found in the Summary of Benefits and Coverage and Uniform Glossary section of the website at http://www.cms.gov/cciio/Resources/Forms-Reports-and-Other-Resources/index.html. Any other concerns or technical assistance inquiries about these fields can be directed to sbc@cms.hhs.gov. Fill out the following data fields for all three coverage examples (*Having a Baby*, *Having Diabetes,* and *Treatment of a Simple Fracture*).

Plan Cost Sharing Attributes	Steps
Deductible #	Enter the numerical value for the deductible.
Copayment #	Enter the numerical value for the copayment.
Coinsurance #	Enter the numerical value for the coinsurance.
Limit #	Enter the numerical value for the benefit limits or exclusion amount.

4.13 Maximum Out-of-Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Not all of the sections should be filled out, depending on whether the medical and drug MOOP and deductibles are integrated, as indicated through the entries in the fields *Medical & Drug Deductibles Out of Pocket Integrated?*

and *Medical & Drug Maximum Out of Pocket Integrated?*. SADP issuers should skip to Sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (For guidance filling out the MOOP and Deductible sections of the template, and ensuring that all requirements are met, see Section 5.1.)

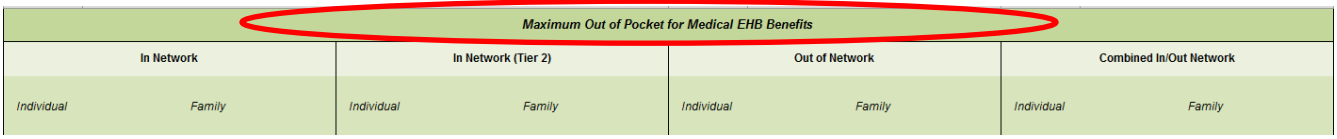
As of PY2016, the *Family* fields for *In Network, In Network (Tier 2),* and *Out of Network* MOOP and deductibles will have additional options. When selecting these fields, a pop-up will appear allowing the issuer to enter a per-group amount and a per-person amount. The per-group amount is the total MOOP or deductible limit when accruing costs for all members in a family (i.e., any coverage other than self-only). The per-person amount is the MOOP or deductible limit that applies separately to each person in a family. The *Per Person* and *Per Group* fields will be displayed to consumers on Plan Compare when they are shopping for coverage with more than one person in the enrollment group. The following requirements apply to this new field:

- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan ($7,350) and for the specific cost sharing reduction plan variations. See Section 5.5 for more details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.
- There must be a per-person amount and per-group amount entered for MOOP; the issuer may not enter **Not Applicable** for all these cells in all *Family* fields. The only exception is if a given plan is available to consumers only as self-only coverage.

4.14 Maximum Out-of-Pocket for Medical EHB Benefits

This section falls after the SBC Scenario section. Its layout is shown in Figure 2D-16.

Figure 2D-16. MOOP Fields



This section is used for inputting MOOP values for medical EHB benefits and is required only if the medical and drug MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for EHB benefits in the following areas of the template.

MOOP Medical EHB Benefits	*Steps*
In Network—Individual ^#	If MOOPs are not integrated, enter the dollar amount for Medical In Network Individual Maximum Out of Pocket for EHB Benefits.
In Network—Family ^#	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Medical In Network Family Maximum Out of Pocket for EHB Benefits.
In Network (Tier 2)—Individual ^	If MOOPs are not integrated and the plan has multiple in-network tiers, enter the dollar amount for Medical In Network (Tier 2) Individual Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and cannot be edited.
In Network (Tier 2)—Family	If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for Medical In Network (Tier 2) Family Maximum Out of Pocket for EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If MOOPs are not integrated, enter the dollar amount for Medical Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Out of Network—Family	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Medical Out of Network Family Maximum Out of Pocket for EHB Benefits.

MOOP Medical EHB Benefits	Steps
Combined In/Out Network—Individual ^#	If MOOPs are not integrated, enter the dollar amount for Medical Combined In/Out of Network Individual Maximum Out of Pocket for EHB Benefits.
Combined In/Out Network—Family #	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Medical Combined In/Out of Network Family Maximum Out of Pocket for EHB Benefits.

4.15 Maximum Out-of-Pocket for Drug EHB Benefits

This section is used for inputting MOOP values for drug EHB benefits and is required only if the medical and drug MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for drug EHB benefits in the following areas of the template.

MOOP Drug EHB Benefits	Steps
In Network—Individual ^#	If MOOPs are not integrated, enter the dollar amount for In Network Individual Maximum Out of Pocket for Drug EHB Benefits.
In Network—Family #	If MOOPs are not integrated, enter the per-person and per-group dollar amount for In Network Family Maximum Out of Pocket for Drug EHB Benefits.
In Network (Tier 2)—Individual ^	If MOOPs are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Individual* field.)
In Network (Tier 2)—Family	If the MOOPs are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Maximum Out of Pocket for Drug EHB Benefits. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Family* field.)
Out of Network—Individual	If MOOPs are not integrated, enter the dollar amount for Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Out of Network—Family	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Individual ^#	If MOOPs are not integrated, enter the Combined In/Out of Network Individual Maximum Out of Pocket for Drug EHB Benefits.
Combined In/Out Network—Family #	If MOOPs are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits.

4.16 Maximum Out-of-Pocket for Medical and Drug EHB Benefits (Total)

This section is used for inputting MOOP values for medical and drug EHB benefits, and is required only if the medical and drug MOOPs are integrated (**Yes** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*). If the MOOPs are not integrated (**No** is entered for *Medical & Drug Maximum Out of Pocket Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the

drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for medical and drug EHB benefits in the following areas on the template.

MOOP Medical & Drug EHB Benefits	Steps
In Network—Individual ^#	If MOOPs are integrated, enter the dollar amount for the Total In Network Individual Maximum Out of Pocket.
In Network—Family #	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total In Network Family Maximum Out of Pocket.
In Network (Tier 2)—Individual ^	If MOOPs are integrated and the plan has multiple in-network tiers, enter the dollar amount for the Total In Network (Tier 2) Individual Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If the MOOPs are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for the Total In Network (Tier 2) Family Maximum Out of Pocket. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If MOOPs are integrated, enter the dollar amount for the Total Out of Network Individual Maximum Out of Pocket.
Out of Network—Family	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Out of Network Family Maximum Out of Pocket.
Combined In/Out Network—Individual ^#	If MOOPs are integrated, enter the dollar amount for the Total Combined In/Out of Network Individual Maximum Out of Pocket.
Combined In/Out Network—Family #	If MOOPs are integrated, enter the per-person and per-group dollar amount for the Total Combined In/Out of Network Family Maximum Out of Pocket.

4.17 Medical EHB Deductible

This section is used for inputting deductible values for medical EHB benefits and is required only if the medical and drug deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for EHB benefits in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for In Network Individual Medical EHB Deductible.
In Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Medical EHB Deductible.
In Network—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. **Note**: If deductibles are not integrated, this is a required field for the AV calculation for those plans using the AVC.
In Network (Tier 2)—Individual ^	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Medical EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.

Medical EHB Deductible	Steps
In Network (Tier 2)—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Medical Deductible.
Out of Network—Family	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Medical EHB Deductible.
Combined In/Out Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Medical EHB Deductible.
Combined In/Out Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Medical EHB Deductible.

4.18 Drug EHB Deductible

This section is used for inputting deductible values for drug EHB benefits and is required only if the medical and drug deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for drug EHB benefits in the following areas on the template.

Drug EHB Deductible	Steps
In Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for In Network Individual Drug EHB Deductible.
In Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Drug EHB Deductible.
In Network—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual ^	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Individual* field.)
In Network (Tier 2)—Family	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Family* field.)
In Network (Tier 2)—Default Coinsurance ^	If deductibles are not integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing. (If the issuer has multiple tiers only for medical EHB benefits and not for drug EHB benefits, this value should be the same as the Tier 1 value in the *In Network—Default Coinsurance* field.)
Out of Network—Individual	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Drug EHB Deductible.
Out of Network—Family	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Drug EHB Deductible.

Drug EHB Deductible	Steps
Combined In/Out Network—Individual ^#	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Drug EHB Deductible.
Combined In/Out Network—Family #	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Drug EHB Deductible.

4.19 Combined Medical and Drug EHB Deductible

This section is used for inputting deductible values for medical and drug EHB benefits and is required only if the medical and drug deductibles are integrated (**Yes** is entered for *Medical & Drug Deductibles Integrated?*). If the deductibles are not integrated (**No** is entered for *Medical & Drug Deductibles Integrated?*), this section must be left blank; the fields will be grayed out and locked for editing. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for medical and drug EHB benefits in the following areas on the template.

Medical & Drug EHB Deductible	Steps
In Network—Individual ^#	If deductibles are integrated, enter the dollar amount for In Network Individual Combined Medical and Drug EHB Deductible.
In Network—Family #	If deductibles are integrated, enter the per-person and per-group dollar amount for In Network Family Combined Medical and Drug EHB Deductible.
In Network—Default Coinsurance ^	If deductibles are integrated, enter the numerical value for the in-network coinsurance. (If deductibles are integrated, this field is required for the AV calculation for plans using the AVC.)
In Network (Tier 2)—Individual ^	If deductibles are integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Family	If deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Combined Medical and Drug EHB Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network (Tier 2)—Default Coinsurance ^	If deductibles are integrated, enter the numerical value for the in-network coinsurance. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual	If deductibles are integrated, enter the dollar amount for Out of Network Individual Combined Medical and Drug EHB Deductible.
Out of Network—Family	If deductibles are integrated, enter the per-person and per-group dollar amount for Out of Network Family Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Individual ^#	If deductibles are integrated, enter the dollar amount for Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible.
Combined In/Out Network—Family #	If deductibles are integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Combined Medical and Drug EHB Deductible.

4.20 Maximum Out-of-Pocket for Dental EHB Benefits

This section is used for inputting MOOP values for dental EHBs. When entering the MOOP values, ensure that the following limits are met: The MOOP values must be equal to or below the required limits of $350 for one covered child (considered the “individual” limit) and $700 for two or more covered children (considered the “family” limit). To include multiple children in child-only plans, use the “family” fields. (For SADPs, an individual is considered one child and a family is considered two or more children.) Using the drop-down menus, enter the

appropriate values for the *Individual* and *Family* MOOP for EHB dental benefits in the following areas of the template.

MOOP Dental EHB Benefits	Steps
In Network—Individual *^#	Enter the dollar amount for Dental In Network Individual MOOP for EHB Benefits.
In Network—Family *#	Enter the per-person and per-group dollar amount for Dental In Network Family MOOP for EHB Benefits.
In Network (Tier 2)—Individual *^	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental for EHB Benefits.
In Network (Tier 2)—Family *	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family MOOP for EHB Benefits.
Out of Network—Individual *	Enter the dollar amount for Dental Out of Network Individual MOOP for EHB Benefits.
Out of Network—Family *	Enter the per-person and per-group dollar amount for Dental Out of Network Family MOOP for EHB Benefits.
Combined In/Out Network—Individual *^#	Enter the dollar amount for Dental Combined In/Out of Network Individual MOOP for EHB Benefits.
Combined In/Out Network—Family *#	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family MOOP for EHB Benefits.

4.21 Dental EHB Deductible

This section is used for inputting deductible values for dental EHB benefits. The deductible value may not be higher than the MOOP value. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* deductible for EHB benefits in the following areas on the template.

Dental EHB Deductible	Steps
In Network—Individual *^#	Enter the dollar amount for Dental In Network Individual Deductible.
In Network—Family *#	Enter the per-person and per-group dollar amount for Dental In Network Family Deductible.
In Network—Default Coinsurance *^	Enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual *^	Enter the dollar amount for Dental In Network (Tier 2) Individual Dental Deductible.
In Network (Tier 2)—Family *	Enter the per-person and per-group dollar amount for Dental In Network (Tier 2) Family Deductible.
Out of Network—Individual *	Enter the dollar amount for Dental Out of Network Individual Deductible.
Out of Network—Family *	Enter the per-person and per-group dollar amount for Dental Out of Network Family Deductible.
Combined In/Out Network—Individual *^#	Enter the dollar amount for Dental Combined In/Out of Network Individual Deductible.
Combined In/Out Network—Family *#	Enter the per-person and per-group dollar amount for Dental Combined In/Out of Network Family Deductible.

4.22 Other Deductible

Issuers should complete this section if they have deductible sub-groups; they can add an unlimited number of deductible sub-groups and name them. Enter the appropriate values for the *Individual* and *Family* data elements in the following areas on the template. (These values are not separate deductibles outside any maximums allowed, and they still contribute to the MOOP and deductible limits.)

Other Deductible	*Steps*
In Network—Individual *^#	If deductibles are not integrated, enter the dollar amount for In Network Individual Other Deductible.
In Network—Family *#	If deductibles are not integrated, enter the per-person and per-group dollar amount for In Network Family Other Deductible.
In Network Tier 2—Individual *^	If deductibles are not integrated and the plan has multiple in-network tiers, enter the dollar amount for In Network (Tier 2) Individual Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
In Network Tier 2—Family *	If deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amount for In Network (Tier 2) Family Other Deductible. If there are not multiple in-network tiers, this field will be grayed out and locked for editing.
Out of Network—Individual *	If deductibles are not integrated, enter the dollar amount for Out of Network Individual Other Deductible.
Out of Network—Family *	If deductibles are not integrated, enter the per-person and per-group dollar amount for Out of Network Family Other Deductible.
Combined In/Out Network—Individual *	If deductibles are not integrated, enter the dollar amount for Combined In/Out of Network Individual Other Deductible.
Combined In/Out Network—Family *	If deductibles are not integrated, enter the per-person and per-group dollar amount for Combined In/Out of Network Family Other Deductible.

4.23 Health Savings Account (HSA)/Health Reimbursement Account (HRA) Detail

HSA/HRA Detail	Steps
HSA-Eligible ^#	Indicate whether the plan meets all requirements to be an HSA-eligible plan. Choose from the following: ◆ **Yes**—if the plan meets all HSA requirements. ◆ **No**—if the plan does not meet all HSA requirements.
HSA/HRA Employer Contribution ^	(Required for small group only; must be left blank for individual market). Indicate whether the employer contributes to an HSA/HRA. Choose from the following: ◆ **Yes**—if the plan has an HSA/HRA employer contribution. ◆ **No**—if the plan does not have an HSA/HRA employer contribution.
HSA/HRA Employer Contribution Amount ^	(Required if **Yes** is entered for *HSA/HRA Employer Contribution*; must be left blank for individual market). Enter a numerical value representing the employer contribution amount to HSA/HRA. The template does not permit an individual market plan to enter an HSA/HRA contribution amount. As discussed at 78 *Federal Register* (FR) 12850, Col. 3 (February 25, 2013), because the issuer uses the AVC to determine a plan's AV, the HSA employer contribution or the amount newly made available by the employer under an integrated HRA that may be used only for cost sharing may be considered part of the AV calculation when the contribution is available and known to the issuer at the time the plan is purchased.

4.24 URLs

This section contains fields for URLs for applicable websites. URLs must start with "http://" or "https://" to work properly for the consumer. To give consumers access to all relevant plan information needed to compare and select plans, CMS asks that issuers ensure that their URLs link directly to up-to-date and accurate information that is readily obtainable on their websites. Issuers should ensure that prospective enrollees can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

Issuer URLs should link directly to each SBC and each plan brochure, respectively, for the standard plan or plan variation in question. This will provide consumers with the best and most accurate shopping experience when searching for available plans through FFMs. Linking directly to the SBCs and plan brochures will guarantee that consumers will see the document that directly applies to the health plan that they are considering for purchase.

As part of the ongoing compliance monitoring, CMS may compare the benefits coverage and cost sharing information inputted in the Plans & Benefits Template with the information issuers provide to consumers on the plan's SBC and plan brochure. Please take care to review the information submitted on this template, as well as what coverage is represented on the plan's SBC and the plan brochure to ensure that all of this information is aligned with the actual terms of coverage before submission.

URLs	Steps
URL for Summary of Benefits & Coverage#	Enter the URL that takes the consumer directly to the SBC content for the specific standard plan or plan variation. As defined in 45 CFR 155.205(b)(1)(ii), plans will not be displayed to consumers if this field is not completed.
Plan Brochure #	◆ Enter the URL that goes directly to the plan brochure for the specific standard plan or plan variation. These documents should clearly communicate any cost sharing and other information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage. For example, if the plan has different cost sharing for benefits depending on service location, further details on these cost sharing differences should be communicated through the plan brochure. ◆ CMS expects that issuers submit SBC and plan brochure URLs by the final deadline for submission of QHP data so that the FFM can meet its responsibility to provide

URLs	Steps
	consumer's access to the appropriate SBCs through its website (see 45 CFR 155.205). CMS expects these links to be active and directly route the user to the appropriate document by the time the issuer has signed its QHP agreements. Issuers are strongly encouraged to submit these links and make them active earlier so that they can fully test their data through Plan Preview.

4.25 AV Calculator Additional Benefit Design

This section contains optional fields, which may be filled out for use as inputs in the AVC.

URLs	Steps
Maximum Coinsurance for Specialty Drugs ^	Indicate whether the per-script coinsurance amount for specialty drugs is capped at a set amount. Enter the maximum coinsurance payments allowed for specialty prescription drugs. If no maximum coinsurance exists, leave the field blank.
Maximum Number of Days for Charging an Inpatient Copay? ^	Indicate whether there is a limit on the number of days that a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day. Enter the maximum number of days allowed (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost-Sharing After a Set Number of Visits? ^	Indicate whether primary care cost sharing begins after a certain number of fully covered visits. Enter the maximum number of fully covered visits (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? ^	Indicate whether primary care visits are subject to the deductible and/or coinsurance after a certain number of primary care visits with copay have occurred. Enter the maximum number of copay visits (1–10) that can occur before visits become subject to the deductible and/or coinsurance. If this option does not apply, leave the field blank.

4.26 Covered Benefits

This section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

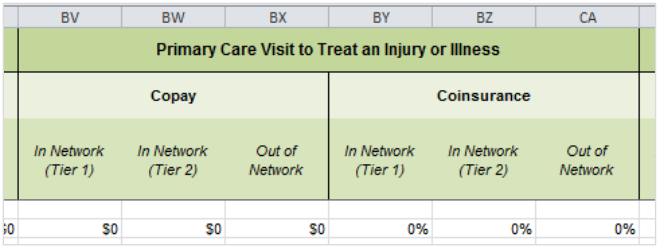
Fill in information for each of the benefits as follows:

1. If the issuer has plans that do not have out-of-network benefits for a given covered benefit, enter "Not Applicable" for the out-of-network copay fields and "100%" for the out-of-network coinsurance fields.
2. As of plan year 2016, there is a drop-down option of "Not Applicable" for all cost sharing fields. This value should be used:
    a. If issuer charges only a copay or a coinsurance for a benefit, enter "Not Applicable" for the other. For example, if an issuer wishes to charge a $20 copay for a benefit, enter "$20" for the copay and "Not Applicable" for the coinsurance. Please note that "No Charge" was used for this scenario in past years, but "Not Applicable" is the correct option in the 2018 template.
    b. If issuer has multiple in-network tiers, for any benefit category that does not have tiers, enter "Not Applicable" for the *In Network (Tier 2)* copay and coinsurance. For example, if the issuer has only multiple in-network tiers for its inpatient hospital covered benefits, it would enter Tier 2 cost sharing as described below. For other covered benefits without multiple in-network tiers, issuers should enter "Not Applicable" for the *In Network (Tier 2)* copay and coinsurance.
3. For further instructions on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see Section 5.8.

4. For further instructions on how to fill out the copayment and coinsurance fields corresponding to the AVC, please see Appendix 1.
5. There are many cost sharing requirements for the cost sharing reduction silver plan variations and the zero and limited cost sharing plan variations (see Section 5.5).
6. If cost sharing varies on the basis of place of service or provider type, ensure that no benefit already specifically applies to the place of service or provider type. If there is not one available, fill out the copay and/or coinsurance most typical for most enrollees (such as the highest utilized); in the *Benefit Explanation* field, add appropriate and brief detail to communicate the cost sharing in the scenarios other than the most common one already entered into the worksheet. An issuer's plan brochure (which the consumer can access via the submitted URL) also should clearly communicate any cost sharing information that may vary on the basis of place of service or provider type.

   Figure 2D-17 shows an example of how the fields for each benefit are laid out.

Figure 2D-17. Benefit Information Fields



BV	BW	BX	BY	BZ	CA
Primary Care Visit to Treat an Injury or Illness					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$0	$0	$0	0%	0%	0%

Covered Benefits	*Steps*
Copay—In Network (Tier 1) *^#	If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter **Not Applicable**. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 2) *^#	If the plan has multiple in-network tiers and an in-network copayment is charged, enter the dollar amount in this field. If no copayment is charged, enter "Not Applicable." For any benefit category that does not have tiers, enter "Not Applicable" for this field, as well as the field *Coinsurance—In Network (Tier 2).* This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a coinsurance is charged.

Covered Benefits	Steps
	◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance, or there are not multiple tiers for this benefit. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—Out of Network *#	If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter **Not Applicable**. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X**—the consumer always pays just the copay, and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **$X Copay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay with deductible**—the consumer first pays the copay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Copay—In Network (Tier 1), Copay—In Network (Tier 2), Copay—Out of Network	The following options are the only available options for the benefits *Inpatient Hospital Services (e.g., Hospital Stay)* and *Skilled Nursing Facility*. Define the copayment as charged per day or per stay. When entering values for plan variations, ensure that all variations follow the same “per day” or “per stay” cost sharing structure. If no copayment is charged, enter **Not Applicable**. The benefits *Mental/Behavioral Health Inpatient Services* and *Substance Abuse Disorder Inpatient Services* include these options as well as those described in the section *Copay—In Network (Tier 1)* above. Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a coinsurance is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no copayment is charged (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Day**—the consumer pays a copayment per day (this indicates that this benefit is not subject to the deductible). ◆ **$X Copay per Stay**—the consumer pays a copayment per stay (this indicates that this benefit is not subject to the deductible).

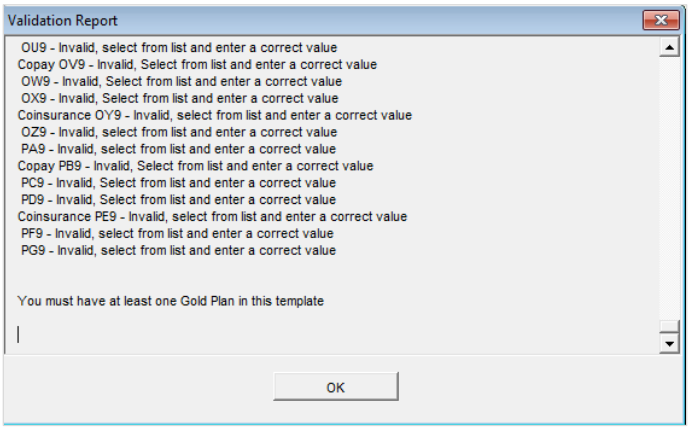
Covered Benefits	Steps
	◆ **$X Copay per Day after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Stay after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Day with deductible**—the consumer first pays the copay per day, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Stay with deductible**—the consumer first pays the copay for the stay, and any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit. For *Inpatient Hospital Services (e.g., Hospital Stay)* and *Skilled Nursing Facility* covered benefits, do not copy and paste cost sharing values entered for other benefits (e.g., $25 copay). The entered values should have the "per day" or "per stay" qualifiers. Copying and pasting any other cost sharing values could negatively affect the AV calculation and the display of this benefit on Plan Compare.
Coinsurance—In Network (Tier 1) *^#	If an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter **Not Applicable**, unless the plan has a Tier 1 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter "0%." Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **Not Applicable**—the consumer only pays a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—In Network (Tier 2) *^#	If the plan has multiple in-network tiers and an in-network coinsurance is charged, enter the percentage the consumer will pay here. If no coinsurance is charged, enter **Not Applicable**, unless the plan has a Tier 2 in-network copayment that the enrollee pays only until the deductible is met. In this case, enter "0%." For any benefit category that does not have tiers, enter **Not Applicable** for this field, as well as for the field *Copay—In Network (Tier 2).* This field may be grayed out on the basis of answers to other data elements. If so, it is locked and cannot be edited. If it is not grayed out, choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a copay is charged.

Covered Benefits	Steps
	◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay, or there are not multiple tiers for this benefit. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
Coinsurance—Out of Network *#	If an out-of-network coinsurance is charged, enter the percentage the consumer pays here. If no coinsurance is charged, enter **Not Applicable**, unless the plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter "0%." If this benefit is not covered out-of-network, enter "100%." Choose from the following options: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note that **Not Applicable**, not **No Charge**, should be used if only a copay is charged. ◆ **No Charge after deductible**—the consumer first pays the deductible, and after the deductible is met, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—the consumer first pays the deductible, and after the deductible is met, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer always pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay. If both copay and coinsurance are **Not Applicable**, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.

4.27 Completed Plans & Benefits Template

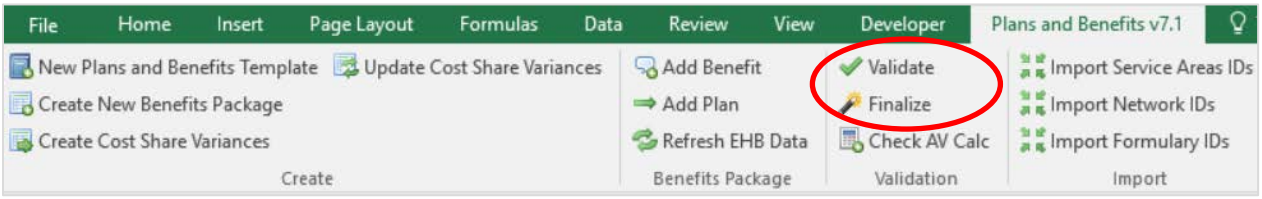
Once the entire template, including all Benefits Package and Cost Sharing Variances worksheets, has been completed, click the **Validate** button on the menu bar under the **Plans & Benefits** ribbon. If there are validation errors, a Validation Report (Figure 2D-18) will appear showing the data element and cell location of each error. The issuer must correct these errors for its Plans & Benefits Template to be accepted.

Figure 2D-18. Validation Report



Once the validation is successful, click the **Finalize** button on the menu bar under the **Plans & Benefits** ribbon (Figure 2D-19) to save the template as an XML file. Upload the saved file in the Benefits and Service Area Module. Before closing the template, save an XLSM version of the Excel file onto the computer for future reference.

Figure 2D-19. Finalize Button



5. Key Requirements and Application Guidance

This section contains guidance and examples for filling out specific sections of the Plans & Benefits Template and describes specific plan requirements. Issuers should read this section to ensure plan compliance.

5.1 MOOP and Deductible Guidance

Several requirements must be met for MOOP and deductible values. Complete the MOOP and deductible sections of the template as follows:

1. Annual Limitation on Cost Sharing.[7] When entering the MOOP values, ensure that the limits listed below are met for the in-network EHB MOOP. (See the 2018 HHS Notice of Benefit and Payment Parameters for more details on the annual limit values.)
    a. If the plan has separate medical and drug MOOP limits, these values are added together before being compared with the annual limitation on cost sharing.
    b. The standard plan's in-network EHB MOOP values must be less than or equal to $7,350 for an individual (self-only) or $14,700 for a family (other than self-only).
    c. For the 73 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to $5,850 for an individual (self-only) or $11,700 for a family (other than self-only).
    d. For the 87 percent and 94 percent AV silver plan variations, the in-network EHB MOOP must be less than or equal to $2,450 for an individual (self-only) or $4,900 for a family (other than self-only).

[7] See the rule on the HHS Notice of Benefit and Payment Parameters for 2018 (81 FR 94058; December 22, 2016). Issuers must comply with policies that are incorporated into the final rule on the HHS Notice of Benefit and Payment Parameters for 2018.

e. For the zero cost sharing plan variations, in- and out-of-network MOOP and deductible values for EHB must be $0. These fields auto-populate and should not be changed for EHB.

f. For the limited cost sharing plan variations, the MOOP and deductible values must be the same as the associated standard plan's EHB MOOP value. These fields auto-populate whenever a value is entered for a standard plan and should not be changed.

2. Family MOOP Requirements. When entering the MOOP values, ensure that the limits listed below are taken into consideration. (See the 2018 HHS Notice of Benefit and Payment Parameters for more details on the annual limit on cost sharing.)

   a. Plans that allow multi-member enrollment (family plans) must have a numeric value for either in-network or combined in- and out-of-network MOOP for both per group and per person. These plans are subject to the annual limitation on cost sharing for other than self-only coverage ($14,700) discussed above, as well as the annual limitation on cost sharing for self-only coverage.

   b. For these plans, the per-person amount for family coverage needs to be less than or equal to the annual limitation on cost sharing for self-only coverage for the standard plan ($7,350) and for the specific cost sharing reduction plan variations as detailed in the annual limitation on cost sharing discussion immediately above.[8]

   c. If a plan is available for self-only coverage only (an individual plan), all family MOOP values may be entered as "Not Applicable." However, this self-only coverage must be reflected on the Business Rules Template when indicating the relationship types allowed. (See the Business Rules Template instructions for more details on offering self-only coverage and eligible dependent relationships.)

3. Definition of **Not Applicable** and **$0** for Deductible and MOOP.

   a. Do not enter **Not Applicable** if there is a zero dollar deductible or MOOP; **$0** is the appropriate data entry. For example, if a plan has a separate medical and drug deductible, and if there is no drug deductible, issuers must enter **$0** as opposed to **Not Applicable**.

   b. **Not Applicable** should be used in the *In Network* MOOP or deductible field only to imply that in-network service costs accumulate toward the entered *Combined In/Out of Network* MOOP or deductible.

   c. If the *Individual In Network* and *Individual Combined In/Out of Network* deductible fields are equal to **Not Applicable**, the template returns an error when calculating the plan's AV using the AVC.

4. To include multiple children in child-only plans, use the "family" MOOP and deductible fields to capture the data.

5. The following explains how the values for various MOOP and deductible fields are related. Complete the fields as follows:

   a. Some plans may have only combined in-network and out-of-network deductibles or MOOPs, rather than separate in-network and out-of-network deductibles or MOOPs. Other plans may have a mixture of in-network, out-of-network, and combined in-network and out-of-network deductibles or MOOPs. When defining deductibles and MOOPs, issuers must adhere to the guidelines.

   b. If the plan does <u>not</u> have multiple in-network tiers, the following applies:

      i. If the *In Network* field is equal to a dollar value ($X), the *Combined In/Out of Network* field can be either a dollar value or **Not Applicable**.

      ii. If the *In Network* field is **Not Applicable**, the *Combined In/Out of Network* field must be equal to a dollar value.

      iii. The *Out of Network* field has no restrictions: it can be either a dollar value or **Not Applicable**.

   c. If the plan has multiple in-network tiers, the following applies:

[8] Ibid.

i. If the *In Network* and *In Network (Tier 2)* fields are equal to dollar values, the *Combined In/Out of Network* field can be either a dollar value or **Not Applicable**.

ii. If the *In Network* field is **Not Applicable**, the *In Network (Tier 2)* field must be **Not Applicable** and the *Combined In/Out of Network* field must be equal to a dollar value.

iii. If the *In Network (Tier 2)* field is **Not Applicable**, the *In Network* field must be **Not Applicable** and the *Combined In/Out of Network* field must be equal to a dollar value.

iv. The *Out of Network* field has no restrictions: it can be either a dollar value or **Not Applicable**.

5.2 Catastrophic Plan Instructions

Consistent with Section 1302(e) of the ACA and regulations codified in 45 CFR 156.155, catastrophic plans have the following characteristics:

1. They can be offered only in the individual market.
2. They are permitted, but not required, to cover multiple-person enrollment (families) when all members meet eligibility requirements for this type of plan.
3. They do not have multiple in-network tiers for EHBs.
4. They have integrated medical and drug deductibles.
5. They have integrated medical and drug MOOPs.
6. They have an in-network deductible and in-network MOOP equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the ACA and in the HHS Notice of Benefit and Payment Parameters for 2018. For PY2018, this limit is $7,350 for individuals (self-only) and $14,700 for families (other than self-only).
7. They have an out-of-network deductible and out-of-network MOOP greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP, and a combined in/out-of-network deductible and combined in- and out-of-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be greater than or equal to the annual limitation on cost sharing or equal to **Not Applicable**.
9. If they have a combined in- and out-of-network deductible and in- and out-of-network MOOP but no specific in-network deductible or in-network MOOP, the combined in- and out-of-network deductible and combined in- and out-of-network MOOP must be equal to the annual limitation on cost sharing.
10. They have in-network cost sharing equal to no charge after the deductible for all EHBs, excluding primary care and preventive health services. (See Section 5.10 for direction on completing the copay and coinsurance fields to have this cost sharing value displayed to the consumer.)
11. All benefits except primary care visits and coverage of preventive health services—in accordance with Section 2713 of the PHS Act—are subject to the in-network deductible. Issuers must provide benefits for at least three primary care visits and coverage of preventive health services (in accordance with Section 2713 of the PHS Act) prior to the consumer reaching the deductible.
12. Coverage of preventive health services (in accordance with Section 2713 of the PHS Act) is not subject to the in-network deductible and does not impose any other cost sharing requirement.

5.3 Actuarial Value Details

For all AVs, whether calculated by the AVC or input by the issuer, the following requirements must be met:

1. A de minimis variation of ±2 percentage points is used for standard plans.
   a. The AV for a bronze plan must be between 58 percent and 62 percent.
   b. The AV for an expanded bronze plan must be between 58 percent and 65 percent.

c. The AV for a silver plan must be between 68 percent and 72 percent.

d. The AV for a gold plan must be between 78 percent and 82 percent.

e. The AV for a platinum plan must be between 88 percent and 92 percent.

2. A de minimis variation of ±1 percentage point is used for silver plan variations.

   a. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent.

   b. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.

   c. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.

3. The AV of a standard silver plan and the AV of the associated 73 percent silver plan variation must differ by at least 2 percentage points.

4. The AV of the zero cost sharing plan variations must be 100 percent.

5. The AV of the limited cost sharing plan variations must be equal to the associated standard plan's AV.

(For more information on how the cost sharing information from the Plans & Benefits Template translates to inputs for the stand-alone AVC, see Appendix 1.)

5.4 Editing the Template

Keep the following in mind when making changes to the template:

1. If a benefit is mistakenly added as an additional benefit, it cannot be manually deleted, but issuers may do one of the following:

   a. Select **Not Covered** under the *Is this Benefit Covered?* column. When the Cost Share Variance worksheet is generated, this benefit will not appear on that worksheet.

   b. Click the **Refresh EHB Data** button on the menu bar under the **Plans & Benefits** ribbon. Doing so deletes the added benefit, but the issuer also loses any other data it has entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.

   c. Additional steps need to be taken if the issuer has already created the Cost Share Variances worksheet. See below.

2. If an issuer changes whether a benefit is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, the benefits will not update the Cost Share Variances worksheet even if the issuer selects the **Update Cost Share Variances** button. Instead the issuer must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon and generate a new worksheet. The updated worksheet then reflects the changes made to the Benefits Package worksheet.

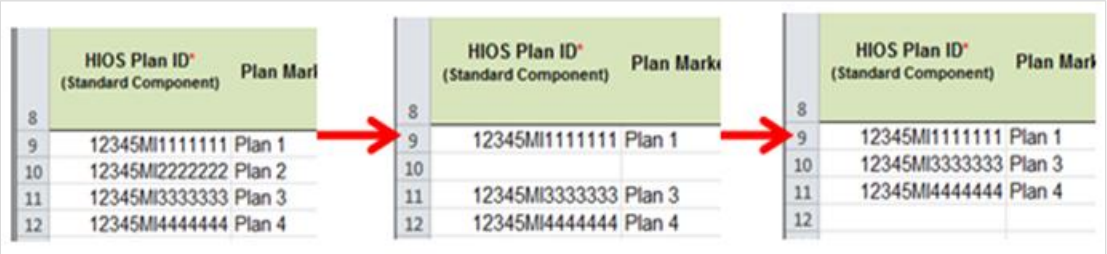
3. Do the following to add a new plan or delete a plan after the Cost Share Variances worksheet has already been created:

   a. After adding a new plan to the Benefits Package worksheet, click the **Update Cost Share Variances** button on the menu bar under the **Plans & Benefits** ribbon. This adds the new plan to the Cost Share Variances worksheet.

   b. To delete a plan on the Benefits Package worksheet, delete all data for that plan's row. If any plans are below that row, cut these rows and paste them into the empty row (see below). This is an important step because if the **Update Cost Share Variances** button is clicked when there is an empty row between plans, all plans below this blank row and their corresponding data are deleted from the Cost Share Variances worksheet.

   c. Example: To delete Plan 2 (Figure 2D-20), delete all data from the plan's row, cut and paste Plan 3 from Row 11 to Row 10, and then copy and paste Plan 4 from Row 12 to Row 11. Once those steps are completed, click the **Update Cost Share Variances** button; Plan 2 is removed from the Cost Share Variances worksheet while Plans 3 and 4 remain.

Figure 2D-20. Deleting a Plan



d. If the issuer changes any benefits package data on a specific plan that already exists, the only changes that will be reflected on the Cost Share Variances worksheet when the issuer clicks the **Update Cost Share Variances** button include the following: Plan Marketing Names will be updated, plans added to the Benefits Package worksheet will be added to the Cost Share Variance worksheet, and plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet. If there is a need to update the information for an existing plan, the issuer must first delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button. All previously entered information for this plan on the Cost Share Variances worksheet will be deleted. Reenter the plan and associated data on the Benefits Package worksheet, and click the **Update Cost Share Variances** button.

5.5 Requirements for Cost-Sharing Reduction Plan Variations

CSR plan variations fall into three types: silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations.

The zero-cost sharing and limited cost sharing plan variations are for American Indians and Alaska Natives. In the zero-cost sharing plan variation, consumers do not have to pay any out-of-pocket costs on EHBs. In the limited cost sharing plan variation, consumers pay no out-of-pocket costs only when they receive services from an Indian health care provider or from another provider if they have a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the amount consumers pay out-of-pocket for deductibles, coinsurance, and copayments, and there is also a lower MOOP. Consumers qualify for these plans if their income is below a certain level.

Each variation type has several requirements.

1. The requirements for zero cost sharing plan variations are as follows:
   a. The template automatically generates a zero-cost sharing plan variation for all metal-level plans (except catastrophic) on the individual market.
   b. The AV of the plan variation must be 100 percent.
   c. All *In Network* MOOP values must be **$0**. *Out of Network* and *Combined In/Out Network* MOOP values should be **$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
   d. All *In Network* deductible values must be **$0**. *Out of Network* and *Combined In/Out Network* deductible values should be **$0** but may also be **Not Applicable** if the associated standard plan is **Not Applicable**.
   e. All EHBs must have cost sharing values of **$0**, **0%**, or "**no charge**" for both in- and out-of-network services.[9] However, if the associated standard plan does not cover out-of-network services, the

[9] Under 45 CFR 155.20, cost sharing means any expenditure required by or on behalf of an enrollee with respect to EHB, including deductibles, coinsurance, copayments, or similar charges, but it excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

zero-cost sharing plan variation is not required to cover them either. (See Section 5.6 for details on indicating whether a benefit is an EHB.)

f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated limited cost sharing plan variation. If the associated standard plan is a silver plan, the cost sharing also must follow successive cost sharing with the associated 94 percent AV silver plan variation. (See Section 5.7 for further explanation and examples of successive cost sharing.)

g. Tier utilization must be the same as the associated standard plan.

2. The requirements for limited cost sharing plan variations are as follows:

   a. The template automatically generates a limited cost sharing plan variation for all metal-level plans (except catastrophic) on the Individual Market.

   b. The AV of the limited cost sharing plan variation must be greater than or equal to the associated standard plan's AV.

   c. All MOOP values for EHB must be the same as the associated standard plan's MOOP values for EHB.

   d. All deductible values must be the same as the associated standard plan's values.

   e. All EHBs must have the same cost sharing values as the associated standard plan's values (see Section 5.6).

   f. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see Section 5.7).

   g. Tier utilization must be the same as the associated standard plan.

3. The requirements for silver plan variations are as follows:

   a. Each silver plan offered on the Individual Market must have 73 percent AV, 87 percent AV, and 94 percent AV silver plan variations.

   b. The AV for the 73 percent AV silver plan variation must be between 72 percent and 74 percent, and it must also be at least 2 percentage points greater than the associated standard plan's AV.

   c. The AV for the 87 percent AV silver plan variation must be between 86 percent and 88 percent.

   d. The AV for the 94 percent AV silver plan variation must be between 93 percent and 95 percent.

   e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to $5,850 for an individual (self-only) or $11,700 for a family (other than self-only).

   f. For the 87 percent and 94 percent AV silver plan variations, the MOOP must be less than or equal to $2,450 for an individual (self-only) or $4,900 for a family (other than self-only).

   g. All MOOP values must follow successive cost sharing for all plan variations (see Section 5.7).

   h. All deductible values must follow successive cost sharing for all plan variations.

   i. The copay and coinsurance for all benefits must follow successive cost sharing for all plan variations.

   j. Tier utilization must be the same as the associated standard plan.

5.6 EHB Variance Reason and EHB Designation

As explained in Section 5.5, benefits in the plan variations have specific requirements, depending on whether a benefit is considered an EHB. A benefit's EHB designation is based on the two fields *EHB* and *EHB Variance Reason* for the benefit on the Benefits Package worksheet as outlined in Section 4.10. Table 2D-1 explains when a benefit is considered an EHB on the basis of different inputs.

Table 2D-1. EHB Designation

***EHB* field value**	***EHB Variance Reason* field value**	***Evaluated as an EHB?***
Yes	Anything other than **Not EHB**	Yes
Blank	**Additional EHB Benefit** or **Other Law/Regulation**	Yes

EHB field value	*EHB Variance Reason* field value	*Evaluated as an EHB?*
Yes	**Not EHB**	No
Blank	Anything other than **Additional EHB Benefit** or **Other Law/Regulation**	No

5.7 Successive Cost Sharing Guidance

As explained in Section 5.5, successive cost sharing is required to be reviewed for multiple plan variations and data fields. The purpose of successive cost sharing is to ensure that a specific element in a given plan variation always has an equal or more generous cost sharing value for the consumer compared with a standard plan or plan variation. (See the HHS Notice of Benefits and Payment Parameters for details on the cost sharing regulatory requirements for cost sharing reduction plan variations.)

The following explains which plan variations should be compared depending on the requirement:

1. A standard silver plan and its associated silver plan variations must follow successive cost sharing for the MOOP, deductible, copay, and coinsurance fields. This includes EHBs and non-EHBs. All of the following must be true:
    a. The cost sharing value of the 73 percent AV silver plan variation must be less than or equal to that of the associated standard plan.
    b. The value of the 87 percent AV silver plan variation must be less than or equal to that of the 73 percent AV silver plan variation.
    c. The value of the 94 percent AV silver plan variation must be less than or equal to that of the 87 percent AV silver plan variation.
2. A zero-cost sharing plan variation must follow successive cost sharing with the associated limited cost sharing plan variation for the copay and coinsurance fields for non-EHBs. This means that the value of the zero-cost sharing plan variation must be less than or equal to that of the limited cost-sharing plan variation.
3. A zero-cost sharing plan variation for a standard silver plan must follow successive cost sharing with the associated 94 percent AV silver plan variation for the copay and coinsurance fields for non-EHBs. This means the value of the zero-cost sharing plan variation must be less than or equal to that of the 94 percent AV silver plan variation.
4. A limited cost-sharing plan variation must follow successive cost sharing with the associated standard plan for the copay and coinsurance fields for non-EHBs. This means the value of the limited cost sharing plan variation must be less than or equal to that of the standard plan. The MOOP, deductible, and EHB cost sharing fields should be equal to that of the associated standard plan.

Again, the fields that may be used for successive cost sharing include MOOP, deductible, copay, and coinsurance. Because successive cost sharing requires that the plan always be equal or preferable to the consumer, changes to the cost sharing structures are not allowed when the consumer in the higher AV plan variation may be worse off and pay increased cost sharing. The following two examples illustrate noncompliant changes to the cost-sharing structure in the template:

1. A plan variation with a benefit that has 20 percent coinsurance may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a $20 copay for the benefit. The better value depends on the total cost of the service.
2. A plan variation with a copay of $5 after deductible may result in higher cost sharing for the consumer than a plan variation with a lower AV that has a $20 copay for a given benefit. The better value depends on whether the deductible has already been reached.

Table 2D-2 through Table 2D-8 show the compliant and noncompliant data entry options for the different cost sharing fields discussed, as well as numerous examples.

Table 2D-2. Compliant and Noncompliant Successive Cost Sharing Data Entry Options for MOOP or Deductible Values

First plan (lower AV) MOOP/deductible value	Compliant second plan (higher AV) MOOP/deductible values	Noncompliant second plan (higher AV) MOOP/deductible values
$X	◆ $Y (when $Y ≤ $X)	◆ Not Applicable ◆ $Y (when $Y > $X)
Not Applicable	◆ Not Applicable	◆ $Y

Table 2D-3. Examples of Compliant (Green) and Noncompliant (Red) Successive Cost Sharing MOOP/Deductible Values

Example	MOOP/deductible	Compliance
Lower AV Plan	$2,200	Compliant
Higher AV Plan	$2,000	
Lower AV Plan	$2,200	Not Compliant
Higher AV Plan	$2,500	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	$2,500	

Table 2D-4. Compliant and Noncompliant Successive Cost Sharing Options for Coinsurance Values

First plan (lower AV) coinsurance value	Compliant second plan (higher AV) coinsurance values	Noncompliant second plan (higher AV) coinsurance values
No Charge	◆ No Charge ◆ 0% Coinsurance ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (all values)
No Charge After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ 0% Coinsurance ◆ 0% Coinsurance After Deductible ◆ Not Applicable	◆ Y% Coinsurance (when greater than 0) ◆ Y% Coinsurance After Deductible (when greater than 0)
X% Coinsurance	◆ No Charge ◆ Y% Coinsurance (when Y% ≤ X%) ◆ Not Applicable	◆ No Charge After Deductible ◆ Y% Coinsurance (when Y% > X%) ◆ Y% Coinsurance After Deductible (all values)
X% Coinsurance After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ Y% Coinsurance (when Y% ≤ X%) ◆ Y% Coinsurance After Deductible (when Y% ≤ X%) ◆ Not Applicable	◆ Y% Coinsurance (when Y% > X%) ◆ Y% Coinsurance After Deductible (when Y% > X%)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ No Charge After Deductible ◆ Y% Coinsurance (all values) ◆ Y% Coinsurance After Deductible (all values)

Table 2D-5. Examples of Compliant and Noncompliant Successive Cost Sharing Coinsurance Values

Plan	Coinsurance	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	0%	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	25%	Compliant
Higher AV Plan	20%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25%	Not Compliant
Higher AV Plan	25% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20% Coinsurance After Deductible	
Lower AV Plan	25% Coinsurance After Deductible	Compliant
Higher AV Plan	20%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30%	
Lower AV Plan	25% Coinsurance After Deductible	Not Compliant
Higher AV Plan	30% Coinsurance After Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	30%	

Table 2D-6. Compliant and Noncompliant Successive Cost Sharing Data Entry Option for Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
No Charge	◆ No Charge ◆ $0 Copay ◆ Not Applicable	◆ No Charge After Deductible ◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
No Charge After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ $0 Copay ◆ $0 Copay After Deductible ◆ Not Applicable	◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (when greater than 0) ◆ $Y Copay With Deductible (all values)
$X Copay	◆ No Charge	◆ No Charge After Deductible

Table 2D-6. Compliant and Noncompliant Successive Cost Sharing Data Entry Option for Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
	◆ $Y Copay (when $Y ≤ $X) ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay After Deductible	◆ No Charge ◆ No Charge After Deductible ◆ $Y Copay (when $Y ≤ $X) ◆ $Y Copay After Deductible (when $Y ≤ $X) ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $Y Copay After Deductible (when $Y > $X) ◆ $Y Copay With Deductible (all values)
$X Copay With Deductible	◆ No Charge ◆ $0 Copay ◆ $Y Copay With Deductible (when $Y ≤ $X) ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay (when greater than 0) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (when $Y > $X)
Not Applicable	◆ Not Applicable ◆ No Charge	◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)

Table 2D-7. Compliant and Noncompliant Successive Cost Sharing Data Entry Options for Inpatient Specific Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
$X Copay Per Day	◆ $Y Copay Per Day (when $Y ≤ $X) ◆ $Y Copay Per Stay (when $Y ≤ $X) ◆ No Charge ◆ Not Applicable	◆ $Y Copay Per Day (when $Y > $X) ◆ $Y Copay Per Stay (when $Y > $X) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Stay	◆ $Y Copay Per Stay (when $Y ≤ $X) ◆ $0 Copay Per Day ◆ No Charge ◆ Not Applicable	◆ $Y Copay Per Stay (when $Y > $X) ◆ $Y Copay Per Day (when greater than 0) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (all values) ◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Day With Deductible	◆ $Y Copay Per Day With Deductible (when $Y < $X) ◆ $Y Copay Per Stay With Deductible (when $Y < $X)	◆ $Y Copay Per Day With Deductible (when $Y > $X) ◆ $Y Copay Per Day (when greater than 0) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Stay With Deductible (when $Y > $X)

Table 2D-7. Compliant and Noncompliant Successive Cost Sharing Data Entry Options for Inpatient Specific Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
	◆ No Charge ◆ No Charge After Deductible ◆ $0 Copay Per Day ◆ $0 Copay Per Stay ◆ Not Applicable	◆ $Y Copay Per Stay After Deductible (all values) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Stay With Deductible	◆ $Y Copay Per Stay With Deductible (when $Y < $X) ◆ $Y Copay Per Day With Deductible (when $Y < $X) ◆ No Charge ◆ No Charge After Deductible ◆ $0 Copay Per Stay ◆ $0 Copay Per Day ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (when $Y > $X) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay Per Stay After Deductible (all values) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Day (when greater than 0) ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Day After Deductible	◆ $Y Copay Per Day After Deductible ($Y < $X) ◆ $Y Copay Per Stay After Deductible ($Y < $X) ◆ $Y Copay Per Day ($Y < $X) ◆ $Y Copay Per Stay ($Y < $X) ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (when $Y > $X) ◆ $Y Copay Per Day (when $Y > $X) ◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (when $Y > $X) ◆ $Y Copay Per Stay (when $Y > $X) ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
$X Copay Per Stay After Deductible	◆ $Y Copay Per Stay After Deductible ($Y < $X) ◆ $Y Copay Per Stay ($Y < $X) ◆ $0 Copay Per Day After Deductible ◆ $0 Copay Per Day ◆ No Charge ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (when $Y > $X) ◆ $Y Copay Per Stay (when $Y > $X) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (when greater than 0) ◆ $Y Copay Per Day (when greater than 0) ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)
No Charge After Deductible	◆ No Charge After Deductible ◆ No Charge ◆ $0 Per Day ◆ $0 Per Stay ◆ $0 Copay Per Day After Deductible ◆ $0 Copay Per Stay After Deductible ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (when greater than 0) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (when greater than 0) ◆ $Y Copay Per Day (when greater than 0) ◆ Not Applicable ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)

Table 2D-7. Compliant and Noncompliant Successive Cost Sharing Data Entry Options for Inpatient Specific Copay Values

First plan (lower AV) copay value	Compliant second plan (higher AV) copay values	Noncompliant second plan (higher AV) copay values
No Charge	◆ No Charge ◆ $0 Per Day ◆ $0 Per Stay ◆ Not Applicable	◆ $Y Copay Per Stay With Deductible (all values) ◆ $Y Copay Per Stay After Deductible (all values) ◆ $Y Copay Per Stay (when greater than 0) ◆ $Y Copay Per Day With Deductible (all values) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Day (when greater than 0) ◆ No Charge After Deductible ◆ $Y Copay (all values) ◆ $Y Copay After Deductible (all values) ◆ $Y Copay With Deductible (all values)

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	No Charge	Compliant
Higher AV Plan	$0	
Lower AV Plan	No Charge	Not Compliant
Higher AV Plan	$40	
Lower AV Plan	No Charge After Deductible	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	$45 Copay With Deductible	
Lower AV Plan	No Charge After Deductible	Not Compliant
Higher AV Plan	$45 Copay After Deductible	
Lower AV Plan	$40	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40	Compliant
Higher AV Plan	No Charge	
Lower AV Plan	$40	Not Compliant
Higher AV Plan	$40 Copay After Deductible	
Lower AV Plan	$40	Not Compliant
Higher AV Plan	$45	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay With Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	

Table 2D-8. Examples of Compliant and Noncompliant Successive Cost Sharing Copay Values

Example	Copay	Compliance
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$40	
Lower AV Plan	$40 Copay After Deductible	Compliant
Higher AV Plan	$35 Copay After Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$35 Copay With Deductible	
Lower AV Plan	$40 Copay After Deductible	Not Compliant
Higher AV Plan	$45	
Lower AV Plan	$40 Copay per Day	Compliant
Higher AV Plan	$30 Copay per Day	
Lower AV Plan	$40 Copay per Stay	Compliant
Higher AV Plan	$40 Copay per Stay	
Lower AV Plan	$40 Copay per Day	Not Compliant
Higher AV Plan	$35 Copay per Stay	
Lower AV Plan	$40 Copay per Day After Deductible	Compliant
Higher AV Plan	$30 Copay per Day	
Lower AV Plan	$40 Copay per Stay After Deductible	Compliant
Higher AV Plan	$40 Copay per Stay	
Lower AV Plan	$40 Copay per Day After Deductible	Not Compliant
Higher AV Plan	$35 Copay per Stay With Deductible	
Lower AV Plan	Not Applicable	Compliant
Higher AV Plan	Not Applicable	
Lower AV Plan	Not Applicable	Not Compliant
Higher AV Plan	$35 Copay per Stay With Deductible	

5.8 Suggested Coordination of Drug Data between Templates

This section describes some options on how to coordinate the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template.

To support the AV calculations using the AVC, the Plans & Benefits Template contains four drug benefit categories that represent a typical four-tier drug design available in the market today: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs. CMS understands that plans may have drug benefits that do not fit neatly into the Plans & Benefits Template. The following are some options for how issuers could translate their cost sharing data from the Prescription Drug Template into the Plans & Benefits Template:

1. Enter the cost sharing data for the tier in the Prescription Drug Template with the highest generic drug utilization into the Generic Drugs benefit category in the Plans & Benefits Template.
2. Enter the cost sharing data for the two tiers in the Prescription Drug Template with the most brand drug utilization into the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories in the Plans & Benefits Template. Enter the tier with the higher cost sharing into the Non-Preferred Brand Drugs category. If the formulary contains only one brand tier, enter the same cost sharing for the Preferred Brand Drugs and Non-Preferred Brand Drugs benefit categories.

3. Enter the cost sharing data for the tier in the Prescription Drug Template with the most specialty drug utilization into the Specialty Drugs benefit category in the Plans & Benefits Template.

Cost sharing data should reflect the following:

1. The *Copay—In Network (Tier 1)* and *Coinsurance—In Network (Tier 1)* fields in the Plans & Benefits Template should generally correspond to the *1 Month In Network Retail Pharmacy Copayment* and *Coinsurance* fields from the Prescription Drug Template.
2. The *Copay—Out of Network* and *Coinsurance—Out of Network* fields in the Plans & Benefits Template should correspond to the *1 Month Out of Network Retail Pharmacy Copayment* and *Coinsurance* fields from the Prescription Drug Template.

The *Copay—In Network (Tier 2)* and *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template do not have corresponding fields in the Prescription Drug Template. While the concept of "tiers" is used as a framework to group drugs in the Prescription Drug Template, in the Plans & Benefits Template, "tiers" refer to provider and pharmacy networks. If the issuer has multiple in-network tiers for medical benefits, it may use the tiered cost sharing field for drugs to represent preferred and non-preferred pharmacies on the Plans & Benefits Template. Following this approach, the issuer could enter the cost sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to *In Network (Tier 1)*.
2. Non-preferred pharmacy cost sharing corresponds to *In Network (Tier 2)*.
3. If the issuer does not have multiple in-network tiers for its medical benefits, representing non-preferred pharmacy cost sharing under the *Tier 2* fields on the Plans & Benefits Template is not necessary.

If the plan has multiple in-network tiers for certain medical benefit categories, but not for drug benefits, set all drug benefit Tier 2 copay and coinsurance fields equal to **Not Applicable**.

The *Maximum Coinsurance for Specialty Drugs* field is defined only once in the Plans & Benefits Template for each plan; it cannot change among plan variations, and it must be the same for *In Network (Tier 1)*, *In Network (Tier 2)*, and *Out of Network*.

Cost sharing reduction plan variations must offer the same Drug List as the applicable standard plan. The cost sharing structure of the formulary for each plan variation must meet the requirements related to cost sharing reductions (45 CFR 156.420). However, issuers are not required to submit a separate formulary in the Prescription Drug Template for their plan variations.

Regardless of the method being used to translate the plan's cost sharing data from the Prescription Drug Template into the Plans & Benefits Template, the inputs into the Plans & Benefits Template for the drug tiers should be reflective of the cost sharing being used in the AV calculation.

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Throughout this section, all data fields that CMS anticipates displaying to consumers on Plan Compare for individual market coverage are **identified by a number symbol (#)** next to the field name. Table 2D-9 and Table 2D-10 list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This should not be viewed as the final list of data elements for display to consumers, and CMS may change this list after these instructions are published. It is provided here as a reference for issuers before they submit QHP Applications.

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
Deductibles and Maximum Out of Pocket Rules	◆ If Medical and Drug amounts are integrated, the combined amount displays.	Plans & Benefits Template

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
	◆ If Medical and Drug amounts are not integrated, only the medical amount displays on the Plan Summary View. (The Drug amount displays in the prescription drug details section.) ◆ If there is only one person in the enrollment group, the individual amount displays. ◆ If there is more than one person in the enrollment group, the Family Per Group amount displays. The dollar amount will display followed by "Per Group." ◆ If there is more than one person in the enrollment group and the plan design does not have a per-group deductible, then the per-person deductible will display on the Plan Summary View. The dollar amount will display followed by "Per Person."	
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above)	Plans & Benefits Template
	Combined Medical & Drug EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Family (Per Group or Per Person as described in the deductible business rule above).	Plans & Benefits Template
Maximum Out of Pocket	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
	Combined Medical & Drug EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Individual	Plans & Benefits Template
	Medical EHB Maximum Out of Pocket: In-Network—Family Per Group	Plans & Benefits Template
Metal Level	Level of Coverage	Plans & Benefits Template
Provider Directory	Network URL	Network ID
Summary of Benefits and Coverage	URL for Summary of Benefits & Coverage	Plans & Benefits Template
Insurance Company + Plan Marketing Name + Plan Type *Issuer Legal Name (HIOS) will display if Issuer Marketplace Marketing Name is null*	Issuer Marketplace Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template

Table 2D-9. Anticipated Plan Compare Data Elements—Plan Summary View

Plan Compare label name	Template value	Template source
Adult Dental Included Adult Dental Not-Included	Routine Dental Services (Adult) Basic Dental Care (Adult) Major Dental Care—Adult **Note**: All three must be available to show Adult Dental Included	Plans & Benefits Template
Pediatric Dental Included Pediatric Dental Not-Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child **Note**: All three must be available to show Pediatric Dental Included	Plans & Benefits Template
National Provider Network Offered/National Network	National Network	Plans & Benefits Template
Health Care Costs	Derived from “Level of Coverage”	Plans & Benefits Template
Reduced Costs	Indicates whether plan is a CSR variant	Based on Consumer Eligibility information

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Plan Brochure	Plan Brochure URL	Plans & Benefits Template
Benefit Data Rules This data displays for each covered benefit below when "Is This Benefit Covered?" value is “Yes”	Tier 1 In-Network Copay Tier 1 In-Network Coinsurance Tier 2 In-Network Copay Tier 2 In-Network Coinsurance Out of Network Copay Out of Network Coinsurance Limit Quantity Limit Unit "Limits and Exclusions Apply" hyperlink displays when Explanation or Exclusions is not null	Plans & Benefits Template
Medical Care Coverage		
Visit to a Primary Care Provider	Primary Care Visit to Treat an Injury or Illness	Plans & Benefits Template
Visit to a Specialist	Specialist Visit	Plans & Benefits Template
X-Rays and Diagnostic Imaging	X-Rays and Diagnostic Imaging	Plans & Benefits Template
Laboratory and outpatient professional services	Laboratory Outpatient and Professional services	Plans & Benefits Template
Hearing Aids	Hearing Aids	Plans & Benefits Template
Routine Eye Exam for Adults	Routine Eye Exam for Adults	Plans & Benefits Template
Routine Eye Exam for Children	Routine Eye Exam for Children	Plans & Benefits Template
Eyeglasses for Children	Eyeglasses for Children	Plans & Benefits Template
Heath Savings Account Eligible Plan	HSA—Eligible	Plans & Benefits Template
Prescription Drug Coverage		
Generic Drugs	Generic Drugs	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Preferred Brand Drugs	Preferred Brand Drugs	Plans & Benefits Template
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs	Plans & Benefits Template
Specialty Drugs	Specialty Drugs	Plans & Benefits Template
List of Covered Drugs	Formulary URL	Prescription Drug Template
3 Month In-Network Mail Order Pharmacy Benefit Offered?	3 Month In-Network Mail Order Pharmacy Benefit Offered?	Prescription Drug Template
Prescription Drug Deductible	Drug EHB Deductible: In-Network—Individual Drug EHB Deductible: In-Network—Family (When "Medical & Drug Deductibles Integrated?" value is “Yes,” "Included with Medical" displays)	Plans & Benefits Template
Prescription Drug Out of Pocket Maximum	Drug EHB Maximum Out-of-Pocket: In-Network—Individual Drug EHB Maximum Out-of-Pocket: In-Network—Family (When "Medical & Drug MOOP Integrated?" value is “Yes,” "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
Provider Directory	Network URL	Network ID
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral required to see a specialist	Plans & Benefits Template
Hospital Based Services		
Emergency Room Services	Emergency Room Services	Plans & Benefits Template
Inpatient Physician and Surgical Services	Inpatient Physician and Surgical Services	Plans & Benefits Template
Inpatient Hospital Services (e.g., Hospital Stay)	Inpatient Hospital Services (e.g., Hospital Stay)	Plans & Benefits Template
Outpatient Physician and Surgical Services	Outpatient Surgery Physician/Surgical Services	Plans & Benefits Template
Outpatient Hospital Services	Outpatient Facility Fee	Plans & Benefits Template
Coverage Examples		
Total Cost of Having a Baby	SBC Scenario—Having a Baby. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template
Total Cost of Managing Diabetes	SBC Scenario—Managing Diabetes. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Total Cost of Treating a Simple Fracture	SBC Scenario—Treatment of a Simple Fracture. Sum of the following data elements: Deductible Copayment Coinsurance Limit	Plans & Benefits Template
Adult Dental Coverage		
Routine Dental Services	Routine Dental Services (Adult)	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Adult	Plans & Benefits Template
Major Dental Care	Major Dental Care—Adult	Plans & Benefits Template
Orthodontia	Orthodontia—Adult	Plans & Benefits Template
Find Dentists	Network URL	Network ID
Pediatric Dental Coverage		
Check-Up	Dental Check-Up for Children	Plans & Benefits Template
Basic Dental Care	Basic Dental Care—Child	Plans & Benefits Template
Major Dental Care	Major Dental Care—Child	Plans & Benefits Template
Orthodontia	Orthodontia—Child	Plans & Benefits Template
Medical Management Programs		
Asthma	Disease Management Programs Offered	Plans & Benefits Template
Heart Disease	Disease Management Programs Offered	Plans & Benefits Template
Depression	Disease Management Programs Offered	Plans & Benefits Template
Diabetes	Disease Management Programs Offered	Plans & Benefits Template
High Blood Pressure & Cholesterol	Disease Management Programs Offered	Plans & Benefits Template
Low Back Pain	Disease Management Programs Offered	Plans & Benefits Template
Pain Management	Disease Management Programs Offered	Plans & Benefits Template
Pregnancy	Disease Management Programs Offered	Plans & Benefits Template
Weight Loss Program	Disease Management Programs Offered	Plans & Benefits Template
Other Benefits		
Acupuncture	Acupuncture	Plans & Benefits Template
Chiropractic Care	Chiropractic Care	Plans & Benefits Template
Infertility Treatment	Infertility Treatment	Plans & Benefits Template
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health Outpatient Services	Plans & Benefits Template
Mental/Behavioral Health Inpatient Services	Mental/Behavioral Health Inpatient Services	Plans & Benefits Template
Habilitative Services	Habilitative Services	Plans & Benefits Template
Bariatric Surgery	Bariatric Surgery	Plans & Benefits Template
Outpatient Rehabilitative Services	Outpatient Rehabilitation Services	Plans & Benefits Template

Table 2D-10. Anticipated Plan Compare Data Elements—Plan Detail View

Plan Compare label name	Template value	Template source
Skilled Nursing Facility	Skilled Nursing Facility	Plans & Benefits Template
Private-Duty Nursing	Private-Duty Nursing	Plans & Benefits Template

5.10 Plan Compare Cost-Sharing Display Rules

Below is a summary of the anticipated deductible, MOOP, copay, and coinsurance cost sharing display logic for Plan Compare for Individual Market coverage effective starting January 1, 2018. It covers the majority of situations but is not exhaustive. This should not be viewed as the final display logic for Plan Compare, and CMS may make changes after these instructions are published. It is provided here as a reference for issuers before submitting QHP Applications.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug amounts are integrated, then the total amount for the medical and drug data element will display on the Plan Summary page. “Included with Medical” will display on the plan details page under the drug amounts.
- If medical and drug amounts are not integrated, only the medical amount displays on the plan summary page. The drug amount displays in the prescription drug details section on the plan detail page.
- If only one person is in the enrollment group, the individual MOOP and deductible amount displays on the plan summary and plan details pages.
- On the plan summary page, if more than one person is in the enrollment group, the Family Per Group MOOP amount displays. The dollar amount will display followed by “Per Group.”
- On the plan summary page, if there is more than one person in the enrollment group, a family per-group deductible amount displays on the plan summary page if the issuer entered either $0 or a positive dollar amount for the family per-group data field. The dollar amount will display followed by “Per Group.” If there is more than one person in the enrollment group and the plan design does not have a per-group deductible (i.e., the Family Per Group Deductible is “Not Applicable”), then the per-person deductible will display on the Plan Summary View. The dollar amount will display followed by “Per Person.”
- On the plan details page, the Family Per Group and the Family Per Person deductible and MOOP amounts will appear.
- The out-of-network deductible and MOOP are not displayed on Plan Compare.

5.10.2 Covered Benefit Plan Compare Display Logic

- Generally speaking, the Plan Compare display logic considers the entered values for copay and coinsurance. For example, if the issuer enters “Not Applicable” for copay and “20%” for coinsurance for a specialist visit, “20%” will display on Plan Compare.
- When copay is “Not Applicable” and rounded coinsurance is greater than zero and less than 100 percent, the coinsurance value is displayed.
- When copay is greater than zero and coinsurance is “Not Applicable,” the entered copay value is displayed.
- If coinsurance is equal to “100%,” a benefit is displayed as “Not Covered.”
- “No Charge After Deductible” is displayed if the following occurs:
  - “No Charge After Deductible” is entered for copay and coinsurance.
  - The issuer entered “Not Applicable” for copay and “No Charge After Deductible” for coinsurance, or vice versa.

- "No Charge" is displayed when the combination of entered copay and coinsurance values include "0," "No Charge," or "Not Applicable." Similarly, if any of the aforementioned values include copay or coinsurance qualifiers of "After Deductible," then "No Charge After Deductible" is displayed.
- When copay and coinsurance are each greater than zero, both are displayed.

5.11 Troubleshooting the Plans & Benefits Add-In File

When opening the Add-In file before the template, Excel sometimes loads an older version of the Add-In file not compatible with the template. This causes run-time errors when entering data into the template or clicking buttons on the **Plans & Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for best results.
2. Never rename the Add-In file to a different name.
3. Ensure that only one copy of the Add-In file is on the computer; delete all extra copies. When downloading a new one, always "Replace" the old version.

If the issuer still experiences run-time errors, Excel may have loaded a previous version of the Add-In file. Take the following steps:

1. Open Excel only (no template or file). The Excel ribbon should not have a **Plans & Benefits** ribbon. If the **Plans & Benefits** ribbon appears, go to File > Options > Add-Ins > Manage: Excel Add-Ins > Go > uncheck Plansbenefitsaddin > OK (Figure 2D-21 through Figure 2D-23). In Excel 2007, the labels may differ slightly.

Figure 2D-21. Excel Options Window

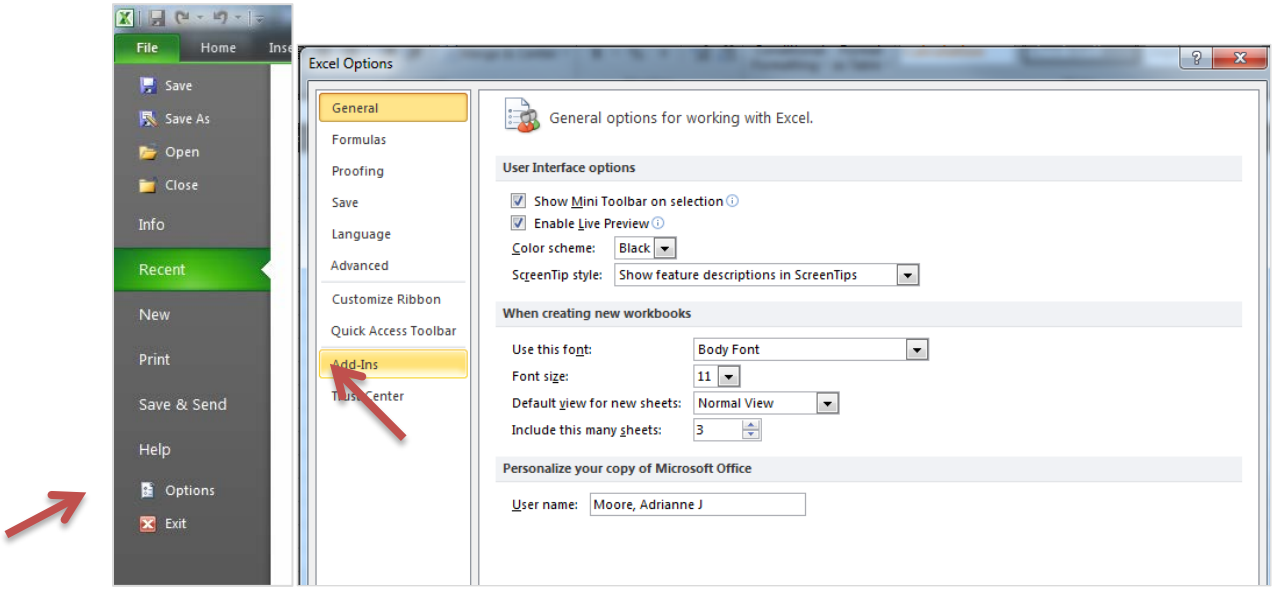


Figure 2D-22. Add-Ins Tab in Excel Options Window

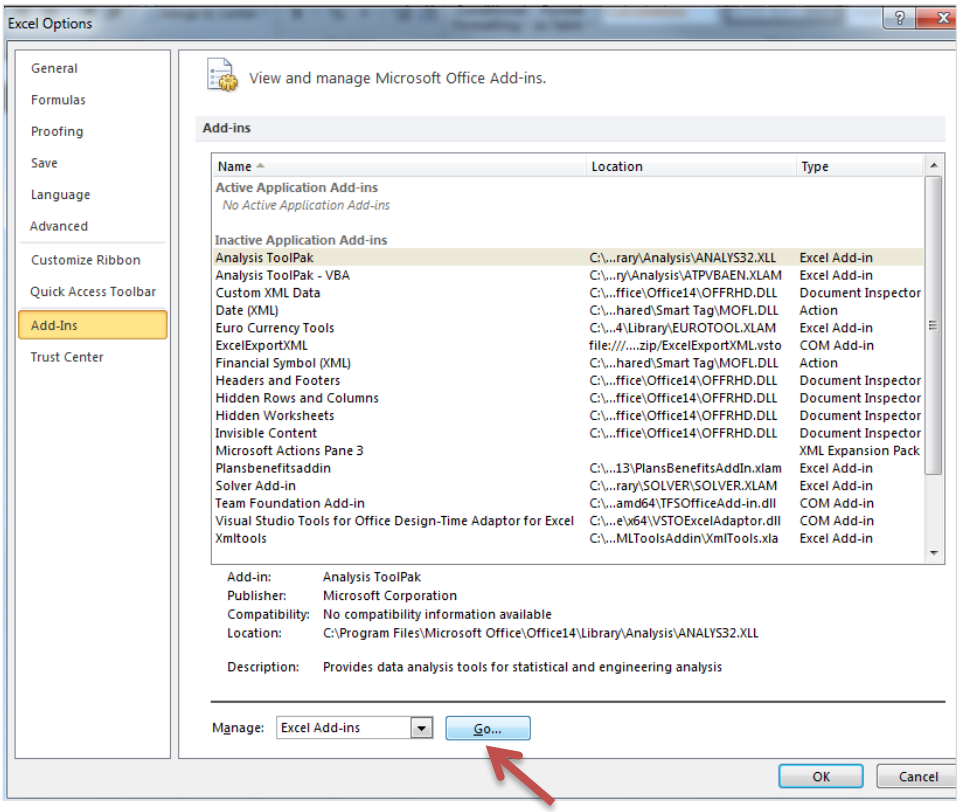
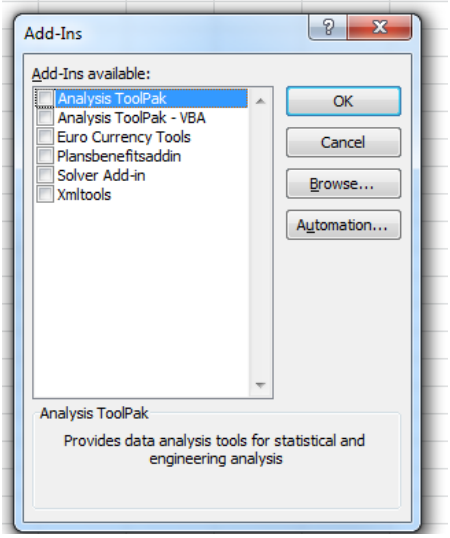


Figure 2D-23. Add-Ins Window



2. Verify that the **Plans & Benefits** ribbon is gone.
3. Open a Plans & Benefits Template.
4. The template should open the Add-In automatically after **Enable Macros** is clicked. This means the template successfully loaded the Add-In.

5.12 Simple Choice Plan Design and Corresponding Add-In File

1. The **Simple Choice Plan** Add-In file is provided to assist users in populating all cost sharing information for plans that are using a Simple Choice plan design. The details for the purpose and parameters of the Simple Choice plans are specified in the HHS Notice of Benefit and Payment Parameters for 2018.
2. The purpose of Simple Choice plan options is to simplify the consumer shopping experience by providing plans that consumers can more easily compare across issuers in the individual market. In each state, there will be one set of Simple Choice plan options with a specified cost sharing structure at each of the bronze, silver, silver CSR (73% AV, 87% AV, and 94% AV plan variation), gold, and bronze HDHP metal levels. Each Simple Choice plan design has a set deductible, MOOP, and copay or coinsurance value for a key set of EHBs. Those benefits include urgent care and all EHBs that are in the AVC, as they comprise a large percentage of the total allowable costs for an average enrollee. Other benefits and plan features are not standardized and may vary by issuers.
3. Table 2D-11 through Table 2D-13 show the covered benefits and cost sharing amounts for each of the Simple Choice plan designs. All plan designs in the second set of standardized options apply to Marketplace(s) in the states of Delaware, Iowa, Kentucky, Louisiana, Missouri, Montana, and New Hampshire. The third set of standardized options applies to the Marketplace in New Jersey. The plan designs in the first set of options apply to issuers in all other states.

   Note: Simple Choice plan designs are not applicable to SADPs, and there are no Simple Choice plan options for the Catastrophic and Platinum metal levels or SHOP plans. Also, note that each silver plan CSR variation has its own Simple Choice plan design.

Table 2D-11. 2018 Simple Choice Plan Options—Set One

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	62.68%	61.97%	71.05%	73.95%	87.61%	94.69%	80.65%
Deductible (Med/Rx)	$6,650	$6,000	$3,500/ $500	$3,000/ $200	$700/$0	$250/$0	$1,400/$0
Annual Limitation on Cost Sharing	$7,350	$6,000	$7,350	$5,850	$2,450	$1,250	$5,000
Emergency Room Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Urgent Care	$75 (*)	No charge after deductible	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*)
Inpatient Hospital Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Primary Care Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Specialist Visit	$75 (*)	No charge after deductible	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*)

Table 2D-11. 2018 Simple Choice Plan Options—Set One

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Mental Health/ Substance Use Disorder Outpatient Office Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Imaging (CT/PET Scans, MRIs)	40%	No charge after deductible	20%	20%	20%	5%	20%
Speech Therapy	40%	No charge after deductible	20%	20%	20%	5%	20%
Occupational Therapy/Physical Therapy	40%	No charge after deductible	20%	20%	20%	5%	20%
Laboratory Services	40%	No charge after deductible	20%	20%	20%	5%	20%
X-rays and Diagnostic Imaging**	40%	No charge after deductible	20%	20%	20%	5%	20%
Skilled Nursing Facility	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Generic Drugs	$35 (*)	No charge after deductible	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	35%	No charge after deductible	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*)
Non-Preferred Brand Drugs	40%	No charge after deductible	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*)
Specialty Drugs	45%	No charge after deductible	40%	40%	30%	25%	30%

(*) = not subject to the deductible.

** Excludes X-rays and diagnostic imaging associated with office visits (except for HDHPs).

Table 2D-12. 2018 Simple Choice Plan Options—Set Two

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	62.79%	61.97%	71.03%	73.88%	87.70%	94.68%	80.60%
Deductible (Med/Rx)	$6,650	$6,000	$3,500/ $500 Rx	$3,000/ $200 Rx	$700/$0	$250/$0	$1,400/$0
Annual Limitation on Cost Sharing	$7,350	$6,000	$7,350	$5,850	$2,450	$1,250	$5,000
Emergency Room Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Urgent Care	$75 (*)	No charge after deductible	$75 (*)	$75 (*)	$40 (*)	$25 (*)	$60 (*)
Inpatient Hospital Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Primary Care Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Specialist Visit	$75 (*)	No charge after deductible	$65 (*)	$65 (*)	$25 (*)	$10 (*)	$50 (*)
Mental Health/ Substance Use Disorder Outpatient Office Visit	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Imaging (CT/PET Scans, MRIs)	40%	No charge after deductible	20%	20%	20%	5%	20%
Speech Therapy	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Occupational Therapy/Physical Therapy	$35 (*)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$20 (*)
Laboratory Services	40%	No charge after deductible	20%	20%	20%	5%	20%
X-rays and Diagnostic Imaging**	40%	No charge after deductible	20%	20%	20%	5%	20%
Skilled Nursing Facility	40%	No charge after deductible	20%	20%	20%	5%	20%

Table 2D-12. 2018 Simple Choice Plan Options—Set Two

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	40%	No charge after deductible	20%	20%	20%	5%	20%
Outpatient Surgery Physician/Surgical Services	40%	No charge after deductible	20%	20%	20%	5%	20%
Generic Drugs	$35 (*)	No charge after deductible	$15 (*)	$15 (*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	$40 (copay applies only after deduct-ible)	No charge after deductible	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$40 (*)
Non-Preferred Brand Drugs	$45 (copay applies only after deduct-ible)	No charge after deductible	$100 (*)	$100 (*)	$50 (*)	$10 (*)	$75 (*)
Specialty Drugs	$50 (copay applies only after deduct-ible)	No charge after deductible	$150 (copay applies only after drug deduct-ible)	$150 (copay applies only after drug deductible)	$75 (*)	$20 (*)	$100(*)

(*) = not subject to the deductible.

** Excludes x-rays and diagnostic imaging associated with office visits (except for HDHPs).

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Actuarial Value (%)	64.84%	61.97%	71.53%	73.63%	87.61%	94.53%	80.80%
Deductible (Med/Rx)	$3,000	$6,000	$2,500	$2,500	$700	$250	$1,000
Annual Limitation on Cost Sharing	$7,150	$6,000	$7,150	$5,850	$2,450	$1,250	$5,000

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Emergency Room Services	50%	No charge after deductible	40%	30%	20%	5%	30%
Urgent Care	$50 (*)	No charge after deductible	$50 (*)	$50 (*)	$40 (*)	$25 (*)	$40 (*)
Inpatient Hospital Services	$500 (per day; applies only after deductible)	No charge after deductible	40%	30%	20%	5%	30%
Primary Care Visit	$35 (*first 3 visits; then subject to deductible and $35 copay after deductible)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*)
Specialist Visit	$75 (applies only after deductible)	No charge after deductible	$60 (*)	$60 (*)	$25 (*)	$10 (*)	$40 (*)
Mental Health/ Substance Use Disorder Outpatient Office Visit	$35 (applies only after deductible)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*)
Imaging (CT/PET Scans, MRIs)	$100 (applies only after deductible)	No charge after deductible	$100 (*)	$100 (*)	$75 (*)	$40 (*)	$100 (*)
Speech Therapy	$35 (applies only after deductible)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*)
Occupational Therapy/Physical Therapy	$35 (applies only after deductible)	No charge after deductible	$30 (*)	$30 (*)	$10 (*)	$5 (*)	$25 (*)
Laboratory Services	50%	No charge after deductible	40%	30%	20%	5%	30%
X-rays and Diagnostic Imaging**	50%	No charge after deductible	40%	30%	20%	5%	30%
Skilled Nursing Facility	$500 (per day; applies only after deductible)	No charge after deductible	40%	30%	20%	5%	30%

Table 2D-13. 2018 Simple Choice Plan Options—Set Three

	Bronze	HSA-eligible Bronze HDHP	Silver	Silver 73% CSR Plan Variation	Silver 87% CSR Plan Variation	Silver 94% CSR Plan Variation	Gold
Outpatient Facility Fee (for example, Ambulatory Surgery Center)	50%	No charge after deductible	40%	30%	20%	5%	30%
Outpatient Surgery Physician/Surgical Services	50%	No charge after deductible	40%	30%	20%	5%	30%
Generic Drugs	$25 (*)	No charge after deductible	$25 (*)	$25(*)	$5 (*)	$3 (*)	$10 (*)
Preferred Brand Drugs	50%	No charge after deductible	$50 (*)	$50 (*)	$25 (*)	$5 (*)	$25 (*)
Non-Preferred Brand Drugs***	50%	No charge after deductible	$75 (*)	$75 (*)	$50 (*)	$10 (*)	$50 (*)

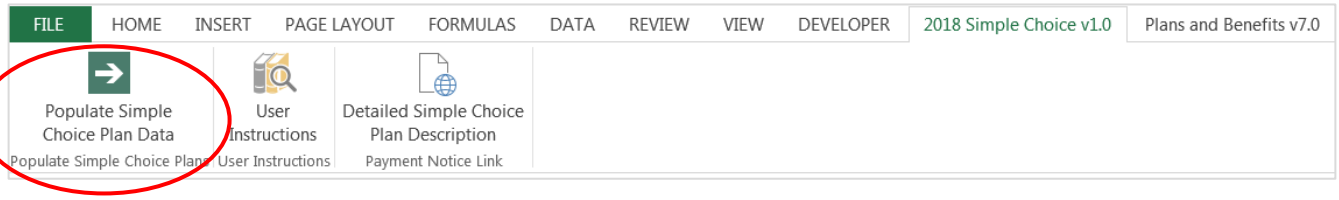
(*) = not subject to the deductible.

** Excludes x-rays and diagnostic imaging associated with office visits (except for HDHPs).

***For compliance with applicable New Jersey state requirements, the Simple Choice plan options are limited to three drug tiers. They do not have a separate specialty drug tier. For the purposes of calculating the AV using the AVC, which is based on a four-drug tier system, the cost saving value for non-preferred brand drugs will be assigned to the specialty drug tier.

4. If the issuer intends to apply the Simple Choice plan design to a plan at a given metal level, it must select **Design 1**, **Design 2**, **Design 3**, **Design 4**, or **Design 5** from the drop-down menu in the *Design Type* field. If the issuer has only one Simple Choice plan at a given metal level, it would select **Design 1**. If the issuer has two or more Simple Choice plans at a given metal level, it would select **Design 1** for the first one, **Design 2** for the second, and so on.
5. Populate the rest of the Benefits Package worksheet following the instructions detailed in Section 4 of these instructions.
    a. On each Benefits Package worksheet that has one or more plans using a Simple Choice plan design, ensure that every benefit listed in Table 0-11 above is set as **Covered** under the *Is this Benefit Covered?* field; otherwise, the Add-In will not run.
6. Create the corresponding Cost Share Variances worksheet using the Plans & Benefits Add-In file. For further instructions on how to create a Cost Share Variances worksheet, please refer to Section 4.
7. To load the Simple Choice Plan Add-In, open the file. Unlike the Plans & Benefits Template Add-In, open the Simple Choice Plan Add-In or it will not load into the Plans & Benefits Template.
8. Press the **Populate Simple Choice Plan** button under the **Simple Choice Plan Add-In** ribbon (Figure 2D-24).

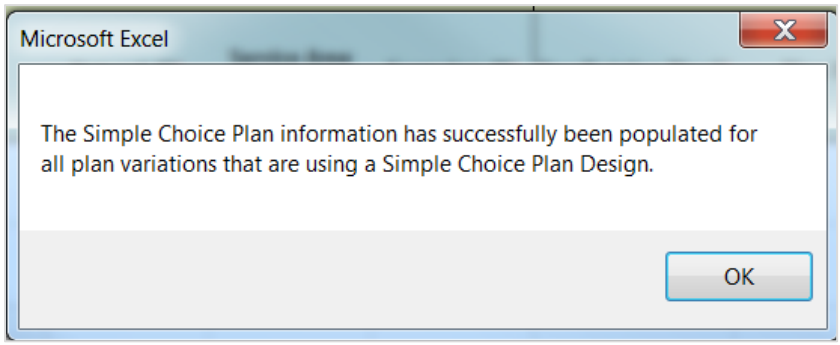
Figure 2D-24. Populate Simple Choice Plan Button



9. If everything runs correctly, the issuer will see the message below appear (Figure 2D-25); otherwise an error message will appear and indicate what needs to be corrected to proceed. After everything has been corrected, press the **Populate Simple Choice Plan** button again.

   a. The **Populate Simple Choice Plan** button will populate every field listed in Table 2D-11 on the Cost Share Variances worksheet. The populated values depend on the metal level of the Simple Choice plan and correspond to the values listed in Table 2D-11.

Figure 2D-25. Successful Population of Simple Choice Plan Data



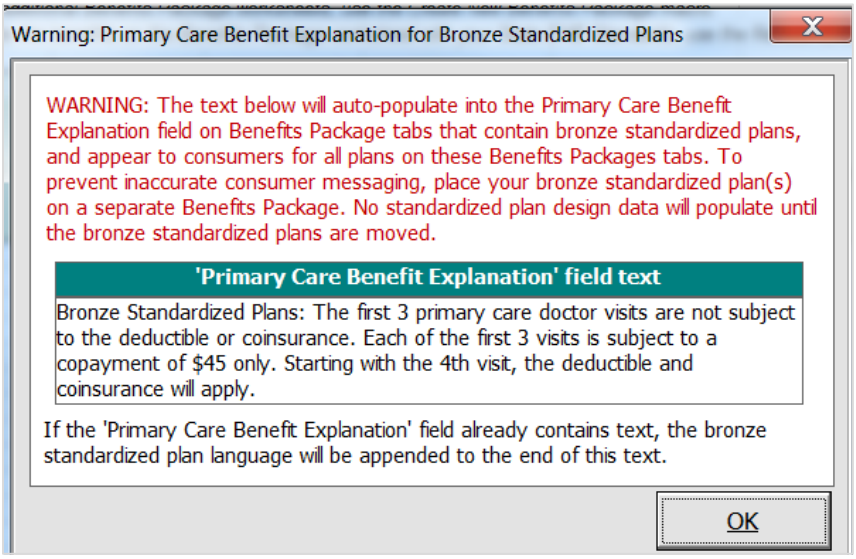
10. There are now two bronze Simple Choice plans in each set: a conventional bronze Simple Choice plan and a bronze high deductible health plan (HDHP). Both of these Simple Choice plans should have the metal level of Expanded Bronze. To indicate which bronze Simple Choice plan the issuer wants to implement, use the *HSA Eligible* field in the Cost Share Variances worksheet to indicate which Simple Choice plan you intend to offer. If you want a plan to follow the Simple Choice plan for the conventional bronze plan, please select “No” for the field *HSA Eligible*." If you want the plan to follow the Simple Choice plan for the HDHP bronze, select “Yes” for the field *HSA Eligible*.

11. For plans in New Jersey (Simple Choice Plan Options—Set Three), the text below will auto-populate into the *Primary Care Benefit Explanation* field on Benefits Package tabs that contain bronze Simple Choice plans, and it will appear to consumers for all plans on these Benefits Package tabs. To prevent inaccurate consumer messaging, place the bronze Simple Choice plan(s) on a separate Benefits Package. No Simple Choice plan data will populate until the bronze Simple Choice plans are moved (Figure 2D-26). If the *Primary Care Benefit Explanation* field already contains text, the bronze Simple Choice plan language will be appended to the end of this text.

    “Bronze Simple Choice Plans: The first 3 primary care doctor visits are not subject to the deductible or coinsurance. Each of the first 3 visits is subject to a copayment of $35 only. Starting with the 4th visit, the deductible and MOOP will apply.”

    Additionally, an error was included in the 2018 Payment Notice for the silver Simple Choice plan. Please note that the cost sharing for “Speech Therapy” and “Occupational and Physical Therapy” is a $30 copay, corrected from a $50 copay. The add-in file will automatically populate the correct amounts.

Figure 2D-26. New Jersey Bronze Simple Choice Plan Warning Message



12. The **Simple Choice Plan** Add-In file contains two buttons in addition to the main **Populate Simple Choice Plan** button.
    a. The **User Instructions** button (Figure 2D-27) contains convenient abbreviated instructions similar to the instructions detailed here for reference while working in the Plans & Benefits Template.
    b. The **Detailed Simple Choice Plan Description** (Figure 2D-28) button hyperlinks to the HHS Notice of Benefit and Payment Parameters for 2018 for a detailed description of the Simple Choice plans purpose and parameters.

Figure 2D-27. User Instructions Button

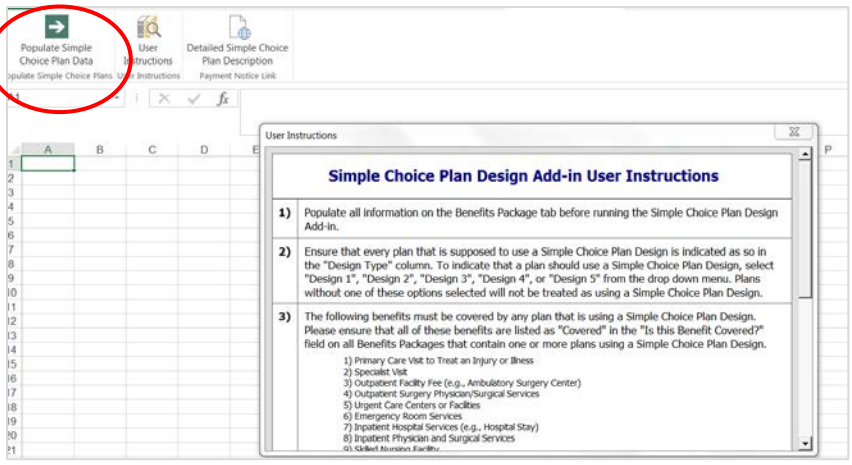


Figure 2D-28. Detailed Simple Choice Plan Description Button