Qualified Health Plan Issuer Application Instructions

Plan Year 2027

August 2026

PY2027 QHP Instructions: Revisions

Changes made after initial document posting are listed by section.

Revision Date	Section	Change
5/19/2026	Introduction	• Removed guidance for non-network plans and for the proposed 20% ECP threshold. • Updated the link to the HHS Notice of Benefit and Payment Parameters for 2027 (Payment Notice) Final Rule and removed references to the Proposed Rule.
5/19/2026	2E: Plans & Benefits	• Removed guidance for non-network plans in the "Key Changes for 2027" tables and throughout the section. • Added new guidance in Sections 4.3 and 5.1 on bronze plan cost-sharing parameters per the HHS Notice of Benefit and Payment Parameters for 2027.
5/19/2026	2H: Network ID, 2J: Network Adequacy	• Removed guidance for non-network plans in the "Key Changes for 2027" tables and throughout the section.
5/19/2026	2I: Essential Community Providers	• Removed guidance for non-network plans and the proposed 20% ECP threshold in the Key Changes for 2027 table and throughout the section. • Removed facility statuses associated with non-network plans in *Table 2I-1. Facility Status Types*. • Updated guidance and *Figure 2I-1. Refresh ECP Results* to reflect the 35% ECP threshold requirement.
5/19/2026	Appendix B: Supporting Documentation	• Removed a row referencing the Non-Network Plan Supplemental Document from *Table B-1. Supporting Documentation and Submission Criteria*.
8/6/2026	Introduction	• Added a reference for the *City of Columbus v. Kennedy,* No. 26-2215 (D. Md) order. • Updated "Table 1. Required Materials" to include the Standardized Plan Options Add-In file and Non-Standardized Plan Option Limit Exception Justification. • Updated the "New for PY2027" section to remove the bullets for the Effective ECP Review and Effective Provider Access Review Programs.
8/6/2026	2E: Plans & Benefits	• Reinstated and updated information on standardized plan options and non-standardized plan options in Sections 4.2, 4.3, 5.12–5.15, consistent with the *City of Columbus v. Kennedy,* No. 26-2215 (D. Md) order. • Removed guidance in Sections 4.3 and 5.1 related to bronze plan cost-sharing parameters. • Added references to the Guidance on Standardized Plan Options and Non-Standardized Plan Option Limits and Exceptions in Light of Stay Order in *City of Columbus v. Kennedy,* No. 26-2215 (D. Md).
8/6/2026	2F: Prescription Drug	• Reinstated information on the issuer requirement to have four drug tiers for all standardized plan options.
8/6/2026	2I: Essential Community Providers	• Removed information indicating that FFE states may conduct their own ECP review if they have an Effective ECP Review Program.
8/6/2026	2J: Network Adequacy	• Removed information indicating that states may conduct their own NA review if they have an Effective Provider Access Review Program.
8/6/2026	Appendix G: Standardized Plan Options Requirements (New)	• Reinstated the SPO Requirement Appendix and updated the standardized plan option values for PY27 in Tables G-1 and G-2.

Terminology Guide

Abbreviation	Term
AAAHC	Accreditation Association for Ambulatory Health Care
ACA	Affordable Care Act
API	application programming interface
AV	actuarial value
AVC	Actuarial Value Calculator
BPCK	brand name pack
CCIIO	Center for Consumer Information and Insurance Oversight
CFR	*Code of Federal Regulations*
CMS	Centers for Medicare & Medicaid Services
COA	certificate of authority
COB	coordination of benefits
CSR	cost-sharing reduction
DCR	data change request
DDS	doctor of dental surgery
DMD	doctor of dental medicine
DO	doctor of osteopathy
DOS	date of service
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECP	essential community provider
EHB	essential health benefit
EOB	explanation of benefits
EPO	exclusive provider organization
FF-SHOP	Federally-facilitated Small Business Health Options Program
FFE	Federally-facilitated Exchange
FIPS	Federal Information Processing Standards
FTE	full-time equivalent
GPCK	generic pack
HDHP	High Deductible Health Plan
HHS	U.S. Department of Health and Human Services
HIOS	Health Insurance Oversight System
HMO	health maintenance organization
HPSA	health professional shortage area
HRA	health reimbursement arrangement
HSA	health savings account
ICD	International Classification of Disease
IP	in patient
IRO	independent review organization
ISS	Interactive Survey System
MD	medical doctor
MOOP	maximum out-of-pocket

Abbreviation	Term
MPMS	Marketplace Plan Management System
MSP	multi-state plan
NA	network adequacy
N/A	not applicable
NADP	National Association of Dental Plans
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
NP	nurse practitioner
NPI	National Provider Identifier
NPPES	National Plan & Provider Enumeration System
PA	physician assistant
PHS	Public Health Service (Act)
PM	plan management
POC	point of contact
POS	point of service
PPO	preferred provider organization
PVMN	plan variant marketing name
PY	plan year
QHP	qualified health plan
QIS	quality improvement strategy
RBIS	Rate & Benefits Information System
RXCUI	RxNorm Concept Unique Identifiers
SADP	stand-alone dental plan
SBC	summary of benefits and coverage
SBD	semantic branded drug
SBE	State-based Exchange
SBE-FP	State-based Exchange on the Federal Platform
SCD	semantic clinical drug
SERFF	System for Electronic Rates & Forms Filing
SHOP	Small Business Health Options Program
TTY	term types
UI	user interface
UMLS	Unified Medical Language System
URR	Unified Rate Review
URRT	Unified Rate Review Template
U.S.C.	*United States Code*
USP	United States Pharmacopeia

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Introduction: Qualified Health Plans for PY2027

As defined in the Affordable Care Act (ACA), a qualified health plan (QHP) is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits (EHBs), follows established limits on cost sharing, satisfies general minimum certification criteria under section 1311(c)(1) of the ACA, and meets several other requirements to display for consumers selecting insurance plans on HealthCare.gov. This document is addressed to issuers who intend to submit a completed QHP Application for plan year (PY) 2027 certification.

Overview of the QHP Certification Process

Issuers must complete and submit a QHP Application that includes all plans they intend to offer on the Federally-facilitated Exchange (FFE) each year. During the annual application and certification process, issuers ensure the plans they submit comply with the ACA and all applicable regulations. The Centers for Medicare & Medicaid Services (CMS) recommends reading all applicable published guidance, including the following items that can be found on the Center for Consumer Information and Insurance Oversight (CCIIO) website:

- The *HHS Notice of Benefit and Payment Parameters (Payment Notice)* provides updated annual guidance for issuers aimed at enhancing consumers' experience. However, on July 16, 2026, in City of Columbus v. Kennedy, No. 1:26-cv-02215, the U.S. District Court for the District of Maryland issued an order staying certain provisions of the 2027 Payment Notice (91 FR 29256) while the litigation remains pending.[1]
- The yearly *Letter to Issuers* provides guidance on offering QHPs, including stand-alone dental plans (SADPs), on the FFEs and in the Federally-facilitated Small Business Health Options Programs (FF-SHOPs).
- The *Market Stabilization Final Rule of 2017*, the *ACA Exchange and Insurance Market Standards for 2015*, and *Beyond Final Rule of 2014* provide additional relevant guidance and regulations.
- The *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year* guidance sets payment parameters.
- The *2025 Marketplace Integrity and Affordability Final Rule (CMS-9884-F)* provides updated guidance for the maximum out of pocket limits and actuarial value (AV) de minimis ranges. However, the August 2025 U.S. District Court for the District of Maryland ruling stayed implementation of these AV de minimis ranges.[2]

Issuers can visit the QHP certification website for these and other resources. The CCIIO website also has general guidance on the Health Insurance Market Reforms and on the Health Insurance Marketplaces.

QHP Application Submission Process

Issuers will submit templates, supporting documentation, justifications, and Marketplace Plan Management System (MPMS) Module user interface (UI) data for all plans they intend to have certified as part of their QHP Application, and make all necessary revisions to their QHP Application before the deadline.

In PY2027, the deadline for submitting the QHP Application Rates Table Template is later than the general QHP Application initial submission deadline. Issuers will submit a complete QHP Application—except for the Rates Table Template and on-Exchange marketing URLs (Summary of Benefits and Coverage, Plan Brochure, Payment, Network, and Formulary)—by the initial submission deadline. Issuers may submit the Rates Table Template by the initial submission deadline but must submit it no later than the secondary submission deadline. These deadlines can be found in the PY2027 QHP Data Submission and Certification Timeline Bulletin.

CMS relies on systems that automate the data collection and validation process. The systems issuers will use to submit their QHP Application materials depend on the Exchange model the issuer's state uses. Review the list

[1] https://litigationtracker.law.georgetown.edu/wp-content/uploads/2026/07/Columbus_2026.07.16_ORDER-ON-MOTION-FOR-STAY.pdf
[2] https://www.govinfo.gov/content/pkg/USCOURTS-mdd-1_25-cv-02114/pdf/USCOURTS-mdd-1_25-cv-02114-0.pdf

of Submission Systems for information on which system(s) an issuer should use to file its QHP Application and supporting data.

All issuers applying for QHP certification must submit their QHP Applications via the MPMS Module in the Health Insurance Oversight System (HIOS).

Some FFE states may choose to collect plan data, which could include copies of QHP Application templates, in both HIOS and in the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF). Even if an FFE issuer's state collects some plan data via SERFF, the issuer must still submit their complete QHP Application in HIOS. CMS does not receive issuer plan data from SERFF for FFE states.

Issuers in states performing plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs) should first submit QHP Applications in SERFF in accordance with state and CMS review deadlines. The state will transfer all QHP Application data from SERFF to HIOS as specified in state guidance; issuers must then submit QHP Application data to CMS within the MPMS Module.

No matter an issuer's state, the Unified Rate Review (URR) Template must be submitted to CMS (see Rate Review Bulletin for deadlines). Issuers in states without an Effective Rate Review Program or states that do not use SERFF (currently FL, OK, TN, and WY) must submit their URR Template in the URR Submissions page of the MPMS Module. Issuers in all other states submit rate filings in SERFF. Dental issuers do not need to submit rate filings.

SADP Issuers

Issuers may offer SADPs if they participate in the dental market as a dental-only issuer or in the medical and dental markets as a dual-product issuer. Certain sections of the QHP Application do not apply to and are not required for dental-only issuers.

SADP and dual issuers must offer the pediatric dental EHBs in the Individual and Small Business Health Options Program (SHOP) Markets. Medical QHPs are not required to offer pediatric dental EHBs on the Exchange in states where pediatric dental EHBs are covered by an SADP on the Exchange.

SADP and dual issuers should use HIOS or SERFF as applicable to complete the relevant application sections and templates.

HIOS

Issuers must register in HIOS to obtain a HIOS Issuer Identifier (ID) and record issuer administrative contact information. Refer to the HIOS Quick Reference Guide and the HIOS Portal User Manual for more information on registering and navigating through the portal. Within HIOS, there are several modules used to submit and review application data.

- The **MPMS Module** is where FFE issuers submit plan benefit, rating, and business data to CMS. All QHP applicants, including issuers in states performing plan management functions and SBE-FP states, access the Plan Validation Workspace in the MPMS Module and submit URL, network adequacy, essential community provider, plan ID crosswalk, transparency in coverage, and interoperability data within this module. The MPMS Module comprises the following components:
  - **Issuer Dashboard**: This is where issuers can access announcements pertaining to applications and metrics about any QHP Application or URR submissions started.
  - **Plan Validation Workspace**: This is where issuers can upload and validate QHP Application templates. Issuers may upload one or more templates at a time for validation and cross validate the current templates uploaded in the system to be associated to a QHP Application for a given issuer ID. All QHP applicants, including issuers in states performing plan management functions and SBE-FP states, will need to use the Plan Validation Workspace.
  - **QHP Applications**: This is where issuers can create or edit QHP Applications, link valid templates previously uploaded in the Plan Validation Workspace to QHP Applications, complete attestations,

provide supplemental documentation, and submit application groups to CMS. Issuers may also access review results, which will display within the CMS Feedback tab as they are available.

  - **URR Submissions**: This page is where issuers in states without an Effective Rate Review Program and states that do not use SERFF for rate review purposes will submit rate filings. All issuers may view URR submissions on this page.
  - **Application Tools**: This section consists of three pages.
    - **Application Materials**: This is where issuers may download application materials such as the prepopulated Plan ID Crosswalk and Network Adequacy Templates.
    - **Issuer Details**: This is where issuers can update their Machine-Readable Index URLs and technical points of contact and view any Machine-Readable URL feedback from CMS.
    - **Plan Preview**: This is where issuers view PY2027 plan and issuer data as it will display in Plan Compare on HealthCare.gov if the issuer plans to offer QHPs or on-Exchange SADPs.
- **Plan Finder Module**: This is where issuers submit, review, and modify administrative data. Refer to the HIOS Plan Finder Issuer User Manual for detailed instructions.

SERFF

Issuers in states performing plan management functions and SBE-FP states submit their QHP Applications via SERFF and the MPMS Module (see Section 1.1 SERFF Issuers and MPMS for additional detail on how SERFF issuers use the MPMS Module). If an issuer's state has an Effective Rate Review Program, the rate filing (including the URR Template) is submitted via SERFF. Issuers should contact their state regulator for any additional application requirements. Questions related to SERFF functionality should be directed to the SERFF Help Desk at serffhelp@naic.org. For information about state systems, contact the relevant state.

Plan Management Community

Issuers use the Plan Management (PM) Community to review issuer- and plan-level data and perform a number of QHP certification–related activities, such as managing contacts at the parent organization level and completing plan confirmation.

Refer to the PM Community webpage of the QHP certification website for more information on using this system.

QHP Application Sections, Associated Templates, and Supporting Documentation

The QHP Application consists of Excel templates and supporting documents that issuers must complete with issuer and plan data. Table 1 lists materials required for the HIOS submission process.

Note: Not all QHP Application sections require the submission of supporting documentation or justifications. Table 1 lists the supporting documentation and justifications in each application section. Appendix B includes additional information such as a description of the files, the submission criteria that determine whether an issuer must submit supporting documentation or a justification, the section to which the supporting documentation or justification applies, and the file-naming convention issuers should use when naming the supporting documentation or justification.

Table 1. Required Materials

Application Group	Application Section	Required Materials
Issuer Attestations and Administrative Information	Administrative	◆ *Issuer Marketplace Information* fields in the HIOS Plan Finder Module[a]
	Interoperability	◆ Interoperability Questions in the MPMS Module (not required for SADP-only, FF-SHOP, and SBE (including SBE-FP) issuers) ◆ Interoperability URLs

Application Group	Application Section	Required Materials
	Program Attestations	◆ Attestation responses in the MPMS Module (FFE issuers)[a] ◆ State Partnership Exchange Issuer Program Attestation Response Form in SERFF (SBE-FP issuers should follow state guidance)
Plan Business Rules	Business Rules	◆ Business Rules Template[a]
Plan Attributes	Plans & Benefits	◆ Plans & Benefits Template[a] ◆ Plans & Benefits Add-In[a] ◆ Plans & Benefits Add-In Change Log ◆ Standardized Plan Options Add-In ◆ AV Calculator Screenshot ◆ Non-Discrimination Cost Sharing Supporting Documentation and Justification ◆ EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification ◆ Unique Plan Design—Supporting Documentation and Justification ◆ Non-Standardized Plan Option Limit Exception Justification[b]
	Prescription Drugs	◆ Prescription Drug Template ◆ Combined Prescription Drug Supporting Documentation and Justification (See Appendix B for notes related to SERFF submitting issuers.) ◆ Non-Discrimination Treatment Protocol Calculator Supporting Documentation and Justification ◆ Non-Discrimination Adverse Tiering Supporting Documentation and Justification
	Service Area	◆ Service Area Template[a] ◆ Service Area Partial County Supplemental Response ◆ Evidence of state approval of the partial county (FFE issuers)
	Network ID	◆ Network ID Template[a]
	Essential Community Providers (ECPs)	◆ ECP data entered via the MPMS Module UI[b] • Completed Network ID Template[a] and Service Area Template[a] needed for submission
	Network Adequacy (NA)	◆ NA Template[a] ◆ NA Justification Form (received and submitted via the MPMS Module)[a]
Plan Crosswalk	Plan ID Crosswalk	◆ Plan ID Crosswalk Template[c] ◆ Plan ID Crosswalk Justification[b] ◆ State Authorization documentation
Issuer Accreditation	Accreditation	◆ Responses to terms and conditions ◆ Accreditation Certificate
Transparency Data	Transparency in Coverage	◆ Transparency in Coverage Template ◆ Transparency in Coverage URL
Issuer Quality	Quality Improvement Strategy (QIS)	◆ QIS
Plan Rates	Rates Table	◆ Rates Table Template[a]
Issuer URLs	URL	◆ URLs for plan information[a]

[a] Applicable to SADP issuers.

[b] Collected via the MPMS Module UI.

[c] Applicable to returning issuers and new issuers receiving enrollees from a non-returning issuer.

Review Periods, Revision Process, and Certification

QHP certification involves data submission, data review, and data revision (as necessary). CMS provides several opportunities for data submission. Issuers must submit materials by each QHP Application submission deadline so that CMS can review them for compliance with market-wide standards and other regulations.

For the PY2027 QHP Application submission process, CMS will release all review results to issuers in the MPMS Module. These review results include required corrections that issuers need to address in their applications, a description of how to correct the errors, and the affected review area.

Between the initial submission deadline and the final submission deadline, issuers may make necessary changes to their QHP Application, including any changes mandated in CMS review, and upload and submit revised QHP data. After the close of the final submission deadline, issuers in FFE states and states performing plan management functions must submit a data change request (DCR) to make changes to their QHP Applications. DCRs are generally not required for issuers to submit CMS-identified corrections. Issuers in SBE-FP states do not submit DCRs to CMS and should work with their state to make changes. All data submitted may be subject to compliance action, including for changes requested by the issuers and states. All CMS-identified data errors and corrections must be addressed before the affected QHPs may be certified or displayed on HealthCare.gov.

CMS certifies plans based on the information contained in the issuer application. After final submission, issuers must notify CMS and their state regulator if they intend to alter a QHP Application. CMS reserves the right to revisit the certification of any plan. CMS also reserves the right to decertify a plan during the plan year if it determines information in the relevant QHP Application is inaccurate, incomplete, or does not meet certification standards or program requirements.

CMS will routinely monitor ongoing compliance with certification standards and other program requirements. These standards and requirements remain in place throughout the entire plan year.

CMS certifies each plan's compliance with QHP standards based on its review of the application and any information CMS receives from the applicable state regulator, including appropriate state approvals. Regardless of CMS determinations, issuers must comply with all applicable state and federal requirements.

New for PY2027

- URR data must be linked to the MPMS Module prior to submitting the Plan Rates application group.
- Issuers submitting via SERFF must use the same Service Area Template across all binders.
- Issuers submitting via SERFF must use the same Network ID Template across all binders.
- Issuers in FFE states and in states performing plan management functions must submit their QIS documents in the Issuer Quality group within the MPMS Module. QIS documents uploaded in SERFF will be ignored and only those documents uploaded in the MPMS Module will be evaluated. Issuers in SBE-FP states will continue to submit their QIS documents via SERFF.

Review Tools

Review tools are provided to facilitate states' review of issuer QHP Application data and help them identify errors that would require corrections. While all issuers may use the review tools, CMS requires that all issuers use the Plan Validation Workspace to validate their data and identify any errors that require correction before submission, as the Plan Validation Workspace performs additional validations that are not included in the public-facing tools. Visit the Review Tools webpage on the QHP certification website to access the review tools. Appendix C provides a high-level description of each tool's functionality.

Using This Document

This document uses screenshots and written guidance to explain each step required to complete the PY2027 QHP Application. Hyperlinks throughout the document will direct issuers to external content that may be needed to complete the application.

Bolded text indicates items and information that are used, entered, or selected from a drop-down menu or via a button, such as the option **Yes** to indicate agreement with an attestation.

Italicized text indicates the names of fields into which information is entered, such as *HIOS Issuer ID*. *Italicized text* may also be used to indicate document titles, such as the *HHS Notice of Benefit and Payment Parameters*.

Underlined text is used for emphasis, such as to specify that a certain step should not be completed.

Hyperlinks are indicated with blue font and are underlined. Clicking a hyperlink will direct to a location outside of this document to reference additional information.

The remainder of this document will serve as step-by-step instructions for completing the PY2027 QHP Application, navigating through the MPMS Module, and identifying specific policy and submission criteria for each section.

1. Using the Marketplace Plan Management System Module

The Qualified Health Plan (QHP) Application is divided into sections and groups within the Marketplace Plan Management System (MPMS) Module. These instructions are ordered according to how sections are grouped in the QHP Application. Refer to Table 1 for details regarding group names, corresponding sections, and materials required to complete each section. Note that the sections displayed will depend on an issuer's product and market type, as indicated by the issuer in its application. For example, stand-alone dental plan (SADP)–only issuers will not see the Interoperability section because SADP-only issuers are not required to submit interoperability data.

After populating templates and creating XML versions, the XML files are uploaded to the Plan Validation Workspace to validate and cross-validate each template. Once a template is found to have no errors, it can be linked to the appropriate section of the application.

After linking the validated templates to the corresponding application section, any necessary supporting documents can then be uploaded. Once each section in a group is completed, that application group can be submitted to the Centers for Medicare & Medicaid Services (CMS) for review.

Application sections will display one of the following statuses:

- *In Progress:* The application section has been started but a valid template or supplemental documentation is missing, or an attestation is completed but other data is needed. Sections will return to an *In Progress* status if an issuer reenters the section after it is submitted.
- *Ready to Submit*: All necessary components of the section, including (as applicable) linked templates, uploaded supporting documentation, responses to questions, and justifications have been saved and completed.
- *Submitted:* The section has been submitted as part of its group and no revisions have since been made.

Each application group will display one of the following statuses:

- *Not Started*: None of the application sections within the group has been started.
- *In Progress:* One or more application sections within the group has been started or one or more application sections has been reentered following initial submission.
- *Submitted*: All application sections within the group were submitted for CMS review and no revisions have since been made.

Detailed instructions on how to use the Plan Validation Workspace, complete the sections of an application, and submit the application can be found in the MPMS User Guide.

1.1 SERFF Issuers and the MPMS Module

Issuers in states performing plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs) will submit the majority of their data through the System for Electronic Rates & Forms Filing (SERFF) but will use the MPMS Module directly to do the following:

- Use the Plan Validation Workspace.
- Create a QHP Application.
- Review and verify Administrative data.
- Submit responses to the Interoperability Questions and Interoperability URLs.
- Submit the Non-Standardized Plan Option (NSPO) Limit Exception Justification.
- Submit essential community provider (ECP) data.
- Submit network adequacy (NA) data and retrieve and submit NA Justifications.
- Submit Plan ID Crosswalk data.

- Submit the Transparency in Coverage URL.
- Submit On-Exchange Marketing URLs.
- Submit Quality Improvement Strategy (QIS) documents (for issuers in states performing plan management functions; issuers in SBE-FP states will continue submitting their QIS documents in SERFF).

SERFF issuers are required to use the Plan Validation Workspace in the MPMS Module to validate templates before submitting them to SERFF. The Plan Validation Workspace will identify validation errors and allow the issuer to correct data before SERFF submission, perform cross-validations on the data, and provide validation warnings regarding data issues that will not prevent submission but may need additional attention from issuers to resolve. SERFF Validate & Transform will only identify validation errors. Thus, issuers are required to use the Plan Validation Workspace to ensure receipt and review of their validation warnings.

SERFF issuers are required to log in to the MPMS Module to create a new QHP Application before their state transfers data from SERFF to the MPMS Module. This approach allows the MPMS Module to customize the application appropriately to display only the sections that are required for the issuer to complete. This approach also allows the issuer to review and submit data that are not dependent on state transfer of data from SERFF. If SERFF-submitting issuers do not create a new QHP Application before their state transfers their application data, the SERFF transfer will trigger the creation of a new application that may include incorrect product types and market types.

The successful transfer of data to the Health Insurance Oversight System (HIOS) from a SERFF state does not complete submission of the application to CMS. Once the state successfully completes a plan transfer, SERFF issuers must also cross-validate and submit the applicable sections in the MPMS Module to finish the application process.

2. Completing the QHP Application

The following instructions sections provide additional detail about submitting required data for the QHP Application. This includes how to complete the QHP Application templates and submit them in the MPMS Module.

Section 2A: Administrative

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

In the Administrative section of the Marketplace Plan Management System (MPMS) Module, issuers provide company specific information that displays to consumers. Administrative information displayed on the HealthCare.gov website will be pulled from the *Issuer Marketplace Information* fields in the Health Insurance Oversight System (HIOS) Plan Finder Module. This section applies to all qualified health plan (QHP) and stand-alone dental plan (SADP) issuers, including those who file through the System for Electronic Rates & Forms Filing (SERFF).

2. Data Requirements

To enter or update issuer Administrative data, the individual managing the information must have the following:

- Submitter role for the HIOS Plan Finder Module. Instructions on how to update fields in the HIOS Plan Finder Module are contained in Section 3.2 of the HIOS Plan Finder Issuer User Manual.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Administrative Section
◆ Issuers will review Administrative data within the MPMS Module to determine if required fields are missing. ◆ Ensure the individual managing the issuer's Administrative data has the Submitter role in HIOS. ◆ Ensure the *Issuer Marketplace Information* fields in HIOS are completed (not the *Issuer General Information* fields).

Additional Resources
◆ There are no supporting documents for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

Once in the MPMS Module, navigate to the Administrative section in the QHP Application. The section identifies missing fields and explains whether the missing fields are required (errors) or optional (warnings). Issuers must make any required corrections within the HIOS Plan Finder Module. Changes made to the HIOS Plan Finder Module will refresh and be displayed in the MPMS Module.

All issuers, including issuers that submit via SERFF, need to review the Administrative data within the MPMS Module to determine if required fields are missing.

This concludes the Administrative section of the QHP Application Instructions.

Section 2B: Interoperability

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP

See Appendix D for additional information.

For the 2027 plan year, all previous year requirements for the interoperability qualified health plan (QHP) certification review remain in place, including those related to the Interoperability and Patient Access Final Rule published on May 1, 2020, per requirements at 45 Code of Federal Regulations (CFR) 156.221.

The Interoperability and Prior Authorization Final Rule, published on February 8, 2024, contains additional requirements to which QHPs must adhere for plan years beginning January 1, 2026, and January 1, 2027. These requirements are detailed in 45 CFR 156.221, 156.222, and 156.223.

These regulations require issuers to implement and maintain multiple application programming interfaces (APIs), along with associated operational processes, supporting documentation, and metrics reporting. For PY2027, issuers are required to provide information to the Centers for Medicare & Medicaid Services (CMS) on enrollees' use of their Patient Access APIs and to publicly report certain prior authorization-related processes and metrics.

For PY2027, there are seven **Yes** or **No** questions in the Interoperability section of the MPMS Module (see Table 2B-1 for additional information). If an issuer answers **No** to any question for which an exception is permitted by regulation (per 45 CFR 156.221 (h)), the system will prompt them to explain the root cause for non-compliance, the impact on enrollees, the current or proposed means of providing the required information, and the solutions and timeline to achieve compliance. Each explanation must include sufficient detail to support an assessment of whether the proposed solutions and timelines are feasible and adequately address the underlying cause of non-compliance.

Only issuers in Federally-facilitated Exchange (FFE) states and states performing plan management functions are required to complete and submit this section. Issuers in State-based Exchanges (SBEs), including State-based Exchanges on the Federal Platform (SBE-FPs), and issuers that only offer stand-alone dental plans (SADPs) or plans in the Small Business Health Options Program (SHOP) Markets are not required to complete this section.

2. Data Requirements

To complete this section, issuers will need the following:

1. Information confirming compliance with the Patient Access API requirements specified at 45 CFR 156.221(a) through (g) and the Prior Authorization requirements specified at 45 CFR 156.223 (a) through (c).
2. If answering **No** to questions related to requirements at 45 CFR 156.221(a) through (g), issuers must be prepared to explain the root cause for non-compliance, the impact on enrollees, the current or proposed means of providing the required information, and the issuer's solutions and timeline to achieve compliance.
3. If answering **No** to questions related to requirements at 45 CFR 156.223 (a) and (c), issuers must provide any available information in the field to explain why the issuer cannot meet this requirement, and CMS will reach out to discuss further.
4. A live URL that links directly to the issuer's public website *and* the Patient Access API technical documentation content specified at 45 CFR 156.221(d).
5. A live URL that links directly to the issuer's public website *and* the required enrollee resources for security and privacy content specified at 45 CFR 156.221(g).
6. A live URL that links directly to the issuer's public website *and* the Prior Authorization API metrics specified at 45 CFR 156.223(c)

7. The following metrics for the 2025 calendar year, as specified at 45 CFR 156.221(f):
    a. The total number of unique enrollees whose data were transferred at least once via the Patient Access API to a health app designated by the enrollee.
    b. The total number of unique enrollees whose data were transferred more than once via the Patient Access API to a health app designated by the enrollee.

3. Quick Reference

Key Changes for 2027
◆ The MPMS Module has been updated to incorporate three new requirements for issuers: ▪ Submit two Patient Access API metrics measuring enrollee access to the Patient Access API in the previous calendar year. ▪ Provide a URL that leads to prior authorization metrics on the issuer's public website. ▪ Attest that the issuer is providing a specific reason for denial in responses to providers whose prior authorization requests have been denied. ◆ Additionally, issuers can now enter justifications for non-compliance directly into the MPMS Module user interface, rather than submitting them using a separate form.

Tips for the Interoperability Section
◆ Verify that any URLs submitted are active and linked to the required content. ◆ Ensure all URLs point to the issuer's public website. "Public" means that anyone can access the information without any preconditions or additional steps, such as any of the following: a fee for access to the documentation, a requirement to receive a copy of the material via email, a requirement to register or create an account to receive the documentation, a requirement to provide a ZIP Code to access required information, or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available. ◆ Ensure that the content available via any URL submitted meets the respective regulatory requirement. The presence of keywords is not sufficient to meet the regulatory requirements. ◆ If the issuer relies on references or links to external sources to meet regulatory requirements, for example, linking to the Creating Access to Real-time Information Now (CARIN) Blue Button Implementation Guide (IG) or the Federal Trade Commission complaint portal, please be sure the external links are live and functioning.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

Issuers are required to answer **Yes** or **No** to 45 CFR 156.221 and 156.223. Issuers that answer **No** to questions for which an exception is permitted by regulation (per 45 CFR 156.221(h)) must provide information using the required justification fields. The issuer is required to provide the following information for each applicable question's justification:

1. Explain why the issuer cannot reasonably satisfy all requirements for the upcoming plan year, and the impact of non-compliance on the issuer's enrollees.
2. Describe the current or proposed means of providing health information to the issuer's enrollees and provide the issuer's solutions and a timeline to achieve compliance with all requirements.

Tables 2B-1 through 2B-2 show each question, the response requirements, and additional information for issuers to consider when completing that question.

Table 2B-1. Descriptions of Required Components and Supporting Information for Patient Access API Submission

Patient Access API Question	Response Requirements	Detailed Guidance
Question 1: For the upcoming plan year, will the issuer maintain a standards based Patient Access Application Programming Interface (API) as required by 45 CFR 156.221(a), that conforms to the technology and content and vocabulary standards as required by 45 CFR 156.221(c)?	**Yes** or **No**. If **No**, issuer is prompted to provide justification.	The issuer must implement and maintain a secure API and its necessary features as detailed in 45 CFR 156.221(a) and 45 CFR 156.221 (c). ◆ Issuers are urged to refer to the "Best Practices for Payers and App Developers" document, which can be found in the CMS Interoperability Guidance. Issuers' use of this document is not required. The document provides valuable implementation and testing guidance for issuers building secure, standards-based APIs. The document is subject to change; issuers using the document should check regularly for any updates.
Question 2: For the upcoming plan year, will the issuer's Patient Access API permit third-party applications to retrieve, with the approval and at the direction of current enrollees or their personal representative, all of the enrollee health data described in 45 CFR 156.221(b)?	**Yes** or **No**. If **No**, issuer is prompted to provide justification.	The issuer's API must include the following content: 1. Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are being appealed, and provider remittances and enrollee cost sharing pertaining to such claims, no later than one business day after a claim is processed. 2. Encounter data from capitated providers, no later than one business day after data concerning the encounter is received by the QHP issuer. 3. Clinical data, including laboratory results, if the QHP issuer maintains any such data, no later than one business day after data is received by the issuer.
Question 3: Has the issuer made complete accompanying technical documentation required by 45 CFR 156.221(d) for its Patient Access API publicly accessible by posting it directly on its website and/or via publicly accessible hyperlinks? Note: The issuer may provide links to the required API technology standards on its public website to meet this requirement.	**Yes** or **No**. If **Yes**, issuer must provide a URL that leads to its Patient Access API technical documentation. If **No**, issuer is prompted to provide justification.	The issuer must demonstrate compliance by making, at minimum, the following information available on its website: 1. API syntax, function names, required and optional parameters and their data types, return variables and their types/ structures, exceptions, and exception handling methods and their returns. 2. The software components and configurations an application must use to successfully interact with the API and process its responses. 3. All applicable technical requirements and attributes for an application to be registered with any authorization server deployed in conjunction with the API. Issuers can demonstrate compliance by linking directly to the required standards on an external website, for example ALL

Patient Access API Question	Response Requirements	Detailed Guidance
		the following required API Interoperability Standards: ◆ United States Core Data for Interoperability, at 45 CFR 170.213 ◆ Fast Healthcare Interoperability Resource (FHIR) Release 4.0.1 ◆ Health Level 7 (HL7) FHIR US Core IG Standard for Trial Use (STU) 3.1.1 ◆ HL7 Substitutable Medical Applications, Reusable Technologies App Launch Framework IG 1.0.0 ◆ OpenID Connect Core 1.0. Issuers can also link directly to the recommended IGs, which include the following: ◆ CARIN for Blue Button IG Version STU 2.0.0 ◆ Da Vinci PDex IG Version STU 2.0.0 ◆ Da Vinci PDex U.S. Drug Formulary IG Version STU 2.0.1. If the issuer chooses to link directly to a required standard or IG to demonstrate compliance with the interoperability requirements, the issuer must ensure that link remains active and points to the required content. More information about the required standards and recommended IGs is available in the CMS APIs website.
Question 4: Has the issuer provided enrollee resources regarding privacy and security in non-technical, simple and easy-to-understand language in an easily accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former enrollees seeking to access their health information held by the QHP issuer, as required by 45 CFR 156.221(g)?	**Yes** or **No**. If **Yes**, issuer must provide a URL that leads to Patient Access API enrollee resources for security and privacy. If **No**, issuer is prompted to provide justification.	The issuer's website content must include educational resources about health information privacy and security, explaining at a minimum: 1. General information on steps the individual may consider taking to help protect the privacy and security of their health information, including factors to consider when selecting an application, including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information, and 2. An overview of which types of organizations or individuals are and are not likely to be Health Insurance Portability and Accountability Act–covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to the OCR and the FTC as described in 45 CFR 156.221. Issuers are urged to refer to the "Best Practices for Payers and App Developers"

Patient Access API Question	Response Requirements	Detailed Guidance
		document, which can be found in the CMS Interoperability Guidance. Issuers' use of this document is not required. The document provides valuable implementation and testing guidance for issuers building secure, standards-based APIs. The document is subject to change; issuers using the document should check regularly for any updates.
Question 5: Has the issuer collected the Patient Access API metrics in the form of aggregated, de-identified data, as required by 45 CFR 156.221(f)?	**Yes** or **No**. If **Yes**, issuer must enter required metrics in the two fields. If **No**, issuer is prompted to provide justification.	Enrollees Who Used Patient Access API 1. Report the total number of unique enrollees whose data were transferred at least once via the Patient Access API to a health app designated by the enrollee in the 2025 calendar year, as required by 45 CFR 156.221(f). Enrollees Who Used Patient Access API Multiple Times 2. Report the total number of unique enrollees whose data were transferred more than once via the Patient Access API to a health app designated by the enrollee in the 2025 calendar year, as required by 45 CFR 156.221(f).

Table 2B-2. Descriptions of Required Components and Supporting Information for the Prior Authorization Submission

Prior Authorization Question	Response Requirements	Detailed Guidance
Question 1: Has the issuer published prior authorization metrics publicly on its website, as required by 45 CFR 156.223(c), for the 2025 calendar year?	**Yes** or **No**. If **Yes**, issuer must provide a URL that leads to the location of the required metrics on the issuer's public website. If **No**, issuer is prompted to provide an explanation why the issuer cannot meet this requirement. Note: CMS will reach out to discuss the explanation provided for failing to meet the requirement.	CMS encourages issuers to consider readability and accessibility when preparing this report and has released similar metrics and a suggested template that can serve as examples. (See Prior Authorization and Pre-Claim Review Statistics for Medicare Fee-For-Service, and Prior Authorization Metrics Reporting - Overview & Template.) ◆ These metrics may, but are not required to, include prior authorization information on drugs.
Question 2: As of no later than plan years beginning on or after January 1, 2026, does the issuer provide a specific reason for denial in responses to providers whose prior authorization requests have been denied, as required per 45 CFR 156.223(a)?	**Yes** or **No**. If **No**, issuer is prompted to provide an explanation why the issuer cannot meet this requirement. Note: CMS will reach out to discuss the explanation provided for failing to meet the requirement.	Issuers must provide a reason for denial to providers whose prior authorization requests have been denied.

Figures 2B-1 through 2B-4 display the Interoperability Patient Access API and Prior Authorization Tabs, including examples of the justification and explanation fields that must be completed in the event of a **No** response.

Figure 2B-1. Interoperability Patient Access API Tab

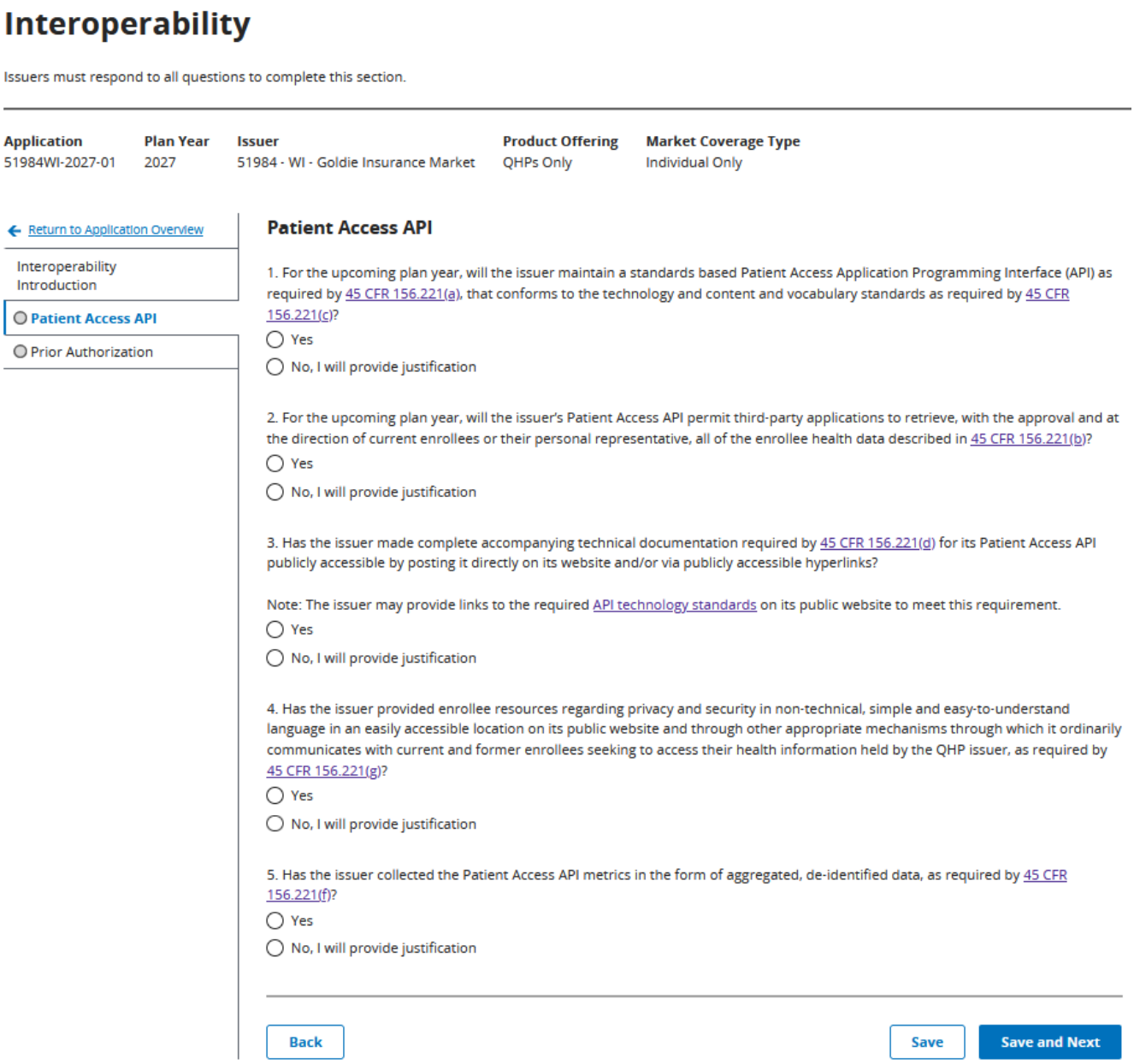


Figure 2B-2. Interoperability Prior Authorization Tab

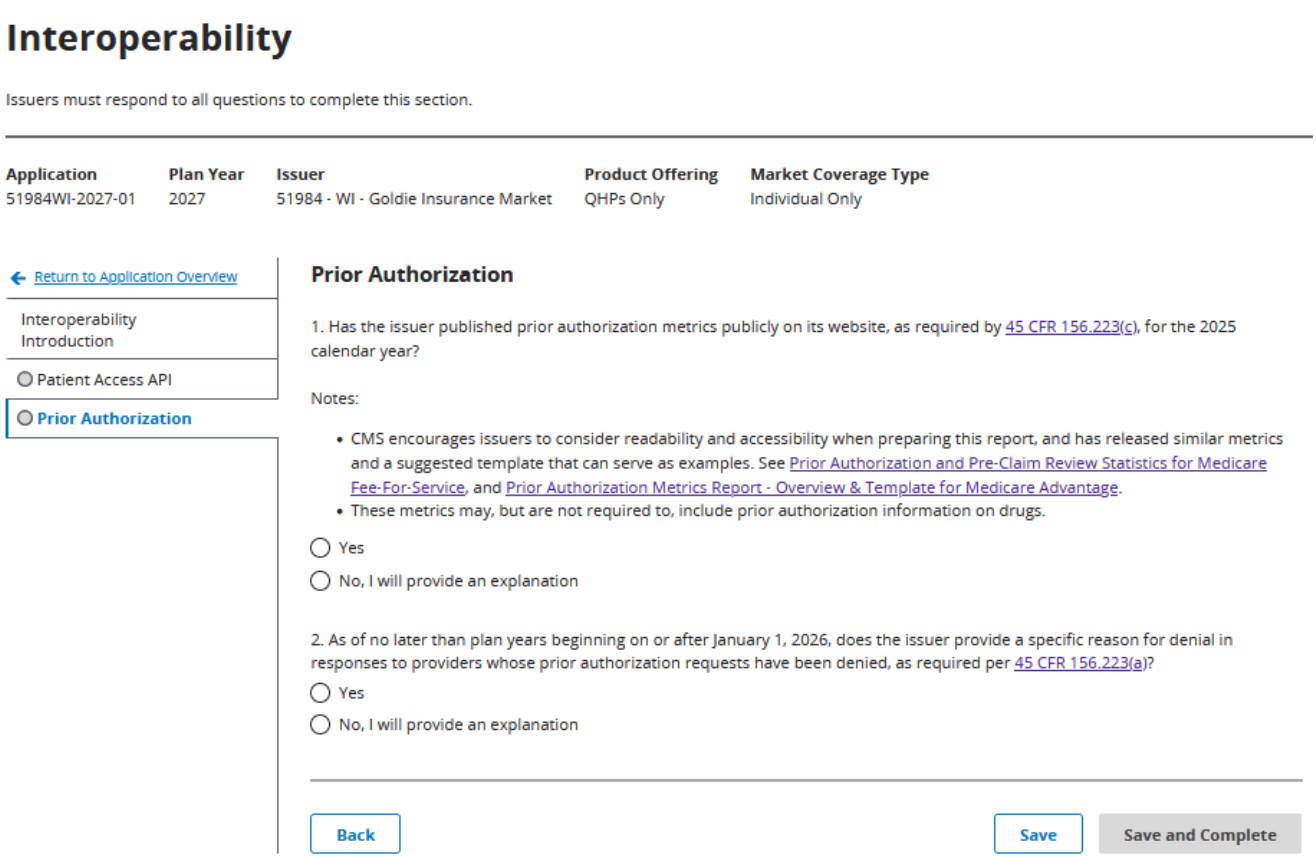


Figure 2B-3. Interoperability Patient Access API Tab with Justification Fields

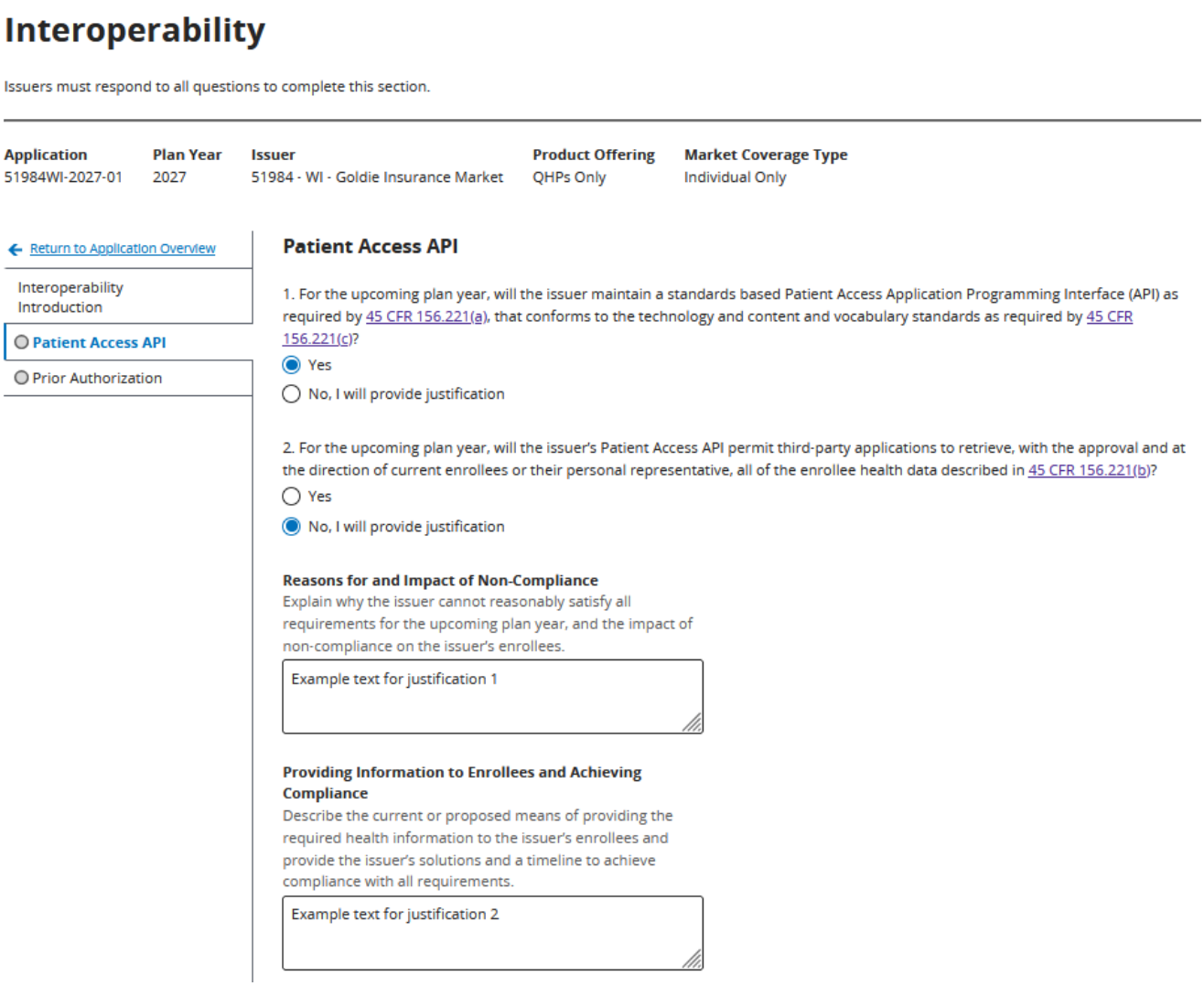
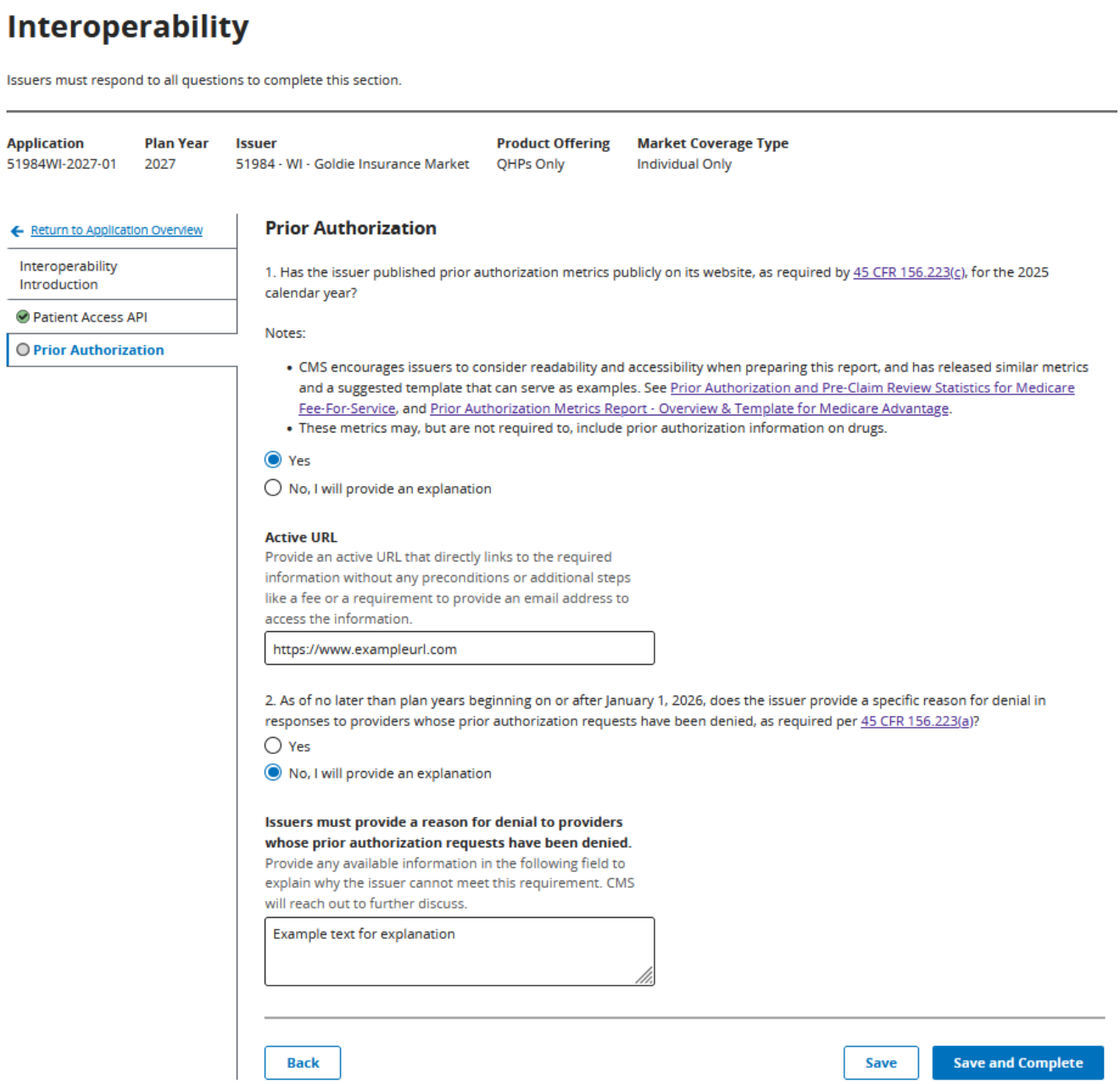


Figure 2B-4. Interoperability Prior Authorization Tab with Explanation Fields



This concludes the Interoperability section of the QHP Application Instructions.

Section 2C: Program Attestations

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

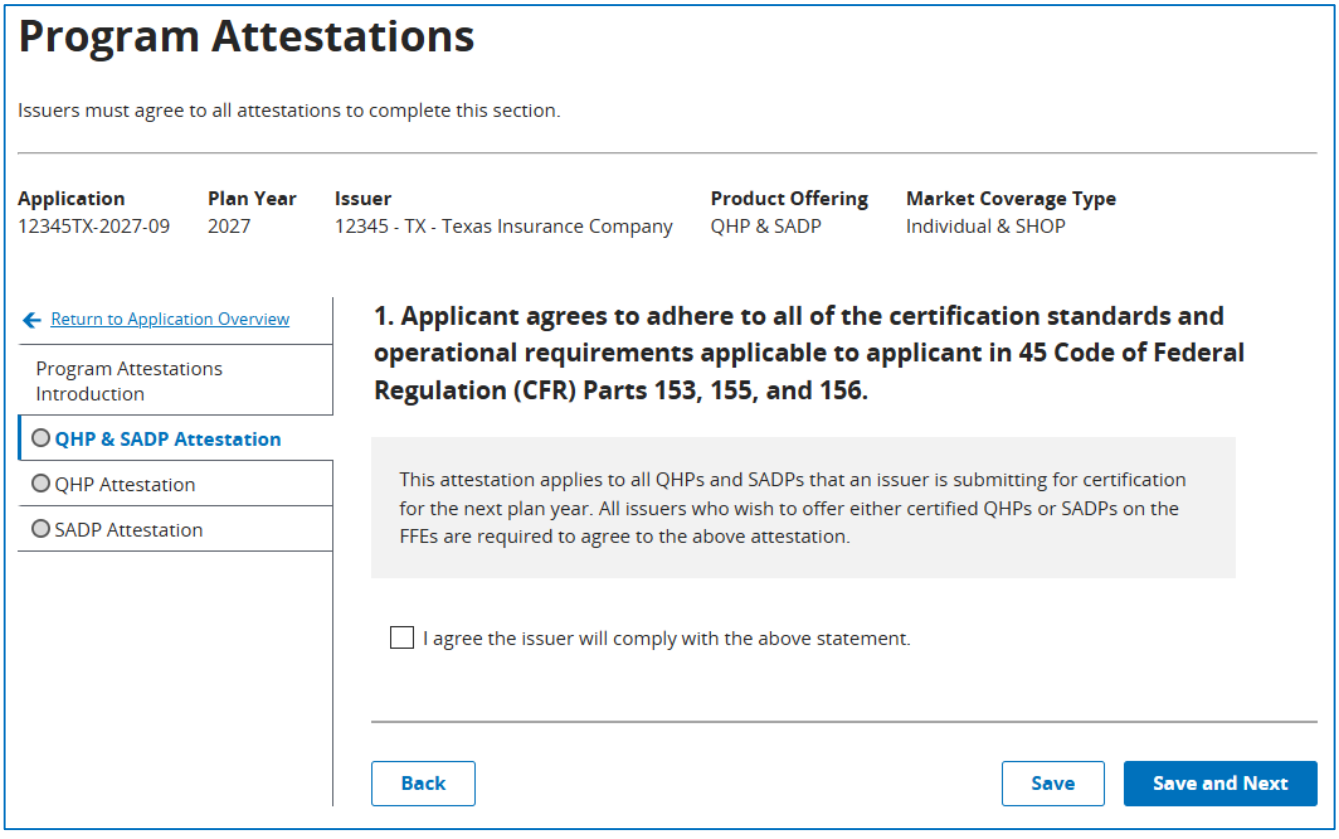
In the Program Attestations section of the Marketplace Plan Management System (MPMS) Module, issuers filing via the Health Insurance Oversight System (HIOS) attest to their intent to comply with Federally-facilitated Exchange (FFE) requirements (Figure 2C-1). This section includes attestations required for the following:

- Both medical qualified health plan (QHP) and stand-alone dental plan (SADP) issuers
- Medical QHP issuers only
- SADP issuers only.

Issuers must respond to all attestations and save the section before they can submit the group.

Issuers in a state performing plan management functions must complete the State Partnership Exchange Issuer Program Attestation Response Form and submit it via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF).

Figure 2C-1. Program Attestations Application Section



2. Data Requirements

To complete this section, issuers in states performing plan management functions submitting in SERFF need the following:

- The State Partnership Exchange Issuer Program Attestation Response Form. Save the form using the naming convention in Table B-1: [Issuer ID]_SPEissuerAttestations.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Program Attestations Section
◆ For HIOS-submitting issuers, only attestations applicable for the submitted plan types will display (e.g., if only medical QHPs are offered for certification, only those attestations relevant for medical QHPs will be displayed). ◆ A "Dual Issuer" offers both a medical QHP and an SADP under the same HIOS Issuer ID. ◆ Issuers must respond to all attestations. ◆ HIOS-submitting issuers must agree with each attestation displayed. ◆ In states performing plan management functions: ▪ Issuers use the State Partnership Exchange Issuer Program Attestation Response Form. ▪ If issuers only offer medical QHPs for certification, they respond **Not Applicable** to the attestations required in the SADP-only issuers subsection. ▪ If issuers only offer SADPs for certification, they respond **Not Applicable** to the attestations required in the medical QHP-only issuers subsection.

Additional Resources
◆ There is a supporting document (for issuers in states performing plan management functions) for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

To participate in the FFE, issuers must respond to the following.

Attestation Area	Steps
Attestations required of both medical QHP and SADP issuers	All issuers must agree with these attestations to offer certified medical QHPs or SADPs: ◆ All HIOS-submitting issuers must check the box agreeing to comply. ◆ All issuers in states performing plan management functions must respond **Yes**.
Attestations required of medical QHP issuers only	Issuers applying for certification of medical QHPs must agree with these attestations to offer certified medical QHPs: ◆ HIOS-submitting issuers offering medical QHPs must check the box agreeing to comply. ◆ Issuers in states performing plan management functions offering medical QHPs must respond **Yes**. ◆ Issuers not applying to offer medical QHPs select **Not Applicable**.
Attestations required of SADP issuers only	Issuers applying for certification of SADPs must agree with these attestations to offer certified SADPs: ◆ HIOS-submitting issuers offering SADPs must check the boxes agreeing to comply. ◆ Issuers in states performing plan management functions offering SADPs must respond **Yes** to each attestation. ◆ Issuers not applying to offer SADPs select **Not Applicable**.

The specific attestations follow.

Attestation Area	Attestation Description
Attestations required of both medical QHP and SADP issuers	Applicant agrees to adhere to all the certification standards and operational requirements applicable to applicant in 45 Code of Federal Regulations (CFR) Parts 153, 155, and 156.
Attestations required of medical QHP issuers only	Applicant agrees to adhere to all applicable requirements in 45 CFR Parts 146, 147, 155, and 156.
Attestations required of SADP issuers only	Applicant agrees to adhere to all the certification standards and operational requirements applicable to applicant in 45 CFR Parts 155 and 156.

This concludes the Program Attestations section of the QHP Application Instructions.

Section 2D: Business Rules

1. Introduction

In the Business Rules section of the Marketplace Plan Management System (MPMS) Module, issuers enter information that is used to calculate rates charged to an enrollee and determine enrollee eligibility for coverage under a plan.

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Business Rules Section
◆ Issuers must enter values for *HIOS Issuer ID* and *Medical, Dental, or Both?* before entering data for the rest of the template. All other fields are locked until you respond to *Medical, Dental, or Both?* ◆ All rules associated with Individual Market and Small Business Health Options Program (SHOP) Market plans must be entered in a single Business Rules Template. ◆ The first row of rules (row 10) is the base set of issuer business rules. Leave the product ID and plan ID fields blank in this row but enter data for all subsequent columns. This row applies to all products and plans associated with the HIOS Issuer ID, including Individual, SHOP, qualified health plan (QHP), and stand-alone dental plan (SADP) products and plans. Define how product or plan rules differ from the base set of issuer business rules in the subsequent rows, as applicable. ◆ The template requires a data entry of age on effective date for the field *How is age determined for rating and eligibility purposes*? for all medical and dental business rules. The template will auto-populate this value for the issuer-level business rule, and any product or plan-level rule.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Note for issuers submitting via the System for Electronic Rates & Forms Filing (SERFF): Issuers must include all rating business rules associated with all plan IDs for on-Exchange QHPs, on-Exchange SADPs, off-Exchange SADPs, Individual Market plans, and SHOP Market plans that are being submitted for QHP certification in one Business Rules Template and submit that identical template in all SERFF binders. The Centers for Medicare & Medicaid Services (CMS) requires submission of a single identical Business Rules Template in all binders to avoid data overwrite issues. If non-identical templates are submitted through multiple different SERFF binders, the MPMS Module will return a validation error upon group submission of the Plan Attributes group.

Dual-product issuers submitting the Business Rules Template via multiple SERFF binders should set *Medical, Dental, or Both?* to **Both** in all submitted Business Rules Templates. Do not enter **Medical** for this field in one template version and **Dental** for this field in another template version.

Complete the Business Rules Template using the following steps. This template cannot be validated until all required fields are completed.

Business Rules Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Medical, Dental, or Both?	Select one of the following from the drop-down menu: ◆ **Medical**—if entering rating business rules for medical plans only. ◆ **Dental**—if entering rating business rules for dental plans only. ◆ **Both**—if entering rating business rules for medical and dental plans within the template. A value for this field must be entered before proceeding. All other fields are locked until a response is provided to *Medical, Dental, or Both?*
Product ID	For products with rules that differ from those entered in row 10, enter the 10-character HIOS-generated product ID (e.g., 12345AZ123) that identifies the product that will be associated with the rules defined in that row. ◆ If a product ID is entered, the rules defined in that row will be applied to all plans associated with that product ID. All other products will use the rules associated with either the HIOS Issuer ID in row 10 or a different product ID rule. ◆ If a product ID is not entered, the rules associated with the HIOS Issuer ID in row 10 will be used.
Plan ID	Enter the 14-character alphanumeric HIOS-generated plan ID (e.g., 12345AZ1234567) that identifies the plan that will be associated with the rules in that row. ◆ If a plan ID is entered, the rules defined in that row will be applied to that plan ID only. All other products and plans will use the rules associated with the HIOS Issuer ID rule, product ID rule, or a different plan ID rule. ◆ If a plan ID is not entered, the rules for the product ID associated with that plan ID will be used. If a product ID rule is also not entered, the rules associated with the HIOS Issuer ID in row 10 will be used.
Medical or Dental Rule?	Select whether the business rule in the template row applies to medical or dental plans. The drop-down options are: ◆ **Medical** ◆ **Dental**. The allowed value for this field depends on the response to *Medical, Dental, or Both?*: ◆ If **Medical** is entered, the issuer-level row (row 10) for *Medical or Dental Rule?* defaults to **Medical**. Only a value of **Medical** may be entered for any subsequent rule. ◆ If **Dental** is entered, the issuer-level row for *Medical or Dental Rule?* defaults to **Dental**. Only a value of **Dental** may be entered for any subsequent rule. ◆ If **Both** is entered, the issuer-level row for *Medical or Dental Rule?* defaults to **Medical**. Either **Medical** or **Dental** may be entered for any subsequent rule and there must be at least one medical rule and one dental rule within the template.
What is the maximum number of rated underage dependents on this policy?	Select the maximum number of rated underage dependents from the drop-down menu. A rated underage dependent is defined as age 0–20. A QHP cannot rate more than the three oldest covered children when determining the total family premium.[1] This rule does not apply to SADPs, who have the option to enter a value of "Not Applicable." If a response of **Medical** is provided for *Medical or Dental Rule*, the following are allowed: ◆ **1** ◆ **2** ◆ **3**. If a response of **Dental** is provided for *Medical or Dental Rule*, the following are allowed: ◆ **1** ◆ **2**

[1] 45 *Code of Federal Regulations* (CFR) 147.102(c)(1).

Business Rules Template	Steps
	◆ **3** ◆ **Not Applicable**. Note: **Not Applicable** means that a dental plan associated with the business rule has no maximum number of rated underage dependents on a policy. This option is not available to medical plans.
Is there a maximum age for a dependent?	Set the maximum age for a dependent for purposes of eligibility at policy issuance or renewal. The maximum age for a dependent applies only to the dependent relationships of Child, Brother or Sister, Foster Child, and Stepson or Stepdaughter. Choose from the following: ◆ **Yes**—if selected, a pop-up will allow the user to enter the maximum age for a dependent. QHP issuers must enter a minimum value of 25 for a medical business rule. SADP issuers must enter a minimum value of 18 for a dental business rule. Note: The age entered is inclusive through that age. For example, entering a value of 25 means the issuer is offering to provide coverage through age 25, up to age 26. ◆ **Not Applicable**—if selected, then there is no maximum age, and the dependent is allowed to enroll regardless of age as long as he or she meets the other eligibility rules. Market rules require QHP issuers that cover child dependents to make such coverage available for children until they attain age 26.[2] Note: Dental plans are not subject to the minimum dependent age of 25 and may have a dependent age as low as 18.
How is age determined for rating and eligibility purposes?	Upon entry of the issuer-level rule and any product or plan-level rule, the template will auto-populate the following value, which defines the method for calculating an enrollee's age for rating and eligibility purposes. ◆ **Age on effective date**—return the rate based on the consumer's age on the effective date. This option must be selected for all Medical and Dental business rules. ▪ The template prevents selection of the following discontinued options: Age on January 1 of the effective date year, Age on insurance date (age on birthday nearest the effective date), or Age on January 1 or July 1. Note: Market rules require QHPs to select **Age on effective date**.[3] SADPs are also required to select **Age on effective date**.[4]
How is tobacco status returned for subscribers and dependents?	Select how to determine if the tobacco rate is returned when calculating rates. Choose from the following: ◆ **Applicable [x] months**—if selected, a pop-up will ask for the number of months used to determine tobacco use. Market rules require QHP issuers to enter a tobacco look-back period of no more than 6 months.[5] SADP issuers are not subject to the look-back period. Rates will be tobacco or non-tobacco depending on whether an enrollee indicates that he or she was an active tobacco user within the last [x] months (tobacco rate) or not an active tobacco user within the last [x] months (non-tobacco rate). In addition, if the enrollee indicates that he or she will complete a tobacco cessation program offered by the plan, the non-tobacco rate will be used. ◆ **Not Applicable**—if selected, tobacco and non-tobacco rates are not separate. If rates are calculated by adding up individual rates, the sum will be a combination of tobacco rates for individuals who qualify for the tobacco rate and non-tobacco rates for individuals who qualify for the non-tobacco rate. For states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers, tobacco rates are not applicable.

[2] 45 CFR 147.120.
[3] 45 CFR 147.102(a)(I)(iii).
[4] Final U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2024.
[5] 45 CFR 147.102(a)(I)(iv).

Business Rules Template	Steps
What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?	Select the relationships that are allowable when returning rates and if the dependent must live in the same household to be eligible to return a rate. All selected relationships will be accepted regardless of the sex of the primary subscriber or dependent. Choose from the following: ◆ Self (selected by default) ◆ Spouse ◆ Child ◆ Stepson or Stepdaughter ◆ Grandson or Granddaughter ◆ Brother or Sister ◆ Life Partner ◆ Nephew or Niece ◆ Collateral Dependent ◆ Ex-Spouse ◆ Foster Child ◆ Ward ◆ Sponsored Dependent ◆ Other Relationship ◆ Other Relative. For each relationship selected, indicate **Yes** or **No** whether the dependent is required to live in the same household as the primary subscriber: ◆ **Yes**—the dependent must live in the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. ◆ **No**—the dependent may live in or outside the same household to be eligible to be on the same plan and included in the rate calculation when the relationship is allowed. Market rules require the entry of **No** for the household residency requirement for child dependents for QHP products and plans that cover child relationships. This rule applies to Child, Foster Child, and Stepson or Stepdaughter relationships. Select **Life Partner** to cover all unmarried partnership relationships, such as life partnerships and domestic partnerships. Relationships are not differentiated by sex. If a plan covers spouses and life partners, same-sex and opposite-sex spouses and life partners are covered.

See Figure 2D-1 for a sample completed Business Rules Template.

Figure 2D-1. Sample Business Rules Template

2027 Business Rules Template v16.0

*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*

Validate

Finalize

Enter the Issuer Rule on the first row (no Product ID or Plan ID).
For each Product rule, enter only the Product ID and the business rules that differ from the Issuer Rule.
For each Plan rule, enter only the Plan ID and the business rules that differ from the Product or Issuer Rule.
Issuer level rule will apply only to plan type indicated in cell C10.

HIOS Issuer ID*	12345
Medical, Dental, or Both?*	Both

Product ID	Plan ID (Standard Component)	Medical or Dental Rule?*	What is the maximum number of rated underage dependents on this policy?	Is there a maximum age for a dependent?	How is age determined for rating and eligibility purposes?	How is tobacco status determined for subscribers and dependents?	What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber?
		Medical	3	25	Age on effective date	6	Self, Yes; Spouse, No; Child, No; Stepson or Stepdaughter, No; Grandson or Granddaughter, No; Brother or Sister, No; Life Partner, No
12345VA001		Dental	Not Applicable		Age on effective date		Self, Yes; Spouse, No; Child, No; Stepson or Stepdaughter, No; Grandson or Granddaughter, No; Brother or Sister, No; Life Partner, No

After entering all data, click **Save** to ensure no data are lost. Once the Business Rules Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML file of the template that will need to be uploaded in the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file in the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Business Rules section of the QHP Application Instructions.

Section 2E: Plans & Benefits

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

In the Plans & Benefits section of the Marketplace Plan Management System (MPMS) Module, issuers enter plan data, list covered benefits with any quantitative limits or exclusions, and provide cost-sharing values and basic plan variation information for each submitted plan, including the deductible, maximum out-of-pocket (MOOP), copay, and coinsurance values. This information is provided via two worksheets—the Benefits Package worksheet and the Cost Share Variances worksheet.

2. Data Requirements

To complete this section, the following are needed:

1. Completed Network ID Template
2. Completed Service Area Template
3. Completed Prescription Drug Templates (qualified health plan [QHP] only)
4. Detailed benefit cost sharing for all plans.

3. Quick Reference

Key Changes for 2027

- There is new guidance on providing information about any waiting periods associated with adult dental services covered under stand-alone dental plans (SADPs).
- See Section 4.5: Plan Dates for information on multi-year catastrophic plans per the HHS Notice of Benefit and Payment Parameters for 2027.

Tips for the Plans & Benefits Section

- Download the most recent versions of the plan year (PY) 2027 Plans & Benefits Template, Plans & Benefits Add-In file, and Actuarial Value (AV) Calculator from the QHP certification website.
- Save the Plans & Benefits Add-In file in the same folder as the Plans & Benefits Template so the macros will run properly.
- All data elements that will be displayed to Individual Market consumers on Plan Compare are identified by a number sign (#) next to the field name in the instructions below.
- All data fields required for SADP issuers are identified by an asterisk (*) next to the field name in the instructions below. Follow the instructions below for details relating to the Benefits Package worksheet. For the Cost Share Variances worksheet, see sections 4.11, 4.20–4.22, 4.24, and 4.25 in this chapter.
- All data fields used by the AV Calculator are identified by a caret (^) next to the field name in the instructions below. See Appendix A for additional AV Calculator instructions.
- Complete and save the Network ID, Service Area, and Prescription Drug (QHPs only) Templates before filling out the Plans & Benefits Template. In the Plans & Benefits Template, issuers must assign a network, service area, and formulary ID (QHPs only) to each plan based on the IDs 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 Create New Benefits Package under the Plans & Benefits Add-In. The *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, and *Dental Only Plan* fields will auto-populate.
- Complete a row in the associated Cost Share Variances worksheet for each plan and associated cost sharing reduction (CSR) plan variation offered.
- The essential health benefit (EHB) percent of total premium calculation should be the multiplicative inverse of the Unified Rate Review (URR) Template *Benefits in Addition to EHB* field (i.e., 1 divided by *Benefits in Addition to EHB*) when rounded to the fourth decimal point.

Tips for the Plans & Benefits Section
◆ The cost sharing entered in the Plans & Benefits Template must reflect what the consumer pays for in-person services. See Appendix A for how these values relate to actuarial value. ◆ Cost sharing and other benefit information included in a plan variant marketing name must accurately reflect plan benefits. For example, a marketing name for a plan variant that requires a $50 copay for specialist visits should not include the phrase, “free specialist visits.” ◆ When a cell is grayed out, it is locked and cannot be edited. The Health Insurance Oversight System (HIOS) will not process data entered in the cell before it was grayed out.

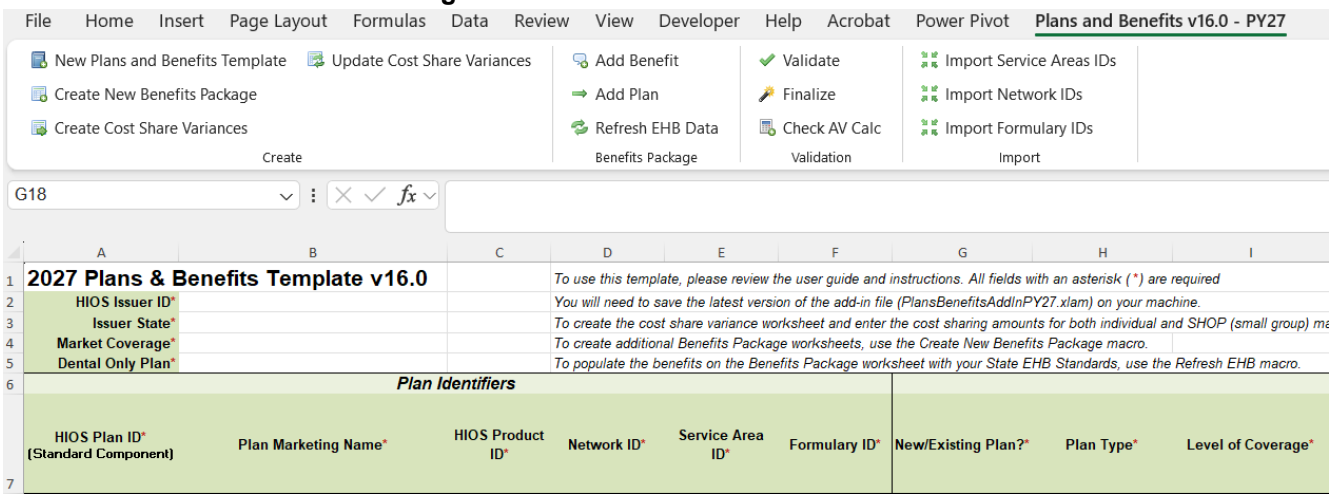
Additional Resources
◆ There are supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Before proceeding, download and use the latest versions of the Plans & Benefits Template and the Plans & Benefits Add-In file from the QHP certification website.

If asked to enable macros when the Plans & Benefits Template is opened, use **Options** on the Security Warning toolbar, and select **Enable Content**. The template will not recognize data entered before the macros were enabled. Any fields completed before enabling the macros will need to be reentered. Once macros are enabled, the **Plans and Benefits** ribbon should appear (Figure 2E-1) as a tab on the file’s toolbar.

Figure 2E-1. Plans and Benefits Ribbon



When completing the Plans & Benefits Template, only the following special characters are allowed in free text fields within the template. Entering other special characters will result in validation errors when uploading the template to the MPMS Module.

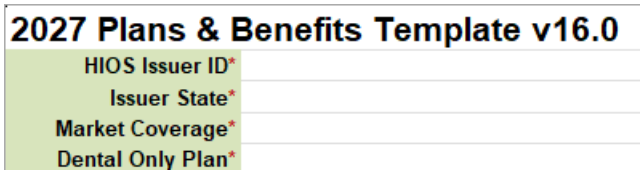
Valid Special Characters for Free Text Fields in the Plans & Benefits Template						
( ) (parentheses)	- (hyphen)	– (en dash)	, (comma)	. (period)	/ (slash)	& (ampersand)
$ (dollar sign)	: (colon)	; (semicolon)	% (percentage)	+ (addition sign)	< (less than)	> (greater than)
= (equal sign)	 (space)	_ (underscore)	@ (at sign)	# (hashtag)	| (vertical bar)	\ (backslash)

Valid Special Characters for Free Text Fields in the Plans & Benefits Template						
! (exclamation point)	‘ ’ (apostrophe/ single quote)	“ ” (quotation marks)	© (copyright)	® (registered trademark)	™ (trademark)	SM (service mark)
[ ] (square brackets)						

4.1 General Information

Enter basic issuer information in the fields in the upper left portion of the Benefits Package worksheet (Figure 2E-2). After this information is entered in the first Benefits Package worksheet, it will auto-populate in any additional Benefits Package worksheets that are generated.

Figure 2E-2. Plans & Benefits Template



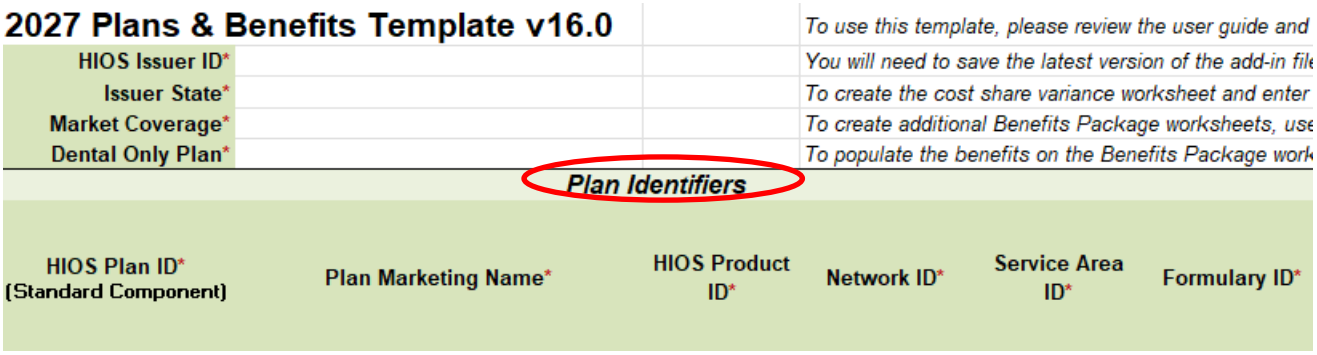
General Plans & Benefits Information	Steps
HIOS Issuer ID*	Enter the five-digit HIOS Issuer ID.
Issuer State*	Select the state in which the issuer is licensed to offer these plans using the drop-down menu.
Market Coverage*	Select the market coverage. Choose from the following: ◆ **Individual**—if the plans are offered on the Individual Market. ◆ **SHOP (Small Group)**—if the plans are offered on the SHOP Market. Note: The Market Coverage for a plan in the *Benefits Package* tab must match the Market Coverage for that plan stored in HIOS.
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 stand-alone dental plans (SADPs) and prevents the fields from accepting data entry. ◆ **No**—if this is not a dental-only package.

4.2 Plan Identifiers

This section of the Benefits Package worksheet has fields for inputting high-level data for each plan, including its plan ID and the network, service area, and formulary (QHPs only) it uses (Figure 2E-3). Complete this section for each standard plan offered as part of this benefits package. A standard plan is a QHP offered at the bronze, silver, gold, platinum, or catastrophic level of coverage or an SADP; 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. After each standard plan in the Benefits Package worksheet is entered, the template will automatically create the necessary plan variations in the Cost Share Variances worksheet.

If no more empty rows for new plans are available, click **Add Plan** on the menu bar under the **Plans and Benefits** ribbon. Each benefits package may include up to 50 plans. Create a second benefits package with an identical structure to accommodate additional plans.

Figure 2E-3. Plan Identifiers Section

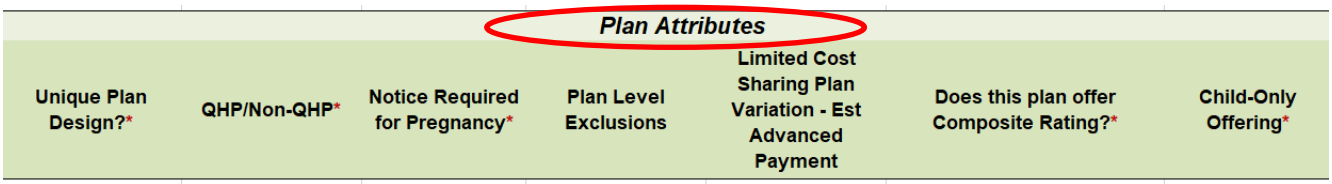


Plan Identifiers	Steps
HIOS Plan ID (Standard Component)*#	Enter the 14-character, HIOS-generated plan ID number. Plan IDs must be unique, even across different markets.
Plan Marketing Name*#	Enter the plan marketing name at the standard plan level. Note: Issuers that want to add cost sharing and other benefit information to a plan marketing name can do so at the plan variant marketing name (PVMN) level. Any cost sharing or other benefit information in a PVMN must accurately reflect that plan variant's benefit information, and any references to telehealth or virtual services must be explained in the applicable Benefit Explanation section. (See Section 4.10 Plan Cost Sharing Attributes for additional guidance.)
HIOS Product ID*	Enter the 10-character, HIOS-generated product ID number.
Network ID*	Click **Import Network IDs** on the menu bar under the **Plans and Benefits** ribbon, select the Network ID Template Excel file completed previously to import its network ID values, then select the appropriate network ID from the drop-down menu.
Service Area ID*	Click **Import Service Area IDs** on the menu bar under the **Plans and Benefits** ribbon, select the Service Area Template Excel file completed previously to import its service area ID values, then select the appropriate service area ID from the drop-down menu.
Formulary ID	Click **Import Formulary IDs** on the menu bar under the **Plans and Benefits** ribbon, select the Prescription Drug Template Excel file completed previously to import its values, then select the appropriate formulary ID from the drop-down menu. Note 1: Standardized plan options (SPOs) of different metal levels must have distinct formulary IDs selected to ensure the appropriate cost sharing is assigned for that plan's level of coverage. Note 2: SPOs and non-SPOs must have distinct formulary IDs selected to ensure appropriate validations are performed across the different design types.

4.3 Plan Attributes

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

Figure 2E-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: ◆ **New**—if this is a new plan that was not offered last year. This includes any plan offered last year that is not considered to be the "same plan" as described in 45 CFR 144.103. New plans should use a new plan ID that was not used for PY2026. ◆ **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. Existing plans should use the same plan ID that was used for PY2026.
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: ◆ Indemnity ◆ PPO (preferred provider organization) ◆ HMO (health maintenance organization) ◆ POS (point of service) ◆ EPO (exclusive provider organization) Note: The plan type for a plan in the *Benefits Package* tab must match the plan type for the product in HIOS.
Level of Coverage^*#	Select the metal level of the plan based on its AV. A de minimis variation of −2/+2 percentage points is allowed for all standard metal-level plans except for expanded bronze plans, for which a de minimis variation of +5/−2 percentage points is allowed. 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 on the Exchange, as described in Section 1302(d)(1) of the Patient Protection and Affordable Care Act (ACA). Choose from the following: ◆ **Bronze**—AV of 60 percent. ◆ **Expanded Bronze**—AV of 58–65 percent. A plan may use this option if it either covers and pays for at least one major non-preventive service 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. SADPs must complete the *Level of Coverage* field. Selecting **High** or **Low** will allow the template to validate for PY2027. The selection will not display to issuers in Plan Preview or to consumers in Plan Compare, as described in 45 CFR 156.140. ◆ **Low**—AV of 70 percent ◆ **High**—AV of 85 percent.
Design Type*	If the plan is not following a standardized plan option (SPO), select "Not Applicable." SADPs and SHOP plans also should select "Not Applicable" for this field. If the plan is following a SPO and is being offered through a Federally-facilitated Exchange (FFE) state or State-based Exchange on the Federal Platform (SBE-FP), excluding the FFE states of Delaware or Louisiana, select "Design Type 1." If the plan design is following a SPO and is being offered in Delaware or Louisiana, select "Design Type 2." 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 the corresponding silver plan variations must follow the cost sharing structure for their respective CSR standardized plan designs. For more information on the standardized plan design and populating plans' cost sharing using the SPOs Add-In, see Section 5.12 Standardized Plan Options and Corresponding Add-In File.

Plan Attributes	Steps
Unique Plan Design	Indicate whether the plan design is unique, meaning it cannot use the standard AV Calculator developed and made available by HHS for the given benefit year. For more information on determining whether a plan is unique, see Appendix A. Choose from the following: ◆ **Yes**—if unique plan design features cause the AV Calculator to yield an AV result that materially differs from that of other approved methods described in 45 CFR 156.135(b). This indicates the plan is not compatible with the AV Calculator. If **Yes** is selected for this reason, upload the Unique Plan Design Supporting Documentation and Justification Form. 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 on the Exchange, only off the Exchange, or both on and off the Exchange. Choose from the following: ◆ **On the Exchange**—if the plan will be offered only on the Exchange. Under the guaranteed availability requirements in 45 CFR 147.104, a plan offered on the Exchange generally must be available to individuals and employers (as applicable) in the state who apply for the plan off the Exchange. Issuers that offer a plan on the Exchange should select **Both** unless an exception to guaranteed availability applies. ◆ **Off the Exchange**—if the plan will be offered only off the Exchange. This includes non-QHPs and plans that are substantially the same as a QHP offered on the Exchange as part of the risk corridor program (see 45 CFR 153.500 for more details). ◆ **Both**—if the plan will be offered both on and off the Exchange. Such plans must have the same premium, provider network, cost sharing structure, service area, and benefits, regardless of where they are offered. Selecting this option creates two separate plan variations when the Cost Share Variances worksheet is created: one on-Exchange plan and one off-Exchange plan.
Notice Required for Pregnancy	Indicate whether consumers or providers must notify the issuer of a pregnancy before pregnancy benefits are covered. Choose from the following: ◆ **Yes**—if a notice is required before pregnancy benefits are covered. ◆ **No**—if a notice is not required before pregnancy benefits are covered.
Plan Level Exclusions*	Enter any plan-level exclusions.
Limited Cost Sharing Plan Variation—Est. Advance Payment	Leave this field blank. This data element is not required for PY2027. As specified in the *2015 HHS Notice of Benefit and Payment Parameters*, beginning with the 2015 plan year, Exchanges will calculate the advance payment amounts for CSRs for limited cost sharing plan variations.
Does this plan offer Composite Rating?	Select **No** for this field. This field is not applicable for PY2027.
Child-Only Offering*	Indicate whether the plan is also offered at a child-only rate or has a corresponding child-only plan (a plan for individuals who have not attained the age of 21 for QHPs and 19 for SADPs at the beginning of the plan year); 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. Catastrophic plans must have a value of **Allows Adult and Child-Only** to validate. Choose from the following: ◆ **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. Children may enroll for this plan, but an adult must be the primary subscriber. This plan needs a corresponding child-only plan (unless the plan's coverage level is catastrophic). Do not select this option for SADPs, which must be available to child-only subscribers. ◆ **Allows Child-Only**—if the plan is a child-only plan that allows only child subscribers. Do not select this option for catastrophic plans.

Plan Attributes	Steps
Child-Only Plan ID	Required if **Allows Adult-Only** is entered in *Child-Only Offering*. Enter the 14-character plan ID for the corresponding child-only plan if this plan does not allow child-only enrollment. The entered plan ID must correspond to a plan in which the *Child-Only Offering* is **Allows Adult and Child-Only** or **Allows Child-Only** and must have the same selection for *Level of Coverage* as the allows adult-only plan for which data is being entered.
Tobacco Wellness Program Offered	Indicate whether 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, as required to rate for tobacco use in the SHOP Market. (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: ◆ **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. ▪ The plan is offered in the SHOP Market and does not rate for tobacco use.
Disease Management Programs Offered#	Indicate whether the plan offers disease management programs. If the plan offers disease management programs, choose one or more of the following: ◆ Asthma ◆ Heart Disease ◆ Depression ◆ Diabetes ◆ High Blood Pressure and 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). Note: This field is not applicable for SHOP Market plans or catastrophic plans. The *EHB Percent of Total Premium* field should be the multiplicative inverse of the URR Template *Benefits in Addition to EHB* field (i.e., 1 divided by *Benefits in Addition to EHB*) when rounded to the fourth decimal point. As part of the data integrity review, the Centers for Medicare & Medicaid Services (CMS) will identify any mismatch between EHB percent of total premium and the multiplicative inverse of *Benefits in Addition to EHB* for a non-catastrophic Individual Market QHP and prompt the issuer to confirm that the submitted values for *EHB Percent of Total Premium* from the Plans & Benefits Template and *Benefits in Addition to EHB* from the URR Template are correct. Certain benefits, including routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, non-medically necessary orthodontia, and specified sex-trait modification procedures (as defined at 45 CFR 156.400) should not be considered EHB, even if the state EHB benchmark plan covers such benefits. [1] A state may require a QHP to offer benefits in addition to the EHB, but generally the state is required to defray the cost of such state-required benefits to the enrollee or to the QHP issuer on behalf of the enrollee. [2] How an Individual Market QHP issuer should handle the portion of the premium related to these services depends on whether the state makes these defrayal payments to the QHP issuer or to the enrollee.

[1] 45 CFR 156.115(d).
[2] 45 CFR 155.170.

Plan Attributes	Steps
	In a state that defrays the cost of a state-required benefit in addition to EHB directly to the QHP issuer: ◆ The cost of the state-required benefit the state is defraying to the issuer should not be factored into the calculation for the *EHB Percent of Total Premium* field on the Plans & Benefits Template, and the cost of the state-required benefit should not be factored into the total premium from which the *EHB Percent of Total Premium* is calculated. Including this information would result in the issuer being paid for this benefit twice. This means if the state is defraying a benefit in addition to EHB directly to the QHP issuer, and all other benefits are covered by the QHP issuer as EHB, then the *EHB Percent of Total Premium* should be 100%. ▪ The benefit should not be marked as EHB in the *EHB* column in the Benefit Information section (see Section 4.7 Benefit Information). For a benefit already listed on the Plans & Benefits Template, select **Not EHB – Defrayed to Issuer** as the *EHB Variance Reason*. To add a benefit not already listed on the Plans & Benefits Template, click the **Add Benefit** button on the menu bar under the **Plans and Benefits** ribbon. Select **Not EHB – Defrayed to Issuer** as the *EHB Variance Reason*. ▪ If a state is defraying to the QHP issuer the cost of a state-required benefit for coverage of abortion for which public funding is prohibited, the QHP issuer should follow the above steps. Assuming all remaining benefits are EHB, following the above steps will result in the plan's *EHB Percent of Total Premium* equaling 100%. In a state that defrays the cost of a state-required benefit in addition to EHB directly to the enrollee: ◆ The cost of the state-required benefit the state is defraying to the enrollee should be factored as a non-EHB in the *EHB Percent of Total Premium* field on the Plans & Benefits Template and therefore excluded from the EHB proportion of the *EHB Percent of Total Premium*. This means the *EHB Percent of Total Premium* can never be 100% if the state defrays the cost of a state-required benefit in addition to EHB directly to the enrollee. However, the cost of the state-required benefit should be included in the total premium from which the *EHB Percent of Total Premium* is calculated (therefore treating it as non-EHB for purposes of the total premium). This ensures the benefit is only paid once. ▪ The benefit should not be marked as EHB in the *EHB* column in the Benefit Information section (see Section 4.7 Benefit Information). For a benefit already listed on the Plans & Benefits Template, select **Not EHB – Defrayed to Enrollee** as the *EHB Variance Reason*. To add a benefit not already listed on the Plans & Benefits Template, QHP issuers can click the **Add Benefit** button on the menu bar under the **Plans and Benefits** ribbon. QHP issuers should mark the benefit as **Not EHB – Defrayed to Enrollee** as the *EHB Variance Reason*. ▪ If a state is defraying the cost of abortion for which public funding is prohibited directly to the enrollee, the QHP issuer should follow the above steps. The *EHB Percent of Total Premium* cannot be 100% when the state is defraying the cost of a state-required benefit directly to the enrollee. ▪ CMS will conduct a review to ensure that no QHP issuer has selected one or more benefits where the *EHB Variance Reason* is **Not EHB – Defrayed to Enrollee** and has an *EHB Percent of Total Premium* of 100%. QHP issuers with deficiencies must work with CMS to fix these data errors, as the *EHB Percent of Total Premium* cannot be 100% when the state is defraying the cost of a state-required benefit directly to the enrollee. For plans that include coverage of abortion services for which public funding is prohibited (also known as non-Hyde abortion services)[3] offered in states where the benefits package of the EHB

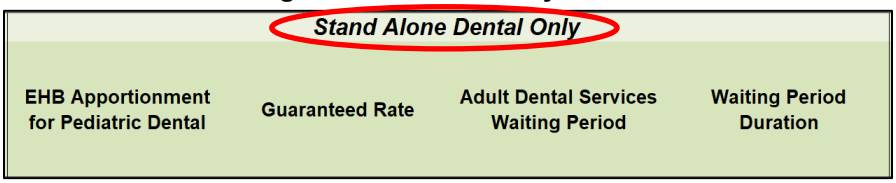
[3] 45 CFR 156.280(d).

Plan Attributes	Steps
	benchmark plan includes such abortion services, issuers must handle the portion of the premium related to these services using one of the two methods described below, as applicable: ◆ If the plan is a QHP offered on the Federally-facilitated Exchange (FFE), State-based Exchange on the Federal Platform (SBE-FP), or a State-based Exchange (SBE), do not include the percentage of the premium associated with such abortion services in the EHB percentage (even if these services are in the EHB benchmark package). The EHB percentage is used to calculate subsidy amounts and subsidy payments may not be provided for costs associated with such abortion services. Therefore, costs associated with such abortion services must be excluded from the EHB proportion and reflected accordingly in the adjustment for benefits in addition to EHB. ▪ The only exception is if the state is defraying the cost of abortion for which public funding is prohibited directly to the QHP issuer, in which case the QHP issuer should follow the steps outlined above applicable to when a state is defraying to the issuer. Assuming all remaining benefits are EHB, following the outlined steps will result in the plan's *EHB Percent of Total Premium* equaling 100%. ◆ If the plan is a QHP that is only offered off the Exchange (not offered in the FFE, SBE-FP, or in an SBE), the percentage of the premium associated with abortion services for which public funding is prohibited may be included in the EHB percentage. For plans that include coverage of abortion services for which public funding is permitted and that is offered in states where the benefits package of the EHB benchmark plan includes such abortion services, the plan should include the percentage of premium associated with these services in the EHB percentage. For plans that include coverage of abortion services for which public funding is prohibited outside of the scope of the state's EHB benchmark package and that is not subject to state defrayal, select **Not EHB** as the *EHB Variance Reason.* Any such covered abortion services are benefits in addition to EHB.

4.4 Stand-Alone Dental Only

The fields in this section apply to SADPs only (Figure 2E-5).

Figure 2E-5. SADP-Only Fields



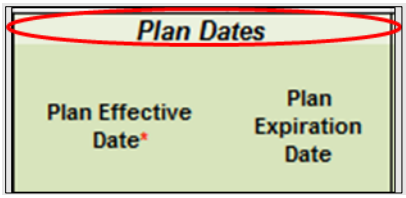
Stand-Alone Dental Only	Steps
EHB Apportionment for Pediatric Dental*	Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies only to pediatric rates. If the rates are family-tiered, use the EHB percent 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). All SADP issuers must attest to the Stand-Alone Dental Plans Attestation. HIOS issuers will complete the attestation in the MPMS Module and issuers in states that perform plan management functions will complete the attestation in the State Partnership Exchange Issuer Program Attestation Response Form. Note: This field is no longer applicable for SHOP Market plans.
Guaranteed Rate*	This indicates whether the rate for this SADP is a guaranteed rate. By selecting **Guaranteed Rate**, issuers commit to charging only the premium shown to the consumer on HealthCare.gov, which is calculated by taking into account the consumer's geographic location, age, and other permissible rating factors within the Rates Table Template and Business Rules Template. Since

Stand-Alone Dental Only	Steps
	PY2024, CMS has stopped allowing SADP issuers to submit estimated rates.[4] If entering a value of **Yes** for the *Dental Only Plan* field, **Guaranteed Rate** will be automatically populated for the *Guaranteed Rate* column on each *Benefits Package* tab of the Plans & Benefits Template. Select that this plan offers guaranteed rates. Choose the following: ◆ **Guaranteed Rate**—if the plan offers a guaranteed rate. SADP issuers must submit guaranteed rates. The template prevents selection of the discontinued option of Estimated Rate.
Adult Dental Services Waiting Period*	◆ Select **Yes** if the plan design places a waiting period on any procedures or services covered under the following non-pediatric EHB dental benefits: ▪ Routine Dental Services (Adult) ▪ Basic Dental Care - Adult ▪ Orthodontia - Adult ▪ Major Dental Care - Adult ▪ Accidental Dental ◆ Select **No** if there are no associated waiting periods.
Waiting Period Duration*	◆ If **Yes** was selected for *Adult Dental Services Waiting Period*, provide detail on the duration (in weeks, months, etc.) of the waiting period.

4.5 Plan Dates

The fields in this section are for each plan's plan effective date and plan expiration (Figure 2E-6). The FFE rating engine uses the rate effective dates in the Rates Table Template, not the Plans & Benefits Template.

Figure 2E-6. Plan Dates



Plan Dates	Steps
Plan Effective Date*	This should be the effective date for the upcoming 2027 plan year—even for existing plans offered on Exchange in 2026. Enter the effective date of the plan using the mm/dd/yyyy format. This must be 01/01/2027 for all plans that will be offered on the FFE and the Federally-facilitated Small Business Health Options Program (FF-SHOP).
Plan Expiration Date*	Enter the date that a plan closes and no longer accepts new enrollments using the mm/dd/yyyy format (this must be 12/31/2027 for the Individual Market). FF-SHOP plans are effective for a 12-month plan year, so the plan expiration date must be 12 months after the plan effective date.

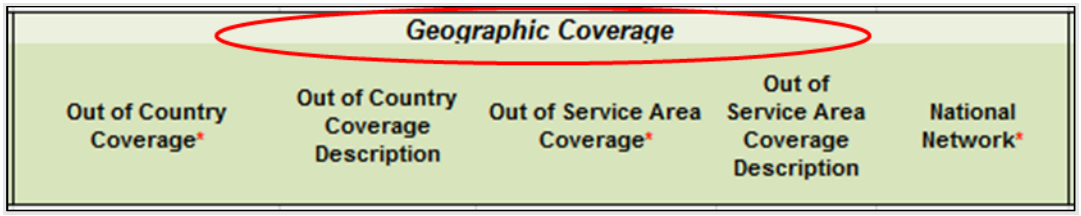
If an issuer intends to offer a multi-year catastrophic plan, as indicated in the HHS Notice of Benefit and Payment Parameters for 2027, CMS requests that the issuer enter 12/31/27 as its plan expiration date and contact its CMS Account Manager upon initial submission to identify the Plan IDs and proposed multi-year term lengths associated with each plan. If the issuer is new to the Marketplace for PY2027 and has not yet been assigned a CMS Account Manager, the issuer should submit a ticket with the above information and the subject line "PY2027 Multi-Year Catastrophic Plans" to CMS_FEPS@cms.hhs.gov. After receipt of this information, CMS will contact the issuer with additional guidance.

[4] Final HHS Notice of Benefit and Payment Parameters for 2024.

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 benefit package for the geographic unit. Issuers should select **No** if the plan covers only emergency services for the geographic unit (Figure 2E-7).

Figure 2E-7. Geographic Coverage Fields

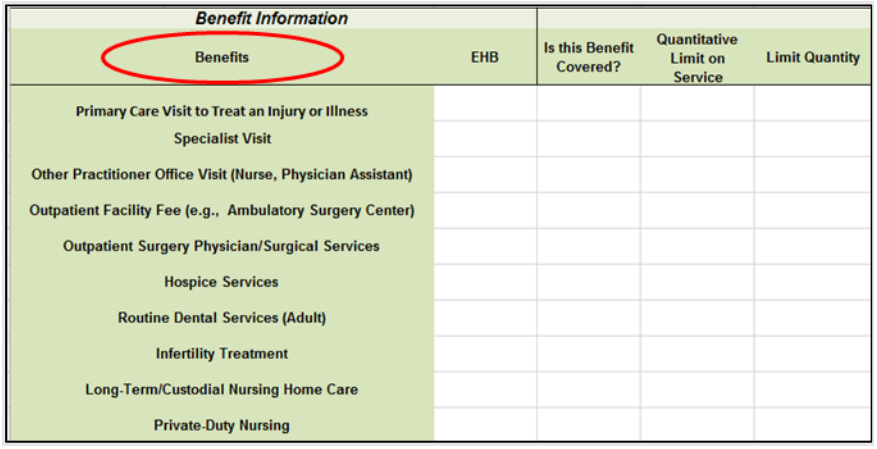


Geographic Coverage	Steps
Out of Country Coverage*	Indicate whether care obtained outside the country is covered under the plan. Choose from the following: ◆ **Yes**—if the plan covers care obtained out of the country. ◆ **No**—if the plan does not cover care obtained out of the country.
Out of Country Coverage Description*	If **Yes** is selected for the *Out of Country Coverage* field, a short description of the care obtained outside the country that the plan covers must be entered.
Out of Service Area Coverage*	Indicate whether care obtained outside the service area is covered under the plan. Choose from the following: ◆ **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*	If **Yes** is selected for the *Out of Service Area Coverage* field, a short description of the care obtained outside the service area that the plan covers must be entered.
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 Benefit Information

The Benefit Information section of the template indicates the scope of benefits the plan covers (Figure 2E-8).

Figure 2E-8. Benefit Information Section



Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. If this benefits package has multi-state plans using an alternate benchmark, click **Yes** in the pop-up. If it does not, 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.

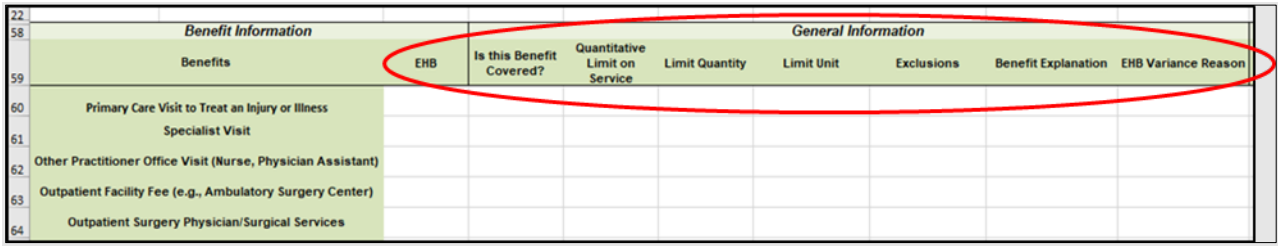
To add a benefit that is not listed on the template, click **Add Benefit** on the menu bar under the **Plans and Benefits** ribbon.

- Determine whether the benefit is listed in the drop-down menu; if it is, select it. If the benefit is not listed in the drop-down menu, click **Custom** and type in the new benefit name. New benefit names must be different from existing benefit names.
- A row for this benefit will appear below the last row in the Benefit Information section.
- If a benefit is added by mistake, do one of the following:
  - Select **Not Covered** under *Is this Benefit Covered?* (see Section 4.9 Out of Pocket Exceptions).
  - Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, and Out of Pocket Exceptions sections, including the benefit added by mistake.
- If adding a benefit that is not found in the state's benchmark, not substituted for an EHB found in the state's benchmark, and not a state-required benefit in addition to EHB, select **Not EHB** as the *EHB Variance Reason*.
- If adding a benefit that is not found in the state's benchmark and substituting it for an EHB found in the state's benchmark, select **Additional EHB Benefit** as the *EHB Variance Reason*.
- If adding a state-required benefit enacted after December 2011 that is in addition to the EHB benchmark plan, select **Not EHB – Defrayed to Issuer** or **Not EHB – Defrayed to Enrollee**, as applicable, as the EHB variance reason. Please see Section 4.3 Plan Attributes under "EHB Percent of Total Premium" for more information on selecting the *EHB Variance Reason*.
- For more information on how to select the correct EHB variance reason, see Section 5.6 EHB Variance Reason and EHB Designation.
- Do not add multiple benefits with the same name to a benefits package. If multiple cost sharing schemas are offered for a given benefit based on multiple limits, choose the cost sharing type that applies to the limits in the *Limit Quantity* and *Limit Unit* fields for each of the network types.

4.8 General Information

Use this section to provide information on each benefit in the benefits package, such as benefit coverage, benefit limits, applicable exclusions, and benefit explanations (Figure 2E-9).

Figure 2E-9. 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. This field is not editable. Note: Carefully review the benefits covered by the applicable EHB benchmark plan as identified in the Information on EHB Benchmark Plans website. After reviewing the applicable EHB benchmark plan documents, issuers should update the Benefits Package worksheet to accurately reflect the plan's EHB benchmark benefits coverage. See the instructions for the *EHB Variance Reason* field for more information on updating the Benefits Package worksheet.
Is this Benefit Covered?*	This field is auto-populated with **Covered** for benefits identified in the template as EHBs. If this field is changed to **Not Covered**, another benefit must be substituted in its place and the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification Form must be provided to support the actuarial equivalence of the substitution (see the *EHB Variance Reason* field). 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: ◆ **Covered**—if this benefit is covered by the plan. A benefit is considered covered if the cost of the benefit is covered via 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 consumer is required to pay the full cost of the services with no effect on deductible and MOOP limits.
Quantitative Limit on Service?*	Complete this field if **Covered** is selected in the *Is this Benefit Covered?* field. This field is auto-populated for EHBs. If this field is changed for an EHB, an EHB variance reason and supporting documents must be provided. For benefits that are not EHBs, choose from the following: ◆ **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, 2018, combined limits may not be imposed on habilitative and rehabilitative services and devices. Therefore, when completing the Benefit Information and General Information sections of the Benefits Package worksheet of the Plans & Benefits Template, a separate limit for those benefits must be provided.
Limit Quantity*#	Complete this field if **Yes** is selected for *Quantitative Limit on Service?* This field is auto-populated for EHBs. If this data element is changed, an EHB variance reason must be provided. For benefits that are not EHBs, enter a numerical value showing the quantitative limits placed on this benefit (e.g., to set a limit of two specialist visits per year, enter **2** here).
Limit Unit*#	Complete this field if **Yes** is selected for *Quantitative Limit on Service?* This field is auto-populated for EHBs. If this data element is changed, select the **Substantially Equal** EHB variance reason. Enter the unit used to restrict this benefit (e.g., to set a limit of two specialist visits per year, enter **Visits per year** here). Choose from the following: ◆ Hours per week ◆ Hours per month ◆ Hours per year ◆ Days per week ◆ Days per month ◆ Days per year

General Information	Steps
	◆ Months per year ◆ Visits per week ◆ Visits per month ◆ Visits per year ◆ Lifetime visits ◆ Treatments per week ◆ Treatments per month ◆ Lifetime treatments ◆ Lifetime admissions ◆ Procedures per week ◆ Procedures per month ◆ Procedures per year ◆ Lifetime procedures ◆ Dollars per year ◆ Dollars per visit ◆ Days per admission ◆ Procedures per episode. Limit units that do not align with the list above (such as a limit of one hearing aid per ear every 48 months for subscribers up to age 18) will not auto-populate in the *Limit Unit* field but will auto-populate in the *Benefit Explanation* field. Quantitative limits that span several types of services will not auto-populate. For instance, the benefit "Outpatient Rehabilitation Services—30 combined visits for physical therapy, speech therapy, and occupational therapy for rehabilitative services" will only appear in the *Benefit Explanation* field. Multiple limit units will not auto-populate. To implement multiple limits, complete the *Limit Quantity* and *Limit Unit* fields with the information that should be displayed on the Plan Compare function of the FFE website, then put all other quantitative limits in the *Benefit Explanation* field. For example, to enter the benefit "Outpatient Rehabilitative Services—90 days per year; two treatments per year," enter **90** in the *Limit Quantity* field, **Days per year** in the *Limit Unit* field, and **Two treatments per year** in the *Benefit Explanation* field. The message "Quantitative limit units apply, see EHB benchmark" may appear in the *Benefit Explanation* field for benefits that do not have quantitative limits in the Benefits and Limits section of the Information on EHB Benchmark Plans website. This message appears when benefits identified in the Other Benefits section of the EHB Benchmark Benefit Template have quantitative limits that do not apply to all services in the higher-level benefit category.
Exclusions*#	Enter any benefit-level exclusions. ◆ If particular services or diagnoses are covered under only some circumstances, list specific exclusions. ◆ If services or diagnoses are not excluded, leave this field blank.
Benefit Explanation*#	Enter any benefit explanations. For the benefits that display on HealthCare.gov, this *Benefit Explanation* field will display to consumers on HealthCare.gov. ◆ Explain additional cost sharing structures if they depend on provider type or place of service, including virtual care and/or telehealth services (see Section 4.24 Covered Benefits), note additional quantitative limits, link to additional plan documents, provide child-specific MOOP or deductible limits, detail descriptions of services provided, and describe. ◆ If the plan has different cost sharing for the virtual version of a benefit that can also be delivered in person, the issuer must note here that this is the case and specify the nature of the difference. For example: Virtual PCP visits $0 copay, In-person PCP visits $25 copay. If the plan requires a referral from a virtual provider for a beneficiary to access in-person services, the issuer must note here that this is the case and specify where more information can be found. For example: Virtual PCP referral required to access in-person services; learn more in plan benefit brochure.

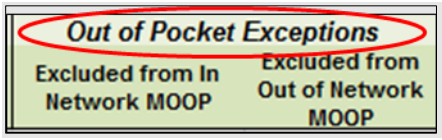
General Information	Steps
EHB Variance Reason*	If *Is this Benefit Covered?*, *Limit Units*, or *Limit Quantity* fields are changed, or if the issuer state's benchmark has an unallowable limit or exclusion under the ACA, complete this field. Select from the following options for *EHB Variance Reason* if this benefit differs from the state's benchmark: ◆ **Not EHB**—if this benefit is not an EHB, is not listed in the state's benchmark, is not substituted for an EHB found in the state's benchmark plan, and not a state-required benefit in addition to EHB, set the *EHB Variance Reason* to **Not EHB**. ▪ If a new benefit not found in the state's benchmark is added, the *EHB* field will be blank and the *EHB Variance Reason* should be set to **Not EHB**. This benefit is not considered an EHB. ▪ If a benefit auto-populated as **Yes** in the *EHB* column, but CMS or the issuer's state have directed that the benefit should not be considered an EHB, set the *EHB Variance Reason* to **Not EHB**. This benefit is not considered an EHB. ◆ **Not EHB – Defrayed to Issuer**—if a benefit in addition to EHB is required by a state, and the state defrays the cost of the state-required benefit directly to the QHP issuer, set the *EHB Variance Reason* to **Not EHB – Defrayed to Issuer**. This benefit is not considered an EHB. ◆ **Not EHB – Defrayed to Enrollee**—if a benefit in addition to EHB is required by a state, and the state defrays the cost of the state-required benefit directly to the enrollee, set the *EHB Variance Reason* to **Not EHB – Defrayed to Enrollee**. This benefit is not considered an EHB. ◆ **Substituted**—if a benefit is included in the issuer state's EHB benchmark, the *EHB* field auto-populates as **Yes**. If a different benefit is substituted for an EHB, set the *EHB Variance Reason* to **Substituted** and *Is this Benefit Covered?* to **Not Covered**. The benefit substituted must be designated as an **Additional EHB Benefit**. ◆ **Substantially Equal**—if the limit quantity or limit unit for a benefit differs from the limit quantity or limit unit in the EHB benchmark but is substantially equal to the EHB benchmark, select **Substantially Equal** as the variance reason. For example, a benchmark limit of 40 hours per month is substantially equal to a plan limit of 5 days per month if a day is defined as 8 hours. ◆ **Using Alternate Benchmark**—select this *EHB Variance Reason* for any benefit that has auto-populated **Yes** in the *EHB* column 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 is not represented in the state's EHB benchmark plan, set *Is this Benefit Covered?* to **Covered** and set the *EHB Variance Reason* to **Other Law/Regulation**. Benefits that fall under variance reason **Other Law/Regulation** are considered EHBs because they are mandated benefits enacted before 2012 and/or are required for the purpose of complying with federal law. For example, a benefit may not appear as an EHB because the benchmark plan is a Small Group plan, and the state requires coverage only in the Individual Market. ◆ **Additional EHB Benefit**—if a benefit is covered by an EHB benchmark but is not included in the auto-populated list, change the benefit to **Covered**, and choose **Additional EHB Benefit** as the *EHB Variance Reason*. For example, covered non-preferred brand drug benefits may not appear to be covered in the auto-populated table. 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 dental EHB is only covered using a separate dental-only plan, set the *EHB Variance Reason* to **Dental Only Plan Available**. For example, if SADPs are offered to cover pediatric dental benefits, pediatric dental does not need to be covered in QHPs. Select **Not Covered** and **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: EHB benchmark plan benefits are based on plans that were sold previously and may not comply with current federal requirements. Therefore, when designing plans that are substantially equal to the EHB benchmark plan, plan benefits may need to be conformed, including coverage and limitations, to comply with these requirements and limitations. Carefully review the information available on the Information on EHB Benchmark Plans website. If more than one *EHB Variance Reason* applies, select the variance reason related to EHB designation instead of the one related to limits because the *EHB Variance Reason* affects non-

General Information	Steps
	discrimination and EHB reviews as well as cost sharing requirements for EHBs and non-EHBs related to CSR plan variations. For example, if an issuer adds a new benefit that is an EHB and changes its limits, select **Additional EHB Benefit** variance reason instead of **Substantially Equal**.

4.9 Out of Pocket Exceptions

This section allows issuers to indicate 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, create a new benefits package and complete a new Cost Share Variances worksheet (Figure 2E-10).

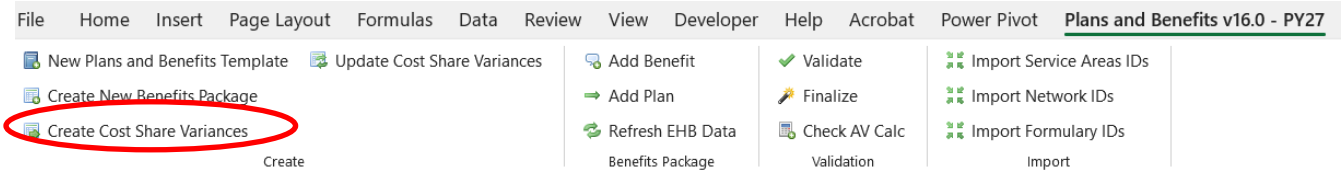
Figure 2E-10. Out of Pocket Exceptions



Out of Pocket Exceptions	Steps
Excluded from In Network MOOP*	Indicate whether this benefit is excluded from the in-network MOOP. Only benefits that are not part of the state EHB benchmark can be excluded from the in-network MOOP. Choose from the following: ◆ **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: ◆ **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?* is **Not Covered** or blank, leave the *Excluded from In Network MOOP* and *Excluded from Out of Network MOOP* fields blank. ◆ If the plans do not have an out-of-network MOOP, select **Yes** for *Excluded from Out of Network MOOP*.	

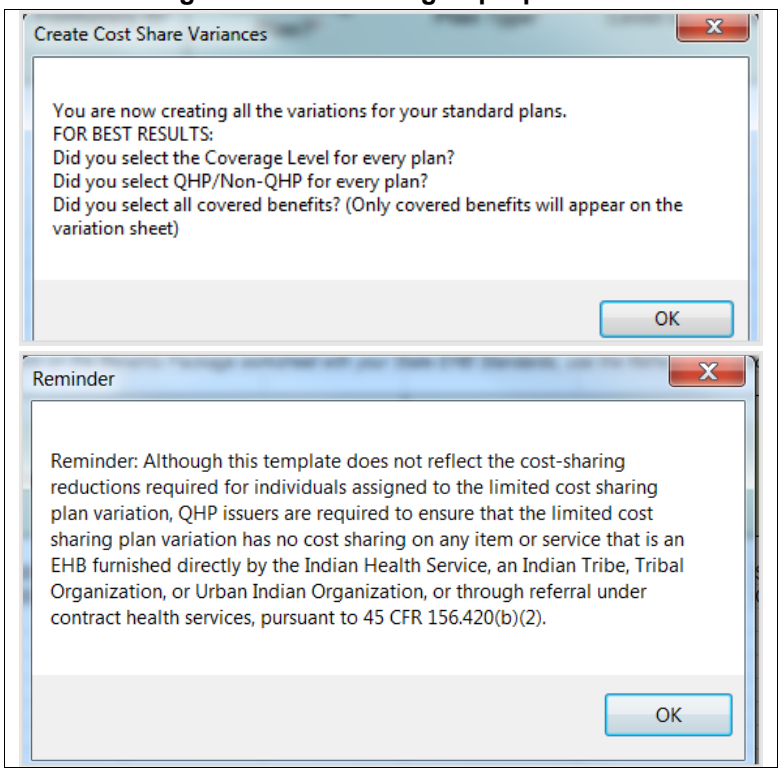
After the above benefit-related information is entered in the Benefits Package worksheet, click **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon (Figure 2E-11). The Cost Share Variances worksheet collects detailed cost sharing benefit design information for all plans in the corresponding benefits package and their associated CSR plan variations.

Figure 2E-11. Create Cost Share Variances Button



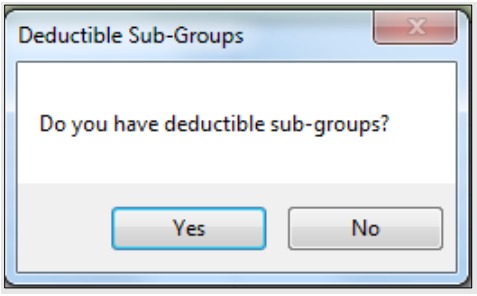
Click **OK** after reading the warnings (Figure 2E-12) and make any necessary changes.

Figure 2E-12. Warning Pop-Up Boxes



After the warnings are addressed, the following series of questions regarding deductible sub-groups appears (Figure 2E-13). Use deductible sub-groups to identify benefits or groupings of benefits that have separate deductibles. Deductible sub-groups are not separate from the maximums allowed, and they still contribute to the overall MOOP and deductible limits. Issuers are not required to use deductible sub-groups.

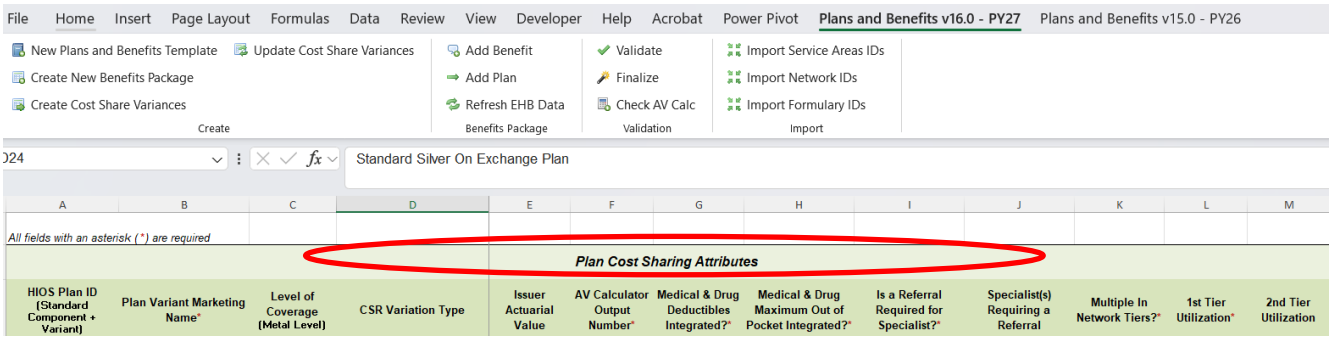
Figure 2E-13. Deductible Sub-Groups



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. If **Yes** is selected for the previous question, the following questions will appear:
   a. How many deductible sub-groups do you have?
      i. Enter the correct number and click **OK**.
   b. What is the name of this deductible sub-group?
      i. Enter a sub-group name and click **OK**. Repeat for each of the deductible sub-groups. A different name must be used for each sub-group.

A new Cost Share Variances worksheet is created for each Benefits Package worksheet (Figure 2E-14). Verify that any auto-populated information is accurate, then enter information for each benefits package in the corresponding Cost Share Variance worksheet, which will be labeled with the same number. For example, enter information on Cost Share Variances 2 for plans created on Benefits Package 2.

Figure 2E-14. Cost Share Variances Worksheet



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

4.10 Plan Cost Sharing Attributes

This section collects basic information for each plan and CSR 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, but CSRs 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 Exchange have a plan ID variant suffix of "−01," and standard plans to be offered off the Exchange have a plan ID variant suffix of "−00." ◆ For the Individual Market, each standard plan (except for catastrophic) has two CSR plan variations for American Indians and Alaska Natives: one with zero cost sharing (plan ID variant suffix "−02") and one with limited cost sharing (plan ID variant suffix "−03"). ▪ In the zero cost sharing plan variation, consumers do not 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 another provider with a referral from an Indian health care provider. ◆ In the Individual Market, each silver plan has three additional CSR plan variations: a 73 percent AV plan (plan ID variant suffix "−04"), an 87 percent AV plan (plan ID variant suffix "−05"), and a 94 percent AV plan (plan ID variant suffix "−06"). ▪ These silver plan variations lower the MOOP and the amounts consumers pay out of pocket for deductibles, coinsurance, and copayments. Consumers qualify for these plans if their income is below a certain level.
Plan Variant Marketing Name*#	The name of the plan auto-populates the standard plan's marketing name for all standard plans and plan variations. Any references to cost sharing or other benefit information must be adjusted in the *Plan Variant Marketing Name* field so that the information is accurate for the applicable plan variation name. The name entered in this field will display to consumers, so enter the name for each plan variation in this field. The field has a limit of 255 characters, but the marketing name must not exceed 150 characters (including spaces). If the marketing name includes references to virtual care or telehealth services, these references must be explained in the applicable *Benefit Explanations* field.

Plan Cost Sharing Attributes	Steps
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, as a standard off-Exchange plan, or as one of the CSR plan variations explained in this section.
Issuer Actuarial Value*	If **Yes** is entered for *Unique Plan Design* in the Benefits Package worksheet, enter the AV. This applies to health plans that indicate they are a unique plan for AV purposes. Note: SADP issuers are not required to enter a value for this field for the template to validate. Instead, attest to the Stand-Alone Dental Plan Attestation. HIOS issuers will complete the attestation in the MPMS Module and issuers in states that perform plan management functions will complete the attestation in the State Partnership Exchange Issuer Program Attestation Response Form, available on the QHP certification website.
AV Calculator Output Number	After completing the cost sharing information and benefits package information, click **Check AV Calc** on the **Plans and Benefits** ribbon and select the correct file to populate this field with the AV for all plans on this worksheet using non-unique plan designs. For more information, see Appendix A. This field is required for QHPs but optional for SADPs.
Medical & Drug Deductibles Integrated?^	Indicate whether the plan's medical and drug deductibles are integrated. An integrated deductible allows both medical and drug charges to contribute to a total plan-level deductible. Separate deductibles indicate medical and drug charges contribute to separate plan level deductibles. Choose from the following: ◆ **Yes**—if the medical and drug deductibles are integrated. If **Yes** is entered, do not enter information in Section 4.16 Medical EHB Deductible or Section 4.17 Drug EHB Deductible. ◆ **No**—if the medical and drug deductibles are not integrated. If **No** is entered, do not enter information in Section 4.18 Combined Medical and Drug EHB Deductible.
Medical & Drug Maximum Out of Pocket Integrated?^	Indicate whether the medical and drug MOOPs are integrated. An integrated MOOP allows medical and drug charges to contribute to a total plan-level MOOP. Separate MOOPs indicate medical and drug charges contribute to separate plan-level MOOP values. Choose from the following: ◆ **Yes**—if the medical and drug MOOPs are integrated. If **Yes** is entered, do not enter information in Section 4.13 Maximum Out of Pocket for Medical EHB Benefits or Section 4.14 Maximum Out of Pocket for Drug EHB Benefits. ◆ **No**—if the medical and drug MOOPs are not integrated. If **No** is entered, issuers should not enter information in Section 4.15 Maximum Out of Pocket for Medical and Drug EHB Benefits (Total).
Is a Referral Required for a Specialist?	Indicate whether consumers must be referred to see a specialist. Choose from the following: ◆ **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#	Enter the types of specialists that require a referral if **Yes** is entered for *Is a Referral Required for a Specialist?*
Multiple In Network Tiers?^*	Indicate whether multiple in-network provider tiers allow the plan to apply different levels of in-network cost sharing depending on the provider or facility tier. The value must be the same for all variations of a plan. Choose from the following: ◆ **Yes**—for multiple in-network provider tiers. Enter Tier 1 information in the *In Network* and *In Network (Tier 1)* sections and Tier 2 information in the *In Network (Tier 2)* sections. ◆ **No**—if there are not multiple in-network provider tiers. If this response is selected, information cannot be entered in the *In Network (Tier 2)* sections, which will be grayed out and locked.
1st Tier Utilization^*	If responding **Yes** to *Multiple In Network Tiers?*, enter the 1st Tier Utilization as a percentage. The tier utilization is the proportion of claims cost anticipated to be incurred in this tier. The field auto-populates to 100% if responding **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 1st Tier Utilization.)
2nd Tier Utilization^*	If responding **Yes** to *Multiple In Network Tiers?*, enter the 2nd Tier Utilization as a percentage. This cell will be grayed out and locked if responding **No** to *Multiple In Network Tiers?* (All plan variations must match the standard plan 2nd Tier Utilization.)

4.10.1 Plan Variant Marketing Name

45 CFR 156.225(c), as finalized in the HHS Notice of Benefit and Payment Parameters for 2024, requires that QHP plan and plan variant marketing names include correct information, do not omit material fact, and do not include content that is misleading. Issuers may, but are not required to, add cost sharing and other benefit information to a plan marketing name here. This information must:

- Accurately reflect the plan variant's benefits, including any quantitative limits (see Section 4.8 General Information) and limitations or cost variations based on tiering, benefit category, or service type. For example:
  - PVMNs that list a non-integrated deductible or MOOP must specify if the deductible refers to "Medical" or "Drug," remove references to a deductible or MOOP, or list the combined deductible or MOOP amount. If including a number without a modifier that refers to a deductible or MOOP, include the full amount for which an enrollee may be responsible.
  - Cost sharing information must include any applicable limitations to a certain prescription drug category, to specific providers, or to a certain number of visits.
  - PVMNs that list cost sharing for a benefit that is subject to the deductible must also specify the deductible requirement in the marketing name.
  - If the plan has tiered benefits, the PVMN must match the highest cost sharing tier, list information for all tiers, or omit this information.
- Correspond to and match information that issuers submit for the plan in the Plans & Benefits Template, and/or in other materials submitted as part of the QHP certification process such as the Summary of Benefits and Coverage (SBC). Cost sharing information in a PVMN must specify any benefits to which it applies, unless it applies to all plan benefits based on the Plans & Benefits Template.
- Be consistent with and clearly resemble the plan or plan variant name in other plan documents, such as the SBC, even if it is not identical.
- Not include references to benefits that the ACA requires all QHPs to cover as though they were unique to that plan, such as "free preventive care" or "no exclusions for pre-existing conditions."
- Not indicate health savings account (HSA) eligibility if the plan is not a high-deductible health plan.
- Not exceed 150 characters (including spaces). Note that PVMNs exceeding 100 characters may be truncated in parts of online Marketplace user interface displays and experiences for accessibility and will include an ellipsis or similar element to indicate that additional content would be available through an interaction.

Consumers applying for coverage should be able to understand references to benefit information in plan marketing names, and they should be able to confirm any information from a plan marketing name in the plan's publicly available benefit descriptions.

Terms such as "telehealth" and "virtual care" are allowed in the PVMN, but issuers must note any limitations and the benefit to which the telehealth-specific cost sharing applies. Issuers must also include an explanation of what these telehealth terms refer to in the Benefit Explanation section of the template, and state whether different cost sharing applies to the corresponding in-person service. Issuers are not expected to list telehealth versus in-person cost sharing for all plan variants in the Benefit Explanation section but should state if telehealth and in-person cost sharing are different for the applicable benefit and refer to where more detailed information is available (for example, in a plan brochure or SBC document).

4.11 Summary of Benefits and Coverage

4.11.1 Summary of Benefits and Coverage Scenario

Three SBC scenarios are completed in this section. Additional information on SBC scenarios and further resources for completing the scenarios can be found on the Summary of Benefits and Coverage and Uniform Glossary page of the CCIIO website. Direct any concerns or requests for technical assistance to sbc@cms.hhs.gov. Complete the following data fields for all three coverage examples (Having a Baby, Having Diabetes, and Treatment of a Simple Fracture). This section is not applicable to SADPs.

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.

4.11.2 Summary of Benefits and Coverage Mapping

The SBC URL review compares the SBC URL's in- and out-of-network cost-sharing data to the cost sharing data in the issuer's Plans & Benefits Template to ensure data consistency. For more information on how to enter cost-sharing data into the Plans & Benefits Template, see Section 4.24 Covered Benefits. As noted in this section, if the cost sharing of a benefit varies based on the benefit setting or the type of provider and the benefit does not specifically imply the place of service or type of provider, fill out the copay and coinsurance for the most common in-person setting for provision of that benefit. The following table shows the benefits in the Plans & Benefits Template that map to the benefits on the SBC Form. This review enables CMS to uncover inaccuracies in an issuer's SBC Form as well as unintentional data errors in an issuer's Plans & Benefits Template.

CMS no longer accepts any cross mappings for maternity-related services. The "If you are pregnant – Office visits" benefit from the SBC Form must correlate to the "Prenatal and Postnatal Care" benefit in the Plans & Benefits Template. The "Childbirth/delivery facility services" benefit cost sharing from the SBC Form must correlate to the "Delivery and All Inpatient Services for Maternity Care" benefit in the Plans & Benefits Template.

Common Medical Event	SBC Form Benefit Name	Plans & Benefits Template Benefit Name
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Care Visit to Treat an Injury or Illness
	Specialist visit	Specialist Visit
	Preventive care/screening/immunization	Preventive Care/Screening/Immunization
If you have a test	Diagnostic test (x-ray, blood work)	X-rays and Diagnostic Imaging
	Imaging (CT/PET scans, MRIs)	Imaging (CT/PET Scans, MRIs)
If you need drugs to treat your illness or condition	Generic drugs	Generic Drugs
	Preferred brand drugs	Preferred Brand Drugs
	Non-preferred brand drugs	Non-Preferred Brand Drugs
	Specialty drugs	Specialty Drugs
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
	Physician/surgeon fees	Outpatient Surgery Physician/Surgical Services
If you need immediate medical attention	Emergency room care	Emergency Room Services
	Emergency medical transportation	Emergency Transportation/Ambulance
	Urgent care	Urgent Care Centers or Facilities
If you have a hospital stay	Facility fee (e.g., hospital room)	Inpatient Hospital Services (e.g., Hospital Stay)
	Physician/surgeon fees	Inpatient Physician and Surgical Services
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental/Behavioral Health Outpatient Services
	Inpatient services	Mental/Behavioral Health Inpatient Services
If you are pregnant	Office visits	Prenatal and Postnatal Care
	Childbirth/delivery professional services	N/A
	Childbirth/delivery facility services	Delivery and All Inpatient Services for Maternity Care

Common Medical Event	SBC Form Benefit Name	Plans & Benefits Template Benefit Name
If you need help recovering or have other special health needs	Home health care	Home Health Care Services
	Rehabilitation services	Outpatient Rehabilitation Services
	Habilitation services	Habilitation Services
	Skilled nursing care	Skilled Nursing Facility
	Durable medical equipment	Durable Medical Equipment
	Hospice services	Hospice Services
If your child needs dental or eye care	Children's eye exam	Routine Eye Exam for Children
	Children's glasses	Eye Glasses for Children
	Children's dental check-up	Dental Check-Up for Children

4.12 Maximum Out of Pocket and Deductible

The next several sections explain how to enter the MOOP and deductible limits for each plan. Complete sections 4.13 and 4.14 only if responding **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; complete section 4.15 only if responding **Yes**. Complete sections 4.16 and 4.17 only if responding **No** to *Medical & Drug Deductibles Integrated?*; complete section 4.18 only if responding **Yes**. SADP-only issuers should skip to sections 4.20 and 4.21 regarding MOOP for Dental EHB Benefits and Dental EHB Deductible. (Section 5.1 MOOP and Deductible Guidance provides direction on completing and meeting all requirements in the MOOP and deductible sections of the template).

The *Family* fields for the *In Network*, *In Network (Tier 2)*, and *Out of Network* MOOP and deductible values will have additional options. When selecting these fields, a dialogue box 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 display 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 field:

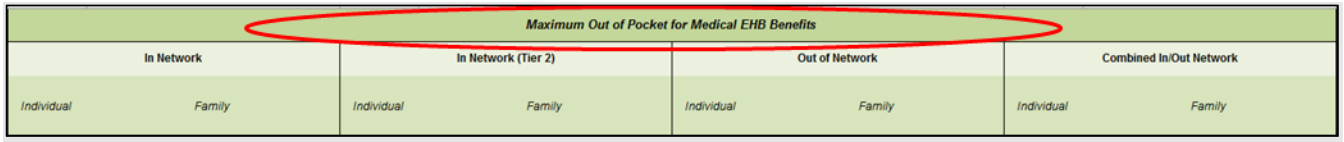
- The per-person amount for family coverage must be less than or equal to the individual MOOP limit for the standard plan and for the specific CSR plan variations.[5] See Section 5.5 Requirements for CSR Plan Variations for details about the individual MOOP limits for the different CSR plan variations that apply to the per-person amounts for family coverage.
- The issuer must enter a per-person amount and per-group amount for MOOP and deductible; **Not Applicable** may not be entered for all these cells in all *Family* fields unless a plan is available to consumers only as self-only coverage.

4.13 Maximum Out of Pocket for Medical EHB Benefits

The layout for this section is shown in Figure 2E-15.

[5] Issuers must comply with the PY2027 MOOP limits provided in the *2025 Marketplace Integrity and Affordability Final Rule (CMS-9884-F)*, which will replace the guidance specified in the *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2026 Benefit Year*.

Figure 2E-15. MOOP Fields



Use this section to input MOOP values for medical EHBs only if the medical and drug MOOPs are not integrated (i.e., issuer responds **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if an issuer responds **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for EHBs in the following areas of the template.

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

4.14 Maximum Out of Pocket for Drug EHB Benefits

Use this section to input MOOP values for drug EHBs only if the medical and drug MOOPs are not integrated (i.e., issuer responds **No** to *Medical & Drug Maximum Out of Pocket Integrated?*; if an issuer responds **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for drug EHBs in the following areas of the template.

MOOP Drug EHB Benefits	Steps
In Network—Individual^#	If the MOOPs are not integrated, enter the dollar amount for *In Network Individual Maximum Out of Pocket for Drug EHB Benefits*.
In Network—Family#	If the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Maximum Out of Pocket for Drug EHB Benefits*.
In Network (Tier 2)—Individual^	If the 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. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* field.)

MOOP Drug EHB Benefits	Steps
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 amounts 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. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
Out of Network—Individual	If the 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 the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.
Combined In/Out Network—Individual^#	If the 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 the MOOPs are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Maximum Out of Pocket for Drug EHB Benefits*.

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

Use this section to input MOOP values for medical and drug EHBs only if the medical and drug MOOPs are integrated (i.e., issuer responds **Yes** to *Medical & Drug Maximum Out of Pocket Integrated?*; if an issuer responds **No**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family MOOPs for medical and drug EHBs in the following areas on the template.

MOOP Medical and Drug EHB Benefits	Steps
In Network—Individual^#	If the MOOPs are integrated, enter the dollar amount for the *Total In Network Individual Maximum Out of Pocket*.
In Network—Family#	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total In Network Family Maximum Out of Pocket*.
In Network (Tier 2)—Individual^	If the 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.
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 amounts 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.
Out of Network—Individual	If the MOOPs are integrated, enter the dollar amount for the *Total Out of Network Individual Maximum Out of Pocket*.
Out of Network—Family	If the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total Out of Network Family Maximum Out of Pocket*.
Combined In/Out Network—Individual^#	If the 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 the MOOPs are integrated, enter the per-person and per-group dollar amounts for the *Total Combined In/Out of Network Family Maximum Out of Pocket*.

4.16 Medical EHB Deductible

Use this section to input deductible values for medical EHBs only if the medical and drug deductibles are not integrated (i.e., issuer responds **No** to *Medical & Drug Deductibles Integrated?*; if an issuer responds **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for EHBs in the following areas on the template.

Medical EHB Deductible	Steps
In Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *In Network Individual Medical EHB Deductible*.
In Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Medical EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are not integrated, this field must be completed for the AV calculation if the plan uses the AV Calculator.
In Network (Tier 2)—Individual^	If the 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.
In Network (Tier 2)—Family	If the deductibles are not integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts 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.
In Network (Tier 2)—Default Coinsurance^	If the 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.
Out of Network—Individual	If the deductibles are not integrated, enter the dollar amount for *Out of Network Individual Medical Deductible*.
Out of Network—Family	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Medical EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *Combined In/Out of Network Individual Medical EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Medical EHB Deductible*.

4.17 Drug EHB Deductible

Use this section to input deductible values for drug EHBs only if the medical and drug deductibles are not integrated (i.e., issuer responds **No** to *Medical & Drug Deductibles Integrated?*; if an issuer responds **Yes**, this section will be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for drug EHBs in the following areas on the template.

Drug EHB Deductible	Steps
In Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *In Network Individual Drug EHB Deductible*.
In Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *In Network Family Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are not integrated, enter the numerical value for the in-network coinsurance.
In Network (Tier 2)—Individual^	If the 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. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Individual* field.)

Drug EHB Deductible	Steps
In Network (Tier 2)—Family	If the 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. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Family* field.)
In Network (Tier 2)—Default Coinsurance^	If the 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. (If the plan has multiple tiers for medical EHBs but not for drug EHBs, this value should match the Tier 1 value in the *In Network—Default Coinsurance* field.)
Out of Network—Individual	If the deductibles are not integrated, enter the dollar amount for *Out of Network Individual Drug EHB Deductible*.
Out of Network—Family	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Drug EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are not integrated, enter the dollar amount for *Combined In/Out of Network Individual Drug EHB Deductible*.
Combined In/Out Network—Family#	If the deductibles are not integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Drug EHB Deductible*.

4.18 Combined Medical and Drug EHB Deductible

Use this section to input deductible values for medical and drug EHBs only if the medical and drug deductibles are integrated (i.e., issuer responds **Yes** to *Medical & Drug Deductibles Integrated?*; a response of **No** will cause this section to be grayed out and locked). Using the drop-down menus, enter the appropriate values for the individual and family deductibles for medical and drug EHBs in the following areas on the template.

Medical and Drug EHB Deductible	Steps
In Network—Individual^#	If the deductibles are integrated, enter the dollar amount for *In Network Individual Combined Medical and Drug EHB Deductible*.
In Network—Family#	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *In Network Family Combined Medical and Drug EHB Deductible*.
In Network—Default Coinsurance^	If the deductibles are integrated, enter the numerical value for the in-network coinsurance. Note: If the deductibles are integrated, this field must be completed for the AV calculation if the plan uses the AV Calculator.
In Network (Tier 2)—Individual^	If the 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.
In Network (Tier 2)—Family	If the deductibles are integrated and the plan has multiple in-network tiers, enter the per-person and per-group dollar amounts 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.
In Network (Tier 2)—Default Coinsurance^	If the 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.
Out of Network—Individual	If the deductibles are integrated, enter the dollar amount for *Out of Network Individual Combined Medical and Drug EHB Deductible*.
Out of Network—Family	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *Out of Network Family Combined Medical and Drug EHB Deductible*.
Combined In/Out Network—Individual^#	If the deductibles are integrated, enter the dollar amount for *Combined In/Out of Network Individual Combined Medical and Drug EHB Deductible*.

Medical and Drug EHB Deductible	Steps
Combined In/Out Network—Family#	If the deductibles are integrated, enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Combined Medical and Drug EHB Deductible*.

4.19 Maximum Out of Pocket for Dental EHB Benefits

Use this section to input SADP MOOP values for dental EHBs. When entering the SADP MOOP values, ensure that the values are equal to or below the required limits for one covered child and two or more covered children as specified in *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year*. To include multiple children in child-only plans, use the *Family* fields. (For SADPs, one child is considered an individual, and two or more children are considered a family.) Using the drop-down menus, enter the appropriate values for the individual and family SADP MOOPs for dental EHBs in the following areas of the template.

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

4.20 Dental EHB Deductible

Use this section to input deductible values for dental EHBs. 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 deductibles for EHBs in the following areas on the template.

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

Dental EHB Deductible	Steps
Combined In/Out Network—Family*#	Enter the per-person and per-group dollar amounts for *Combined In/Out of Network Family Dental Deductible*.

4.21 Other Deductible

Complete this section if the plan has deductible sub-groups. Issuers can add and name an unlimited number of deductible sub-groups. 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. Any value entered under Other Deductible contributes to the MOOP and deductible limits.)

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

4.22 Health Savings Account (HSA)/Health Reimbursement Arrangement (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. Note: All bronze, expanded bronze, and catastrophic plans in the individual market that are offered on the Exchange (or both on and off the Exchange) must be designated as high-deductible health plans and HSA-eligible, regardless of their deductible or MOOP values.[6] This field will auto-populate with a value of **Yes** for all applicable bronze and catastrophic plan variants. Submit a value of **Yes** for all applicable bronze and catastrophic plan variants. Select **No** for any zero cost sharing plan variations and limited cost sharing plan variations that are not bronze, as they do not meet the requirements to be HSA-eligible. Entering an incorrect response will result in a validation error when uploading to the MPMS Module.

[6] Public Law 119-21

HSA/HRA Detail	Steps
HSA/HRA Employer Contribution^	If the plan is a Small Group plan, indicate whether the employer contributes to an HSA/HRA. Leave this field blank for the Individual Market. 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^	If responding **Yes** to *HSA/HRA Employer Contribution*, enter a numerical value representing the employer contribution amount to the HSA/HRA. Leave this field blank for Individual Market plans; the template does not permit an Individual Market plan to enter an HSA/HRA contribution amount. As discussed at 78 *Federal Register* 12850, Col. 3 (February 25, 2013), because the issuer uses the AV Calculator 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.

4.23 AV Calculator Additional Benefit Design

This section contains optional fields, which may be filled out to use as inputs in the AV Calculator.

AV Calculator Additional Benefit Design	Steps
Maximum Coinsurance for Specialty Drugs^	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?^	Enter the maximum number of days a patient can be charged a copay for an inpatient stay if inpatient copays are charged per day (1–10). If this option does not apply, leave the field blank.
Begin Primary Care Cost Sharing After a Set Number of Visits?^	Enter the maximum number of fully covered visits before primary care cost sharing begins (1–10). If this option does not apply, leave the field blank. If a value (1–10) is entered in this field, follow the guidance in part 4b of Section 4.24 Covered Benefits to input cost sharing for this benefit.
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?^	Enter the maximum number of copay primary care visits that can occur before visits become subject to the deductible and/or coinsurance (1–10). If this option does not apply, leave the field blank. If a value (1–10) is entered in this field, follow the guidance in part 4b of Section 4.24 Covered Benefits to input cost sharing for this benefit.

4.24 Covered Benefits

Use this section to enter copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances worksheet.

1. If the cost sharing of a benefit varies based on the benefit setting or the type of provider, and the benefit does not specifically imply the place of service or type of provider (i.e., "Laboratory Services"), fill out the copay and coinsurance for the most common in-person setting for provision of that benefit. Explain the cost sharing for any less common settings, and if applicable for telehealth settings, in the *Benefit Explanation* field. Clearly communicate any cost sharing information that varies based on the location of service or type of provider in the plan brochure.

   For example:

   a. If a Specialist Visit could take place in an office setting or a hospital, and the copay or coinsurance could differ depending on the location, issuers should input the cost sharing for the in-person location in which enrollees are likely to redeem the benefit most often. Describe the cost sharing for the less common setting in the *Benefit Explanation* field.

   b. If a virtual Primary Care Visit would have a copay of $0, and an in-person visit would have a copay greater than $0, issuers should input the copay for the in-person visit in the copay field, and describe

the availability of $0 copay or otherwise discounted virtual visits in the *Benefit Explanation* field, with a reference as needed to where more detail on telehealth-specific cost sharing can be found.

c. If cost sharing differs between office visits and outpatient services (non-office visits) for the benefit Mental/Behavioral Health Outpatient Services, issuers should input the cost sharing for the in-person setting in which enrollees are likely to redeem the benefit most often. Explain details regarding cost sharing for the less common setting in the *Benefit Explanation* field and refer to where more information can be found. Alternatively, if cost sharing does not differ between office visits and other outpatient services (non-office visits) for Mental/Behavioral Health Outpatient Services, explain this in the *Benefit Explanation* field.

2. If the plan does not cover a given benefit out of network at 100 percent charge to the consumer, enter **Not Applicable** for the out-of-network copay fields and **100%** for the out-of-network coinsurance fields.
3. If the plan charges only a copay or a coinsurance for a benefit, enter **Not Applicable** for the one the plan does not charge. For example, if a plan charges a $20 copay for a benefit, enter **$20** for the copay and **Not Applicable** for the coinsurance.
4. Set the *Multiple In Network Tiers?* drop-down menu option to **Yes** if the plan has multiple in-network tiers, and evaluate whether the following scenarios apply:

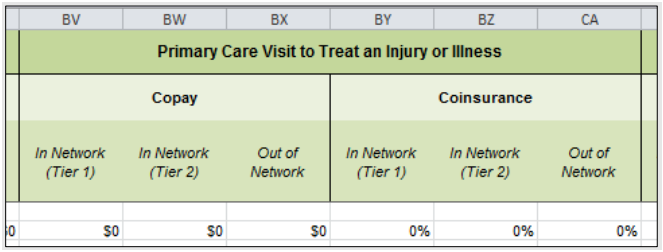
   a. If the plan has multiple in-network tiers, enter the cost sharing for Tier 1 In Network and the cost sharing for In Network Tier 2 by benefit. For those benefits without in-network tiering, enter **Not Applicable** for the *In Network (Tier 2)* cost sharing. For example, if the plan has multiple in-network tiers only for inpatient hospital covered benefits, enter the cost sharing for both tiers for inpatient hospital covered benefits, and **Not Applicable** for the *In Network (Tier 2)* copay and coinsurance for other covered benefits.

   b. If cost sharing does not vary by network and changes after a set number of visits for the specified benefit, input the highest-charged cost sharing into *In Network (Tier 1)* and set *In Network (Tier 2)* copay and coinsurance for that benefit to **Not Applicable**. Briefly detail any exceptions to the highest-charged cost sharing in the *Benefit Explanation* field. For example, if Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? is > 0, input the coinsurance into the *Coinsurance—In Network (Tier 1)* field and set the *Copay—In Network (Tier 1)* to **Not Applicable**. Briefly explain the exceptions for the set number of copays for this benefit in the *Benefit Explanation* field.

5. For further instructions on coordinating the prescription drug data entered in the Plans & Benefits Template and the Prescription Drug Template, see Section 5.8 Suggested Coordination of Drug Data between Templates.
6. For further instructions on filling out the copayment and coinsurance fields corresponding to the AV Calculator, please see Appendix A.
7. See Section 5.5 Requirements for CSR Plan Variations for cost sharing requirements for the CSR silver plan variations and the zero and limited cost sharing plan variations.

Figure 2E-16 shows an example of how the fields for each benefit are laid out.

Figure 2E-16. 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%	0%

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

Covered Benefits	Steps
	◆ **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 are only available for Inpatient Hospital Services (e.g., hospital stay) and Skilled Nursing Facility benefits. 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 *Copay—In Network (Tier 1)* above. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for copayment if only a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copay 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). ◆ **$X Copay per Day after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay per day (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Stay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay per stay (this indicates that this benefit is subject to the deductible). ◆ **$X Copay per Day with deductible**—after the consumer pays the copay per day, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). This means the consumer pays the copay per day and pays any net remaining allowed charge until the deductible is met. Clearly explain this cost sharing structure in the *Benefit Explanation* field. ◆ **$X Copay per Stay with deductible**—after the consumer pays the copay per stay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). This means the consumer pays the copay per stay and pays any net remaining allowed charge until the deductible is met. Clearly explain this cost sharing structure in the *Benefit Explanation* field. ◆ **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 and Skilled Nursing Facility covered benefits, do not copy and paste cost sharing values entered for other benefits (e.g., $25 copay). Instead, enter values with 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 in this field. If coinsurance is not 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: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer pays just the coinsurance, and the issuer pays the remainder of allowed charges (this indicates that this benefit is not subject to the deductible).

Covered Benefits	Steps
	◆ **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 in this field. If a coinsurance is not 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** in this field and in the *Copay—In Network (Tier 2)* field. This field may be grayed out and locked depending on answers to other data elements. If it is not grayed out, choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer 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 a coinsurance is not 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 the plan does not cover this benefit out of network, enter **100%**. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). ◆ **X%**—the consumer 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.

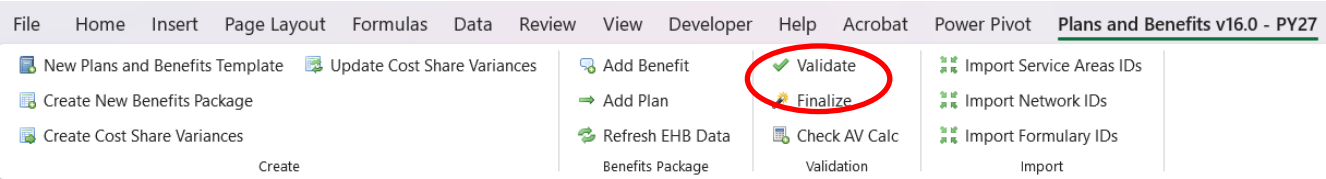
4.25 Completed Plans & Benefits Template

After entering all data, including all Benefits Package and Cost Share Variances worksheets, click **Save** to ensure no data are lost. Once the Plans & Benefits Template is completed, it must be validated, finalized, and uploaded into the MPMS Module (Figure 2E-17).

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** on the menu bar under the **Plans and Benefits** ribbon. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.

Template Validation and Submission Step	Step Description
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** on the menu bar under the **Plans and Benefits** ribbon to create the .XML version of the template that will be uploaded in the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file in the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

Figure 2E-17. Validate and Finalize Buttons



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. Read this section to ensure plans comply with all requirements.

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. See the *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* for more details on the annual limitation on cost sharing values. Ensure that the following limits are met for the in-network EHB MOOP:
    a. If a plan has separate medical and drug MOOP values, these values are added together before being compared with the annual limitation on cost sharing.
    b. For standard and AV silver plan variations, the plan's in-network EHB MOOP values must be less than or equal to the MOOP for an individual (self-only) or the MOOP for a family (other than self-only) as set forth in the guidance described above.
    c. For the zero cost sharing plan variations, the in- and out-of-network MOOP and deductible values for EHBs must be $0. These fields will auto-populate and should not be changed for EHBs.
    d. 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 will auto-populate with the values entered for a standard plan and should not be changed.
2. Family MOOP Requirements.[7] Ensure that the following limits are taken into consideration:
    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

[7] See the guidance titled *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year*.

are subject to the annual limitation on cost sharing for self-only and other than self-only coverage as detailed in Annual Limitation on Cost Sharing above.

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 and for the specific CSR plan variations as detailed in Annual Limitation on Cost Sharing above.

c. For plans that allow only self-only coverage (individual plans), 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 Section 2D: Business Rules for more details on offering self-only coverage and eligible dependent relationships.)

3. Family Deductible Requirements.[8] Ensure that the following limits are taken into consideration:

   a. Plans that allow multi-member enrollment (family plans) should have a numeric value for either in-network or combined in- and out-of-network deductible for both per group and per person.

   b. For plans that allow only self-only coverage (individual plans), all family deductible 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 Section 2D: Business Rules for more details on offering self-only coverage and eligible dependent relationships.)

   c. For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, HealthCare.gov will not be able to display the total health and medical deductibles.

   d. For plans with non-integrated deductibles with a family per group medical or prescription drug deductible of **Not Applicable**, the per person in group deductible will display on HealthCare.gov.

4. Definition of **Not Applicable** and **$0** for deductibles and MOOPs.

   a. Enter **$0**, not **Not Applicable** if there is a zero-dollar deductible or MOOP. For example, if a plan has separate medical and drug deductibles, but there is no drug deductible, issuers must enter **$0**.

   b. Enter **Not Applicable** in the *In Network* MOOP or deductible fields only to imply that in-network service costs accumulate toward the *Combined In/Out of Network* MOOP or deductible.

   c. If issuers enter **Not Applicable** in *Individual In Network* and *Individual Combined In/Out of Network*, the template will return an error when calculating the plan's AV using the AV Calculator.

5. Use the *Family* MOOP and deductible fields to include multiple children in child-only plans.

6. The following explains how the values for various MOOP and deductible fields are related:

   a. Plans may have a combined deductible and combined MOOP, separate deductibles and separate MOOPs, or a combination of both (deductibles combined and MOOPs separate OR deductibles separate and MOOPs combined) for both in-network and out-of-network charges. When defining deductibles and MOOPs, issuers must ensure plans adhere to the guidelines.

   b. If the plan does not have multiple in-network tiers, the following apply:

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

      ii. If *In Network* is **Not Applicable**, *Combined In/Out of Network* must *contain* a dollar value.

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

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

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

[8] See the guidance titled *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year*.

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

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

iv. *Out of Network* 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 multi-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. See *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* for more details on the maximum annual limitation on cost sharing values.
7. They have an out-of-network deductible and an out-of-network MOOP greater than or equal to the annual limitation on cost sharing or that are identified as **Not Applicable**.
8. If they have an in-network deductible and in-network MOOP and a combined in- and 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 identified as **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 Deductible** for all benefits, excluding primary care and preventive health services. (See Section 5.10. Plan Compare Cost Sharing Display Rules for direction on completing the copay and coinsurance fields for how cost sharing information is displayed to the consumer on Plan Compare.)
11. They have an HSA-eligible value equal to **Yes**.
12. All benefits except primary care visits and coverage of preventive health services are subject to the in-network deductible and benefits must be provided for at least three primary care visits and cover preventive health services before the customer reaches the deductible, in accordance with Section 2713 of the PHS Act.
13. Coverage of preventive health services is not subject to the in-network deductible and does not impose any other cost sharing requirement, in accordance with Section 2713 of the PHS Act.

5.3 Actuarial Value Details

The following requirements must be met for all AVs, whether calculated by the AV Calculator or input by the issuer:

1. The standard –01 variant de minimis variations are within the following percentage ranges.

    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 (Individual, on-Exchange) must be between 70 percent and 72 percent.

d. The AV for a silver plan (Individual, off-Exchange or Small Group) must be between 68 percent and 72 percent.

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

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

2. A de minimis variation of −0/+1 percentage points is used for silver plan variations.

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

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

   c. The AV for the 94 percent AV silver plan variation must be between 94 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 AV Calculator, see Appendix A.)

5.4 Editing the Template

The following should be kept in mind when changing the template:

1. If a benefit is added as an additional benefit by mistake, one of the following actions can be taken to remove it:

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

   b. Click **Refresh EHB Data** on the menu bar under the **Plans and Benefits** ribbon. Doing so removes all data entered in the Benefit Information, General Information, Deductible, and Out of Pocket Exceptions sections, including the benefit added by mistake.

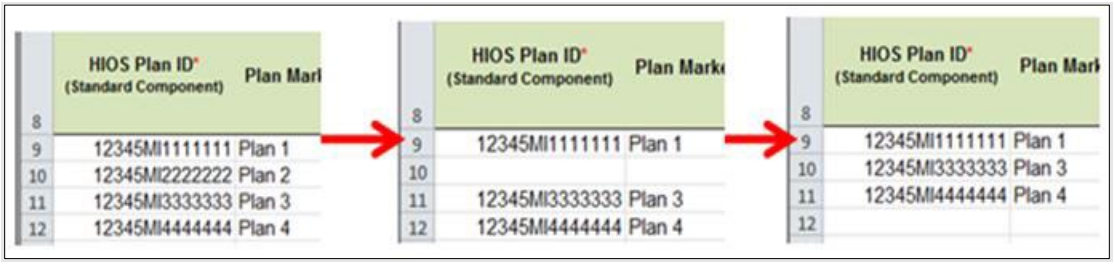
2. To remove an additional benefit or change whether it is **Covered** on the Benefits Package worksheet after the Cost Share Variances worksheet is created, delete the entire Cost Share Variances worksheet and generate a new one by clicking **Create Cost Share Variances** on the menu bar under the **Plans and Benefits** ribbon.

3. To add or remove plans after creating the Cost Share Variances worksheet:

   a. Add the new plan to the Benefits Package worksheet, then click **Update Cost Share Variances** on the menu bar under the **Plans and 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, then cut and paste the data for any plans beneath that row up to fill the empty row (as shown in Figure 2E-18) and click **Update Cost Share Variances**. For example, to delete Plan 2, delete all data from row 10, cut and paste Plan 3 into row 10 and Plan 4 into row 11, then click **Update Cost Share Variances** to remove Plan 2 from the Cost Share Variances worksheet, but leave Plan 3 and Plan 4. Any plans below an empty row and their corresponding data will be deleted from the Cost Share Variances worksheet if **Update Cost Share Variances** is clicked when there is an empty row between plans.

Figure 2E-18. Deleting a Plan



c. If any benefits package data for an existing plan are changed, only the following changes will be reflected on the Cost Share Variances worksheet when **Update Cost Share Variances** is clicked:

   i. Plan Marketing Names will be updated.

   ii. Plans added to the Benefits Package worksheet will be added to the Cost Share Variances worksheet.

   iii. Plans removed from the Benefits Package worksheet will be removed from the Cost Share Variances worksheet.

d. To update the information for an existing plan:

   i. Delete that plan on the Benefits Package worksheet, as explained in 3b, then click **Update Cost Share Variances** to delete it from the Cost Share Variances worksheet.

   ii. Reenter the plan and associated data on the Benefits Package worksheet and click **Update Cost Share Variances** to add the plan back to the Cost Share Variances worksheet.

5.5 Requirements for CSR Plan Variations

There are three types of CSR plan variations: 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 with a referral from an Indian health care provider.

Silver plan variations offer a discount that lowers the MOOP and the amount consumers pay out of pocket for deductibles, coinsurance, and copayments. Consumers qualify to enroll in 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. For bronze plans, the HSA-eligible value must be **Yes**.

f. 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 zero cost sharing plan variation is not required to cover out-of-network services either. (See Section 5.6 EHB Variance Reason and EHB Designation for details on indicating whether a benefit is an EHB.)

g. 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 Successive Cost Sharing Guidance for further explanation and examples of successive cost sharing.)

h. 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 EHBs must be the same as the associated standard plan's MOOP values for EHBs.

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

   e. For bronze plans, the HSA-eligible value must be **Yes.**

   f. All EHBs must have the same cost sharing values as the associated standard plan's values (see Section 5.6 EHB Variance Reason and EHB Designation).

   g. For benefits that are not EHBs, the cost sharing must follow successive cost sharing with the associated standard plan (see Section 5.7 Successive Cost Sharing Guidance).

   h. Tier utilization must be the same as the associated standard plan's tier utilization.

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 73 percent and 74 percent, and must 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 87 percent and 88 percent.

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

   e. For the 73 percent AV silver plan variation, the MOOP must be less than or equal to the annual limitation on cost sharing as described in Section 1302(c)(1) of the ACA and in the *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* for an individual (self-only) and 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 the annual limitation on cost sharing as described in Section 1302(c)(1) of the ACA and in the *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year* for an individual (self-only) and for a family (other than self-only).

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

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

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's tier utilization.

5.6 EHB Variance Reason and EHB Designation

As explained in Section 5.5 Requirements for CSR Plan Variations, 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 responses in *EHB* and *EHB Variance Reason* on the Benefits Package worksheet as outlined in Section 4.9 Out of Pocket Exceptions. Table 2E-1 explains when a benefit is considered an EHB based on different inputs.

Table 2E-1. EHB Designation

EHB Field Value	EHB Variance Reason Field Value	Evaluated as an EHB?
Yes	Anything other than **Not EHB**, **Not EHB – Defrayed to Issuer**, and **Not EHB – Defrayed to Enrollee**	Yes
Blank	**Additional EHB Benefit** or **Other Law/Regulation**	Yes
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 Requirements for CSR Plan Variations, successive cost sharing is required to offer multiple plan variations and data fields. Successive cost sharing ensures that parts of a given plan variation always offer equal or more generous cost sharing value for the consumer than a standard plan or plan variation.

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 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. 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. 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. 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.

MOOP, deductible, copay, and coinsurance may be used for successive cost sharing. Because successive cost sharing requires that the plan always be equal or preferable to the consumer, the cost sharing structures may not be changed such that the consumer in the higher AV plan variation may pay increased cost sharing in any circumstance. The following 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 cost of the service determines which is the better value.
2. A plan variation with a copay of $5 after the deductible is met 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 if the deductible has not been reached.

Tables 2E-2 through 2E-8 show compliant and noncompliant data entry options for cost sharing fields, as well as numerous examples.

Table 2E-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 2E-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 2E-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)

First Plan (Lower AV) Coinsurance Value	Compliant Second Plan (Higher AV) Coinsurance Values	Noncompliant Second Plan (Higher AV) Coinsurance Values
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 2E-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 2E-6. Compliant and Noncompliant Successive Cost Sharing Data Entry Options 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 ◆ $Y Copay (when $Y ≤ $X) ◆ Not Applicable	◆ No Charge After Deductible ◆ $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 ◆ $Y Copay (when $Y < $X) ◆ $Y Copay With Deductible (when $Y ≤ $X) ◆ No Charge After Deductible ◆ Not Applicable	◆ $Y Copay (when $Y > $X) ◆ $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 2E-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)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay 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) ◆ No Charge ◆ No Charge After Deductible ◆ $Y Copay per Day (when $Y < $X) ◆ $Y Copay per Stay (when $Y < $X) ◆ Not Applicable	◆ $Y Copay Per Day With Deductible (when $Y > $X) ◆ $Y Copay Per Day (when $Y > $X) ◆ $Y Copay Per Day After Deductible (all values) ◆ $Y Copay Per Stay With Deductible (when $Y > $X) ◆ $Y Copay Per Stay After Deductible (all values) ◆ $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 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)

First Plan (Lower AV) Copay Value	Compliant Second Plan (Higher AV) Copay Values	Noncompliant Second Plan (Higher AV) Copay 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)
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 2E-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	
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	

Example	Copay	Compliance
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 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 AV Calculator, the Plans & Benefits Template contains four drug benefit categories that represent a typical four-tier drug design: 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. Issuers may translate their cost-sharing data from the Prescription Drug Template into the Plans & Benefits Template using any of the following methods:

1. Enter the cost-sharing data for the tier in the Prescription Drug Template that has the highest generic drug utilization in 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 that have 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 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 that has 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 correspond to the *1 Month In Network Retail Pharmacy Copayment* and *1 Month In Network Retail Pharmacy 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 *1 Month Out of Network Retail Pharmacy 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. Although tiers are used as a framework to group drugs in the Prescription Drug Template, tiers in the Plans & Benefits Template refer to provider and pharmacy networks. Issuers with multiple in-network tiers for medical benefits may use the tiered cost sharing field for drugs to represent preferred and non-preferred pharmacies on the Plans & Benefits Template. Following this approach, issuers would enter the cost-sharing data in the following manner:

1. Preferred pharmacy cost sharing corresponds to *In Network (Tier 1)*.
2. Nonpreferred pharmacy cost sharing corresponds to *In Network (Tier 2)*.
3. Issuers without multiple in-network tiers for their medical benefits do not need to represent non-preferred pharmacy cost sharing under the Tier 2 fields in the Plans & Benefits Template.

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 to **Not Applicable**.

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

CSR 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 CSRs (45 CFR 156.420). However, issuers are not required to submit a separate formulary in the Prescription Drug Template for plan variations.

Regardless of how each plan's cost-sharing data is translated 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 used in the AV calculation.

5.9 Anticipated Template Data Elements to Be Shown on Plan Compare

Table 2E-9 and Table 2E-10 list the Plans & Benefits Template data elements that CMS anticipates displaying on Plan Compare. This list is not final and may change after these instructions are published, but issuers should use it as a reference while preparing QHP Applications.

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

Plan Compare Label Name	Template Value	Data Source
Deductibles and Maximum Out of Pocket Rules	◆ If medical and drug amounts are integrated, the combined amount will display. ◆ If medical and drug amounts are not integrated, the medical and drug amount will display on the Plan Summary page (the drug amount will also display in the Prescription Drug Details section). Medical and prescription drug deductibles will also display in the Details section. ◆ For non-integrated deductibles, the total deductible (Medical + Prescription Drug) will display in the Plan Summary/Plan Results page. ◆ If there is only one person in the enrollment group, the Individual Per Person amount will display. ◆ If there is more than one person in the enrollment group, the Family Per Group amount will display. The dollar amount will display followed by the text "Per Group." ◆ For plans with non-integrated deductibles with a Family Per Group medical or prescription drug deductible of **Not Applicable**, HealthCare.gov will not be able to display the total health and medical Family Per Group deductibles. ◆ For plans with non-integrated deductibles with a Family Per Group medical or prescription drug deductible of **Not Applicable**, the Per Person In Group deductible will display on HealthCare.gov.	Plans & Benefits Template
Deductibles	Combined Medical & Drug EHB Deductible: In-Network—Family (Per Group or Per Person as described in sections 4.16–4.18)	Plans & Benefits Template
	Combined Medical & Drug EHB Deductible: In-Network—Individual	Plans & Benefits Template

Plan Compare Label Name	Template Value	Data Source
	Medical EHB Deductible: In-Network—Individual	Plans & Benefits Template
	Medical EHB Deductible: In-Network—Family (Per Group or Per Person as described in sections 4.16–4.18)	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	URL Template
Insurance Company + Plan Marketing Name + Plan Type (Issuer Legal Name as recorded in HIOS will display if the Issuer Exchange Marketing Name is null)	Issuer Exchange Marketing Name, Plan Marketing Name, Plan Type	HIOS, Plans & Benefits Template
Adult Dental Benefits Included Some Adult Dental Benefits Included Adult Dental Benefit Not Included	Routine Dental Services (Adult) Basic Dental Care—Adult Major Dental Care—Adult Note: One benefit must be available to show Some Adult Dental Benefits Included. Two or three benefits must be available to show Adult Dental Benefits Included.	Plans & Benefits Template
Pediatric Dental Benefits Included Some Pediatric Dental Benefits Included Pediatric Dental Benefit Not Included	Dental Check-Up for Children Basic Dental Care—Child Major Dental Care—Child Note: One benefit must be available to show Some Pediatric Dental Benefits Included. Two or three benefits must be available to show Pediatric Dental Benefits 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 the plan is a CSR variant	Based on Consumer Eligibility information

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

Plan Compare Label Name	Template Value	Template Source
Benefit Data Rules (These data display for each covered benefit below when the *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, Exclusions, or Limitations are 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
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	URL 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 the *Medical & Drug Deductibles Integrated?* value is **Yes**, the text "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 the *Medical & Drug MOOP Integrated?* value is **Yes**, the text "Included with Medical" displays)	Plans & Benefits Template
How to Access Doctors and Hospitals		
National Provider Network	National Network	Plans & Benefits Template
Referral Required to See a Specialist	Referral Required to See a Specialist	Plans & Benefits Template

Plan Compare Label Name	Template Value	Template Source
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
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
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

Plan Compare Label Name	Template Value	Template Source
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
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

This section lists the anticipated display logic for the deductible, MOOP, copay, and coinsurance cost sharing on Plan Compare for Individual Market coverage that is effective starting January 1, 2027. It covers most situations but is not exhaustive. This list is not final and may change after these instructions are published, but issuers should use it as a reference while preparing QHP Applications.

5.10.1 Deductible and MOOP Plan Compare Display Logic

- If medical and drug MOOP and deductible amounts are integrated, the combined total for the medical and drug data element will display on the Plan Summary page. The text “Included in Plan Deductible/Included in Plan’s Out-of-Pocket Maximum” will display on the Plan Details page under the drug amounts.
- If medical and drug MOOP and deductible amounts are not integrated, the medical and drug amount will display on the Plan Summary page. The medical amount will display in the Costs for Medical Care section on the Plan Details page, and the drug amount will display in the Prescription Drug Details section on the Plan Details page.
- If there is only one person in the enrollment group, the individual MOOP and deductible amounts will display on the Plan Summary and Plan Details pages.
- If more than one person is in the enrollment group, the Family Per Group MOOP amount will display on the Plan Summary page. The dollar amount will display followed by the text “Per Group.”
- If there is more than one person in the enrollment group and $0 or a positive dollar amount was entered for Family Per Group, the Family Per Group deductible amount will display on the Plan Summary page. The dollar amount will display followed by the text “Per Group.”
- On the Plan Details page, the Family Per Group and Family Per Person deductible and MOOP amounts will display.
- The out-of-network deductible and MOOP will not display on Plan Compare.

5.10.2 Covered Benefit Plan Compare Display Logic

- The Plan Compare display logic considers the entered values for both 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 will display.
- When copay is greater than zero and coinsurance is **Not Applicable**, the entered copay value will display.
- For the benefits Primary care, Specialist care, Urgent care, and Outpatient mental health, "per visit from day 1" will display in Plan Compare, Plan Summary Page, and Plan Details if the Plans & Benefits Template indicates the benefit is available for a copay not subject to the deductible.
- Plan Compare will direct consumers to "View plan details for full list of benefits, limits, and exclusions" for the benefits listed in Plan Summary Page.
  - All other benefits will display the copay value only (e.g., would not display the language "per visit from day 1" after a copay not subject to the deductible).
- If coinsurance is equal to **100%**, "Not Covered" will display for that benefit.
- "No Charge After Deductible" will display if one of the following occurs:
  - The issuer entered **No Charge After Deductible** for copay and coinsurance.
  - The issuer entered **Not Applicable** for copay and **No Charge After Deductible** for coinsurance, or vice versa.
- "No Charge" will display 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" will display.
- When copay and coinsurance are each greater than zero, both will display.

5.11 Troubleshooting the Plans & Benefits Add-In File

If the Plans & Benefits Add-In file is opened before the Plans & Benefits Template, Excel sometimes loads an older version of the Add-In file that is not compatible with the template, which can cause run-time errors when entering data in the template or clicking buttons on the **Plans and Benefits** ribbon.

1. Always save the Plans & Benefits Template in the same folder as the Add-In file for the best results.
2. Never rename the Add-In file.
3. Delete all extra copies of the Add-In file on the computer. When downloading a new copy or version of the Add-In file, always choose the option to replace the old version.

If run-time errors still occur, Excel may have loaded a previous version of the Add-In file; take the following steps to remove the previous version:

1. Open a new blank sheet in Excel. Excel should not load the **Plans and Benefits** ribbon.
   a. If the **Plans and Benefits** ribbon appears, go to File > Options > Add-Ins (Figure 2E-19) > Manage: Excel Add-Ins > Go (Figure 2E-20) > uncheck Plansbenefitsaddin > OK (Figure 2E-21).
2. Verify that the **Plans and Benefits** ribbon is gone. Ensure that only the correct version of the Add-In file is saved on the computer.
3. Open the Plans & Benefits Template.
4. If the template opens the Add-In automatically after clicking **Enable Macros**, the template has successfully loaded the Add-In.

Figure 2E-19. Excel Options Window

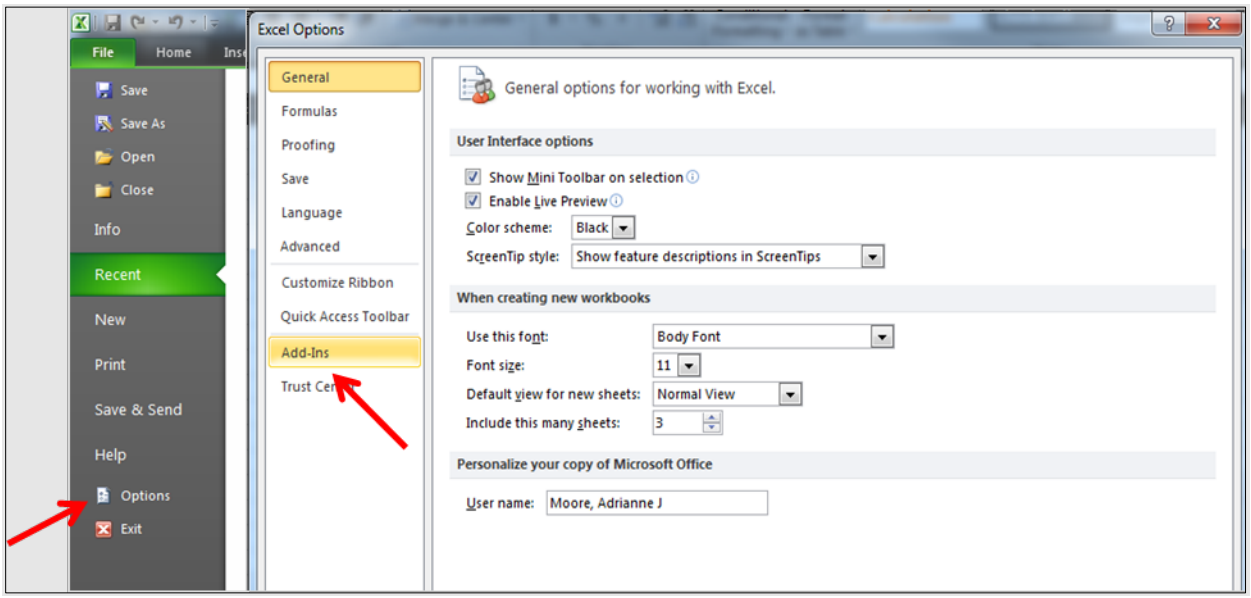


Figure 2E-20. Add-Ins Tab in Excel Options Window

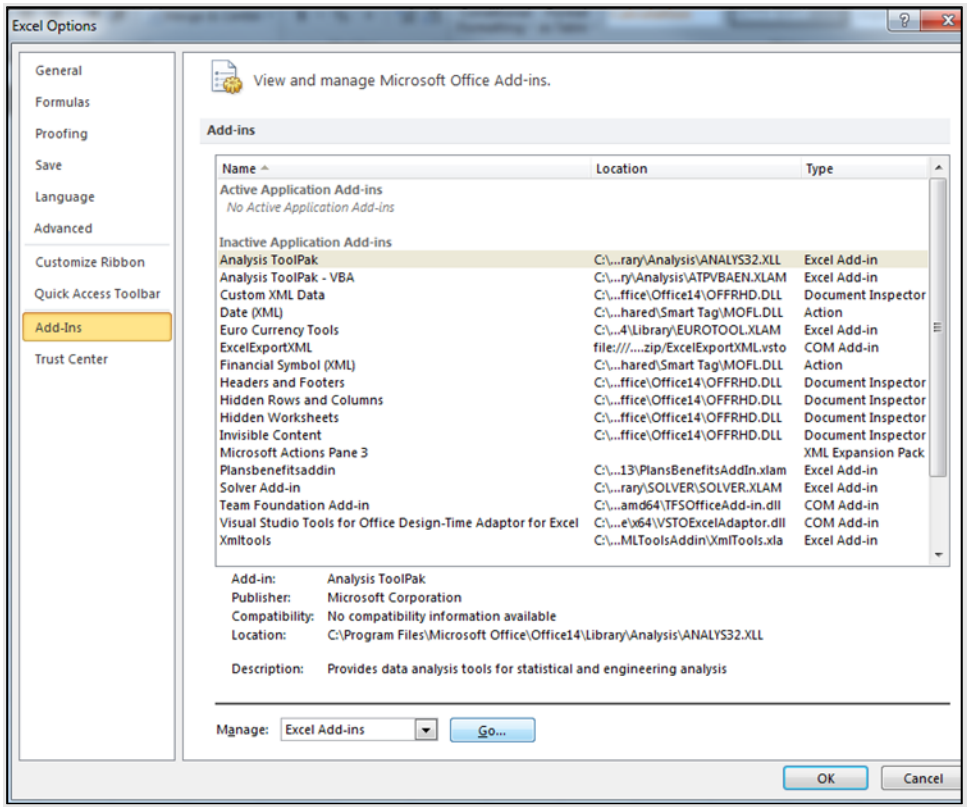
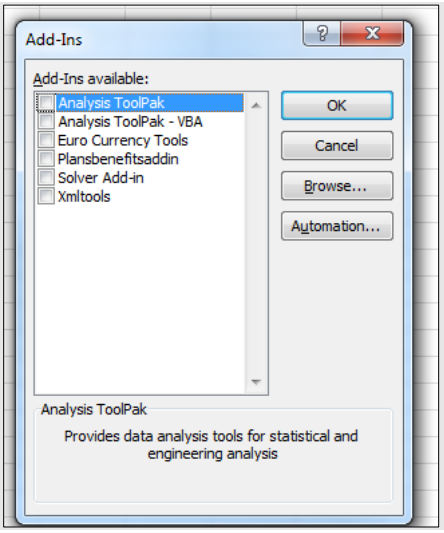


Figure 2E-21. Add-Ins Window



5.12 Standardized Plan Options and Corresponding Add-In File

1. The SPOs Add-In file is provided to help users populate the cost sharing information for plans that are using SPOs. Details regarding the purpose and parameters of the standardized plan options are specified in the Guidance on Standardized Plan Options and Non-Standardized Plan Option Limits and Exceptions in Light of Stay Order in *City of Columbus v. Kennedy,* No. 26-2215 (D. Md).

2. SPOs have fixed MOOP values, fixed deductibles, and fixed copayment amounts or coinsurance rates for a key set of EHBs. These benefits correspond to the EHB categories in the AVC, with the addition of the urgent care benefit category. Altogether, these benefit categories are responsible for a large percentage of the total allowable costs for an average enrollee. With the MOOPs, deductibles, and cost sharing parameters for EHB standardized, consumers can take other important plan attributes into consideration during the plan selection process, such as plans' provider networks, formularies, quality ratings, and premiums.
   Each state has one set of SPOs with a specified MOOP, deductible, and cost sharing structure at each of the expanded bronze, silver, silver CSR (73% AV, 87% AV, and 94% AV plan variations), gold, and platinum metal levels. HHS did not create standardized plan options for catastrophic plans. Issuers of QHPs are required to offer SPOs in accordance with 45 CFR 156.201 to offer QHPs through the Exchanges. The SPO requirements at 45 CFR 156.201 are not applicable to SADPs or SHOP plans.

3. The plan designs indicate the covered benefits and cost sharing parameters for each SPO.

4. Populate the rest of the Benefits Package worksheet following the instructions detailed in Section 4. Detailed Section Instructions of these Plans & Benefits instructions. For details about the benefits and cost sharing parameters for each standardized plan option, including specific drug benefit cost sharing requirements, refer to Guidance on Standardized Plan Options and Non-Standardized Plan Option Limits and Exceptions in Light of Stay Order in *City of Columbus v. Kennedy,* No. 26-2215 (D. Md) (also found in Appendix G). The first set of standardized plan options applies to all FFE and SBE-FP issuers, excluding those in Delaware, Louisiana, and Oregon. The second set of standardized plan options applies to issuers in Delaware and Louisiana.

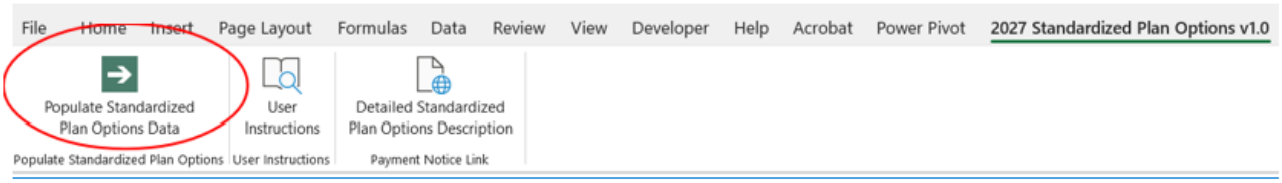
   a. On each Benefits Package worksheet that has one or more plans using an SPO, set every benefit listed in the applicable SPO table as **Covered** under the *Is this Benefit Covered?* field; otherwise, the Add-In will not run.

5. 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. Detailed Section Instructions.

6. To load the SPO Add-In, open the file. Unlike the Plans & Benefits Template Add-In, the SPO Add-In must be opened, or it will not load into the Plans & Benefits Template.

7. Press the **Populate Standardized Plan Options Data** button under the SPO Add-In ribbon (Figure 2E-22).

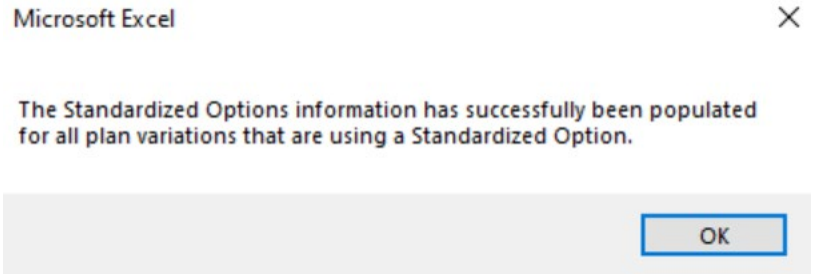
Figure 2E-22. Populate Standardized Plan Options Data Button



8. If everything runs correctly, the message in Figure 2E-23 will appear; otherwise, an error message will appear and indicate what needs to be corrected to proceed. After everything has been corrected, press the **Populate Standardized Plan Options Data** button again.

    a. The **Populate Standardized Plan Options Data** button will populate all applicable fields on the Cost Share Variances worksheet. The populated values depend on the metal level of the standardized plan option and correspond to the values listed in the standardized plan options set forth in the Final HHS Notice of Benefit and Payment Parameters for 2027. Note: Issuers in the state of Oregon will encounter an error message indicating that the tool will not populate Oregon standardized plan option values.

Figure 2E-23. Successful Population of Standardized Plan Option Data



9. The SPO Add-In file contains two buttons in addition to the main **Populate Standardized Plan Options Data** button.

    a. The **User Instructions** button (Figure 2E-24) contains convenient abbreviated instructions similar to the instructions detailed here for reference while working in the Plans & Benefits Template.

    b. The **Detailed Standardized Plan Options Description** (Figure 2E-25) button hyperlinks to the Final HHS Notice of Benefit and Payment Parameters for 2027 for a detailed description of the standardized plan options purpose and parameters.

Figure 2E-24. User Instructions Button

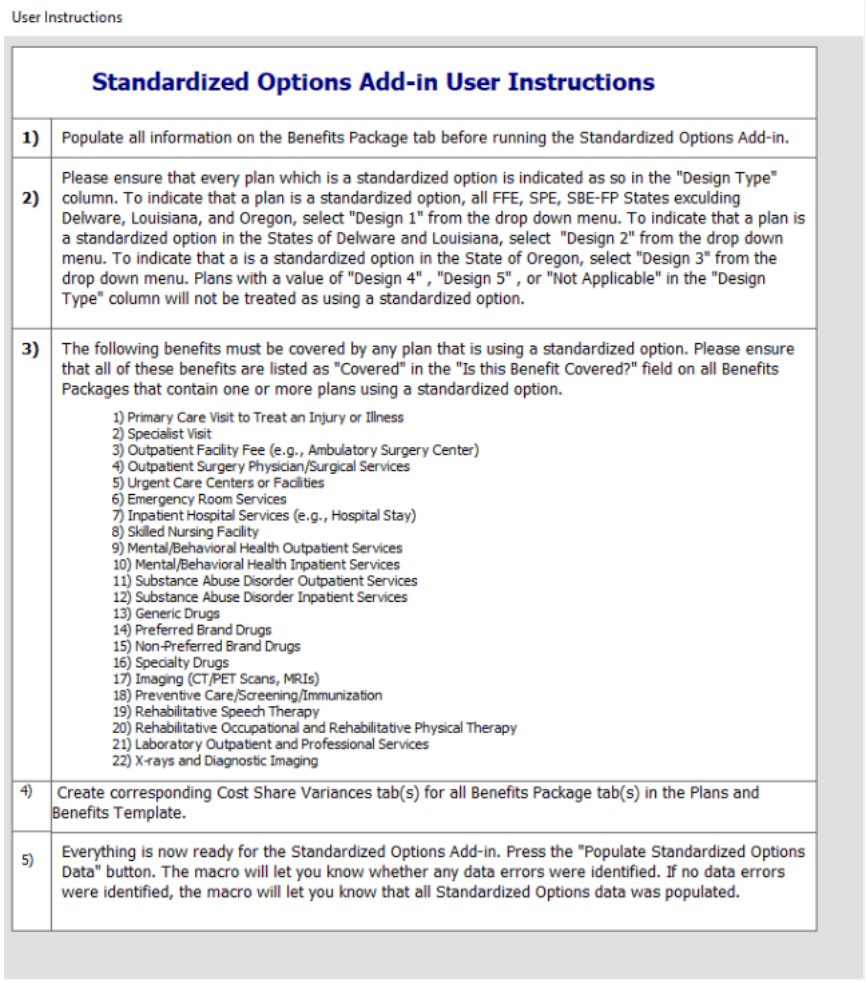
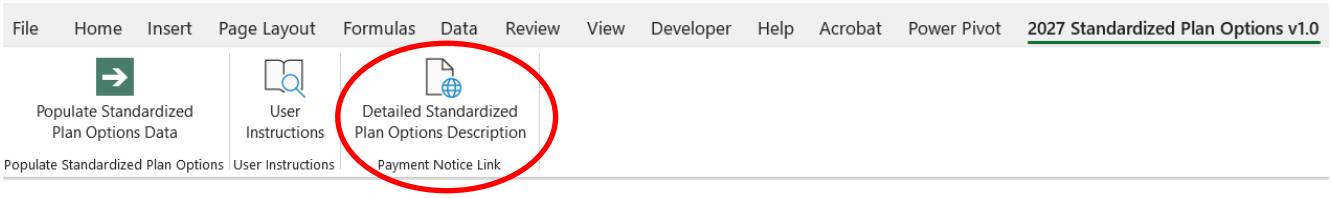


Figure 2E-25. Detailed Standardized Plan Options Description Button



After all data are entered, click **Save** to ensure no data are lost.

5.13 Meaningful Difference Review

In accordance with 45 CFR 156.201, the meaningful difference review determines whether the covered benefits, provider networks, covered drugs, or a combination of some or all these factors in an issuer's specific SPO meaningfully differs from its other SPOs in a given product network type, metal level, and service area. CMS evaluates the extent to which each issuer's SPO meaningfully differs from its other SPOs with respect to several key characteristics:

- Issuer

- Plan Type[10]
- Metal level (expanded bronze, silver, gold, or platinum)
- Service areas covered
- Provider networks
- Benefits offered
- Covered drugs.

This is accomplished by determining whether consumers are likely to be able to distinguish a particular plan from other QHP offerings from the same issuer in a given plan type, metal level, and service area. Conceptually, this review is performed in the following order for a given issuer in a state:

- An issuer's SPOs from a given state are grouped according to plan type, metal level, and overlapping counties/service areas.
- Each subgroup of plans is sequentially reviewed to determine meaningful difference. If a plan meets any of the following criteria, the plan is viewed as meaningfully different:
  - Difference in Network ID
  - Difference in Drug List ID
  - Difference in product ID (the first 10 characters of the plan ID).

Any two or more plans from a given issuer that do not pass this sequence of review criteria are flagged as an error. Issuers can respond to this validation error either by modifying a plan offering or withdrawing one of the plans.

5.14 Non-Standardized Plan Option Limits

1. Details regarding limits on non-standardized plan options are specified in § 156.202 of the preamble to the Final HHS Notice of Benefit and Payment Parameters for 2027. Under the requirements at 45 CFR 156.202, issuers are limited to offering two non-standardized plan options through Exchanges on the Federal platform (including SBE-FPs) per product network type, metal level (excluding catastrophic plans), inclusion of adult dental benefit coverage, pediatric dental benefit coverage, adult vision benefit coverage, or a combination of some or all these factors, in any service area, for PY2024 and subsequent years, as a condition of QHP certification. The non-standardized plan option limit requirements at 45 CFR 156.202 are not applicable to SADPs or SHOP plans.
2. For PY2027, issuers may offer up to two non-standardized plan options per the following combination:
   a. Product network type, as described in the definition of "product" at 45 CFR 144.103
   b. Metal level (excluding catastrophic plans)
   c. Service area (defined by county)
   d. Adult dental benefit coverage, pediatric dental benefit coverage, adult vision benefit coverage, or a combination of some or all these factors (Figure 2E-26).

[10] Plan types are defined as preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO).

3. Differing in dental and/or vision benefit coverage is indicated by plans offering a different combination of adult dental benefit coverage, pediatric dental benefit coverage, and adult vision benefit coverage.

   a. Adult dental benefit coverage is defined as covering any combination of the following in the "Benefits" column within the Plans & Benefits Template:

      i. Routine Dental Services (Adult)

      ii. Basic Dental Care—Adult

      iii. Major Dental Care—Adult.

   b. Pediatric dental benefit coverage is defined as covering any combination of the following in the "Benefits" column within the Plans & Benefits Template:

      i. Dental Check-Up for Children

      ii. Basic Dental Care—Child

      iii. Major Dental Care—Child.

   c. Adult vision benefit coverage is defined as covering the following in the "Benefits" column within the Plans & Benefits Template:

      i. Routine Eye Exam (Adult).

Figure 2E-26. Non-Standardized Plan Option Limits—Applicable Benefits for the Inclusion of Dental and/or Vision Benefits within the Plans & Benefits Template



Benefit Information		
Benefits	**EHB**	**Is this Benefit Covered?**
Primary Care Visit to Treat an Injury or Illness	Yes	Covered
Specialist Visit	Yes	Covered
Other Practitioner Office Visit (Nurse, Physician Assistant)	Yes	Covered
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Yes	Covered
Outpatient Surgery Physician/Surgical Services	Yes	Covered
Hospice Services	Yes	Covered
Routine Dental Services (Adult)		
Infertility Treatment		
Long-Term/Custodial Nursing Home Care		
Private-Duty Nursing		
Routine Eye Exam (Adult)		
Urgent Care Centers or Facilities	Yes	Covered
Dental Check-Up for Children	Yes	Covered
Rehabilitative Speech Therapy	Yes	Covered
Rehabilitative Occupational and Rehabilitative Physical Therapy	Yes	Covered
Well Baby Visits and Care	Yes	Covered
Laboratory Outpatient and Professional Services	Yes	Covered
X-rays and Diagnostic Imaging	Yes	Covered
Basic Dental Care – Child	Yes	Covered
Orthodontia – Child	Yes	Covered
Major Dental Care – Child	Yes	Covered
Basic Dental Care – Adult		
Orthodontia – Adult		
Major Dental Care – Adult		
Abortion for Which Public Funding is Prohibited		

4. More than two plans may be offered in each product type, metal level, and service area combination due to differing dental and/or vision benefit coverage, as described above. However, non-standardized plan options are only permitted to have up to two distinct sets of cost-sharing data for plans sharing the same product type, metal level, and service area. This includes the following fields within the Plans & Benefits Template:

   a. Maximum Out of Pocket (Figure 2E-27)

      i. *Maximum Out of* Pocket *for Medical and Drug EHB Benefits (Total)—In Network (Tier 1 or* Tier 2)—Individual or Family

   b. EHB Deductible (Figure 2E-28)

      i. *Medical EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*

      ii. *Drug EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*

iii. *Combined Medical & Drug EHB Deductible—In Network (Tier 1 or Tier 2)—Individual or Family*

c. In Network (Tier 1) and In Network (Tier 2) Copay and Coinsurance for all benefits except the following dental and vision benefits:

i. Routine Dental Services (Adult)

ii. Basic Dental Care—Adult

iii. Major Dental Care—Adult

iv. Routine Eye Exam (Adult)

v. Dental Check-up for Children

vi. Basic Dental Care—Child

vii. Major Dental Care—Child

viii. Routine Eye Exam for Children

ix. Orthodontia—Child

x. Orthodontia—Adult

xi. Eyeglasses—Adult

xii. Eyeglasses for Children.

Figure 2E-27. Non-Standardized Plan Option Limits—Applicable MOOP/Deductible Sections within the Plans & Benefits Template

*All fields with an asterisk (*) are required*

Plan Cost Sharing Attributes

HIOS Plan ID (Standard Component + Variant)	Plan Variant Marketing Name*	Level of Coverage (Metal Level)	CSR Variation Type	...ier ...arial ...ue	AV Calculator Output Number*	Medical & Drug Deductibles Integrated?*	Medical & Drug Maximum Out of Pocket Integrated?*	Is a Referral Required for Specialist?*	Specialist(s) Requiring a Referral	Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
10333TX0050020-00	PB Med Indl 1	Bronze	Standard	Off Exch	60.00%			No		No	100%	
10333TX0050020-01	PB Med Indl 1	Bronze	Standard	On Exch	60.00%	Yes	Yes	Yes	Podiatrist	No	100%	
10333TX0050020-02	PB Med Indl 1	Bronze	Zero Cost Plan V		100.00%	Yes	Yes	No		No	100%	

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

In Network		In Network (Tier 2)		Out of Network	
...idual	*Family*	*Individual*	*Family*	*Individual*	*Family*
				$2,403	$7000 per person | $13000 per group
$9,100	$9100 per person | $18200 per group			$2,403	$7000 per person | $13000 per group
$0	$0 per person | $0 per group			$0	$0 per person | $0 per group
$9,100	$9100 per person | $18200 per group			$2,403	$7000 per person | $13000 per group
$9,400	$9400 per person | $18800 per group			$9,000	$9000 per person | $18000 per group
$9,400	$9400 per person | $18800 per group			$9,000	$9000 per person | $18000 per group

Figure 2E-28. Non-Standardized Plan Option Limits—Applicable Cost Sharing Sections within the Plans & Benefits Template

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)*
$50.00		$50.00	75.00%	
No Charge after deductible		$50.00	Not Applicable	
$0.00		$0.00	0.00%	
No Charge after deductible		$50.00	Not Applicable	
$50.00		$0.00	Not Applicable	

5. There may be no more than two variations of each non-standardized plan option per issuer, product network type, metal level, and service area combination for each plan structure with unique cost-sharing data. However, in addition to offering up to two non-standardized plan options (each with a distinct set of cost-sharing data), issuers may offer each one of those plans in sixteen variations based on the inclusion of dental and vision benefit coverage:

Plan	Network Type	Cost Sharing Structure	Adult Dental	Pediatric Dental	Adult Vision
1	HMO	A	—	—	—
2	HMO	A	Covered	—	—
3	HMO	A	—	Covered	
4	HMO	A	—	—	Covered
5	HMO	A	—	Covered	Covered
6	HMO	A	Covered	—	Covered
7	HMO	A	Covered	Covered	—
8	HMO	A	Covered	Covered	Covered
9	HMO	B	—	—	—
10	HMO	B	Covered	—	—
11	HMO	B	—	Covered	—
12	HMO	B	—	—	Covered
13	HMO	B	—	Covered	Covered
14	HMO	B	Covered	—	Covered
15	HMO	B	Covered	Covered	—
16	HMO	B	Covered	Covered	Covered
17	PPO	C	—	—	—
18	PPO	C	Covered	—	—
19	PPO	C	—	Covered	—
20	PPO	C	—	—	Covered
21	PPO	C	—	Covered	Covered
22	PPO	C	Covered	—	Covered
23	PPO	C	Covered	Covered	—
24	PPO	C	Covered	Covered	Covered
25	PPO	D	—	—	—
26	PPO	D	Covered	—	—
27	PPO	D	—	Covered	—
28	PPO	D	—	—	Covered
29	PPO	D	—	Covered	Covered
30	PPO	D	Covered	—	Covered
31	PPO	D	Covered	Covered	—
32	PPO	D	Covered	Covered	Covered

5.15 Non-Standardized Plan Option Limit Exceptions Justifications

In PY2027, issuers that submit more than two non-standardized plan options per product network type, metal level, inclusion of adult dental benefit coverage, pediatric dental benefit coverage, adult vision benefit coverage, or a combination of some or all these factors, in any service area, must submit a justification for each plan above the limit as specified at 45 CFR 156.202(d). To utilize this exceptions process in PY2027, issuers will only be required to submit an attestation stating that the plan being offered in excess of the non-standardized plan option limit facilitates the treatment of a particular chronic and high-cost condition and would otherwise comply with the requirements of the exceptions process at § 156.202(d) through (e). Submission of this attestation must occur via the existing Non-Standardized Plan Option Limit Exceptions justification form in MPMS.

5.15.1 MPMS Justification Form

CMS will automatically prompt issuers to submit the following form for review if any application includes more than the two plans permitted by the two non-standardized plan option limit.

In the form, issuers must answer the following questions:

1. For the HIOS plan ID associated with this justification form, select "Justify" if you intend to justify this plan or "Withdraw" if you intend to withdraw this plan from PY2027 QHP Certification at a later time.

2. Select "Yes" to attest to the following:

   I attest that the plan ID identified in Question #1 fulfills the requirements for plans reducing the cost sharing for benefits pertaining to the treatment of chronic and high conditions in accordance with § 156.202 (d) (1) through (5).

3. Provide any additional information that may support CMS in its review of the justification. Leave this field blank if no additional information is required.

Issuers are not required but may choose to optionally upload supplemental information about these plans via the MPMS Module. Refer to the MPMS User Guide for instructions on how to navigate to the justification form as well as additional details about how to use the Plan Validation Workspace, complete the sections of an application, and submit the application.

This concludes the Plans & Benefits section of the QHP Application Instructions.

Section 2F: Prescription Drug

1. Introduction

In the Prescription Drug section of the Marketplace Plan Management System (MPMS) Module, issuers create cost sharing values for each tier of drug benefits and select the drugs offered at each tier level. These instructions do not apply to stand-alone dental plan (SADP)–only issuers.

The instructions for this section apply to the following issuer type:

- QHP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

- A drug list with RxNorm Concept Unique Identifiers (RXCUIs) and formulary tier numbers. Issuers can offer drugs without associated RXCUIs but do not include such drugs on the Prescription Drug Template.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

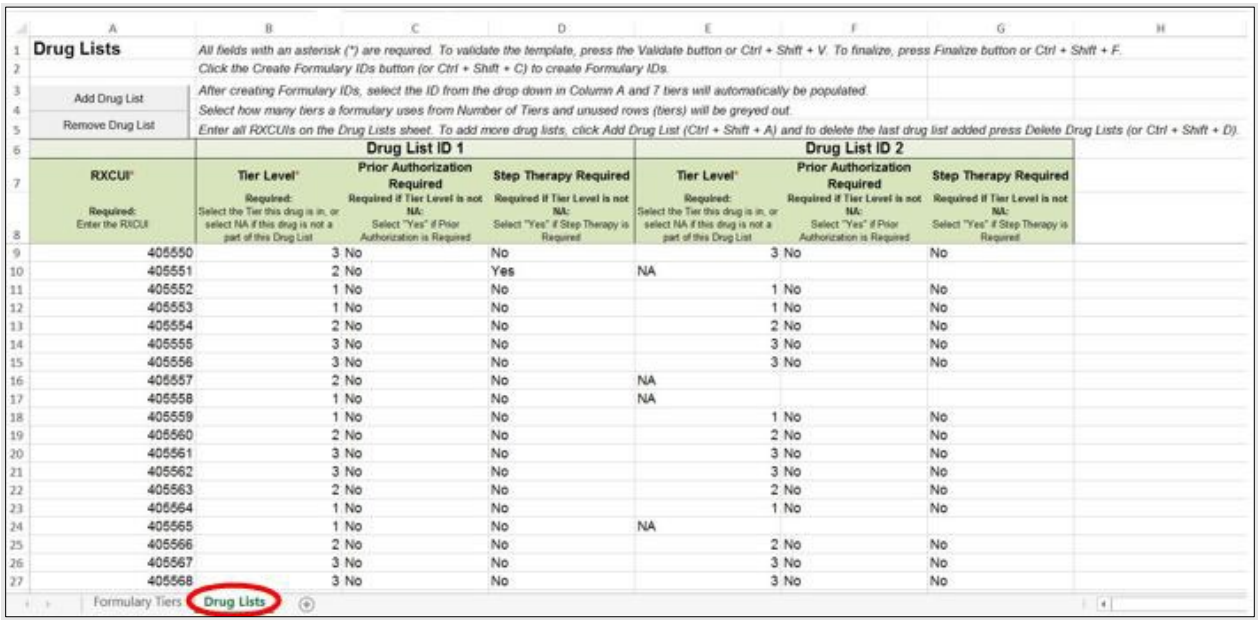
Tips for the Prescription Drug Section
◆ RXCUIs should have one of the following term types (TTYs): semantic branded drug (SBD), semantic clinical drug (SCD), brand name pack (BPCK), or generic pack (GPCK). ◆ Issuers should set Tier Level equal to "NA" (not applicable) if the drug is not part of a given drug list. ◆ Each drug list can have only one tier structure, as indicated by the number of tiers and drug tier types, and all formularies associated with each drug list must be identical. The .XML file generated from the template and submitted to the MPMS Module includes only the Number of Tiers and Drug Tier Type fields for the first formulary associated with each drug list. ◆ Issuers offering plans in the Individual and Small Business Health Options Program (SHOP) Markets must create separate formulary IDs for each market, regardless of whether the formulary serves both markets. Issuers submitting via the National Association of Insurance Commissioners' (NAIC's) System for Electronic Rates & Forms Filing (SERFF) must use the same Prescription Drug Template across all binders or ensure that no formulary IDs repeat across the binders. ◆ Issuers should map RXCUIs covered on the Zero Cost Share Preventive Drugs tier type that can incur cost sharing or be prescribed for treatment to an additional drug tier on the Drug Lists tab of the Prescription Drug Template.

Additional Resources
◆ There are supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Issuers must complete the Drug Lists worksheet before filling out the Formulary Tiers worksheet in the template. See Figure 2F-1 for a sample completed Drug Lists worksheet.

Figure 2F-1. Drug Lists Worksheet



	A	B	C	D	E	F	G	H
1	**Drug Lists**	*All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*						
2		*Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.*						
3	Add Drug List	*After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.*						
4		*Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.*						
5	Remove Drug List	*Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).*						
6		**Drug List ID 1**			**Drug List ID 2**			
7	**RXCUI***	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	
8	Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3	No	No	3	No	No	
10	405551	2	No	Yes	NA			
11	405552	1	No	No	1	No	No	
12	405553	1	No	No	1	No	No	
13	405554	2	No	No	2	No	No	
14	405555	3	No	No	3	No	No	
15	405556	3	No	No	3	No	No	
16	405557	2	No	No	NA			
17	405558	1	No	No	NA			
18	405559	1	No	No	1	No	No	
19	405560	2	No	No	2	No	No	
20	405561	3	No	No	3	No	No	
21	405562	3	No	No	3	No	No	
22	405563	2	No	No	2	No	No	
23	405564	1	No	No	1	No	No	
24	405565	1	No	No	NA			
25	405566	2	No	No	2	No	No	
26	405567	3	No	No	3	No	No	
27	405568	3	No	No	3	No	No	

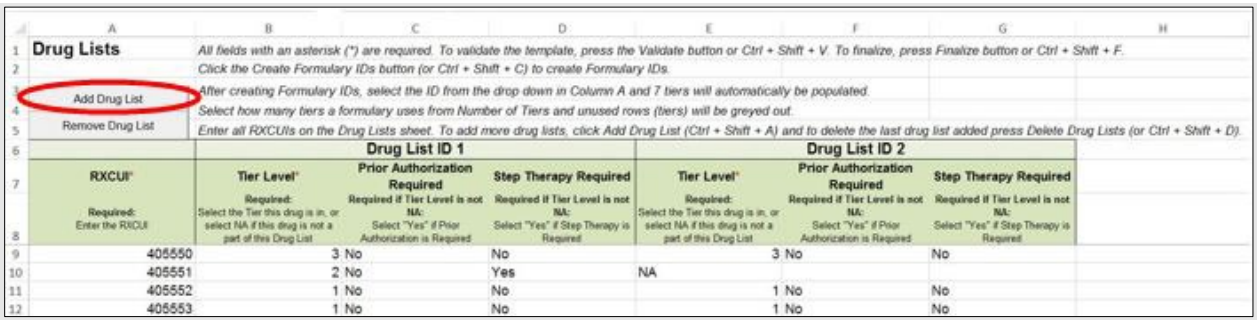
Formulary Tiers | Drug Lists

Before entering details for each drug list, enter all RXCUIs from any of the drug lists in Column A, beginning in Row 9. After entering all the unique RXCUIs, enter the drug list-specific information in each row.

Drug List	Steps
RXCUI	When selecting RXCUIs to include, use the December 1, 2025, full monthly release of RxNorm data to find a list of valid RXCUIs. To download the file, issuers need a Unified Medical Language System (UMLS) Metathesaurus License and a UMLS Terminology Services Account, which issuers can obtain at no charge by following the instructions at the National Library of Medicine. Issuers can find application resources, including the Essential Health Benefit (EHB) Rx Crosswalk, a reformatted RxNorm database, and state review tools, on the Review Tools page of the qualified health plan (QHP) certification website. RXCUIs should have one of the following TTYs: SBD, SCD, BPCK, or GPCK. The drug list includes all drugs on the issuer's formulary, even those not in a category or class in the summary of EHB benchmark information and all drugs the issuer lists as "medical service drugs."
Tier Level	For each drug, select the RXCUI's cost-sharing tier level from the drop-down menu or "NA" if the drug is not part of the drug list.
Prior Authorization Required	Indicate whether the drug requires the prescribing physician to obtain prior authorization before the plan covers the drug. Choose from the following: ◆ **Yes**—if prior authorization is required. ◆ **No**—if prior authorization is not required. If Tier Level is "NA," leave this column blank.
Step Therapy Required	Indicate whether the plan requires the enrollee to try at least one other drug before the plan covers the given drug. Choose from the following: ◆ **Yes**—if step therapy is required. ◆ **No**—if step therapy is not required. If Tier Level is "NA," leave this column blank.

To add another drug list, click **Add Drug List** (Figure 2F-2). Issuers must complete the *Tier Level*, *Prior Authorization Required*, and *Step Therapy Required* columns as described for each new drug list.

Figure 2F-2. Add Drug List Button

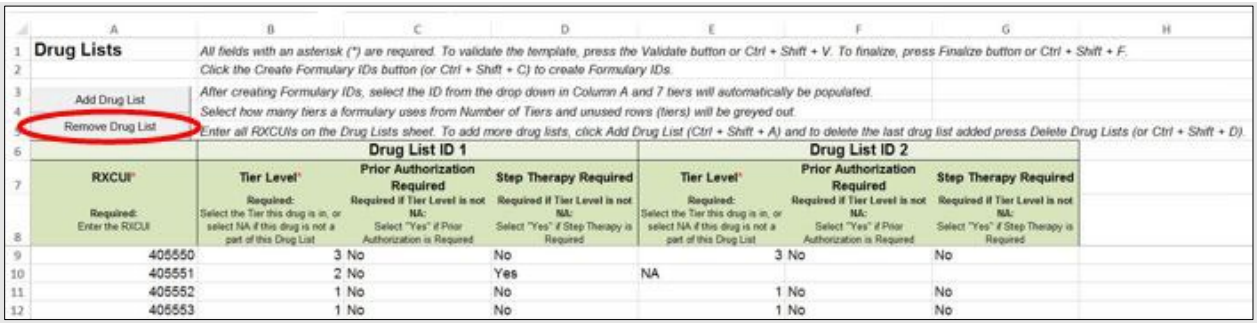


	A	B	C	D	E	F	G	H
1	**Drug Lists**	*All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*						
2		*Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.*						
3	Add Drug List	*After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.*						
4		*Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.*						
5	Remove Drug List	*Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).*						
6		**Drug List ID 1**			**Drug List ID 2**			
7	**RXCUI***	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	
8	Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3	No	No	3	No	No	
10	405551	2	No	Yes	NA			
11	405552	1	No	No	1	No	No	
12	405553	1	No	No	1	No	No	

To remove a drug list, click **Remove Drug List** (Figure 2F-3). Drug lists are removed in reverse order, with the last drug list created removed first. To remove a drug list other than the last drug list created, copy the data from the last created drug list and paste it into the drug list to be deleted to overwrite the data that should be removed, then click **Remove Drug List** to remove the final drug list that was just duplicated.

Delete any unused drug lists that link to formulary IDs but do not link to a standard component ID in the Plans & Benefits Template. Before deleting a drug list, link all remaining formulary IDs to the correct drug lists.

Figure 2F-3. Remove Drug List Button



	A	B	C	D	E	F	G	H
1	**Drug Lists**	*All fields with an asterisk (*) are required. To validate the template, press the Validate button or Ctrl + Shift + V. To finalize, press Finalize button or Ctrl + Shift + F.*						
2		*Click the Create Formulary IDs button (or Ctrl + Shift + C) to create Formulary IDs.*						
3	Add Drug List	*After creating Formulary IDs, select the ID from the drop down in Column A and 7 tiers will automatically be populated.*						
4		*Select how many tiers a formulary uses from Number of Tiers and unused rows (tiers) will be greyed out.*						
5	Remove Drug List	*Enter all RXCUIs on the Drug Lists sheet. To add more drug lists, click Add Drug List (Ctrl + Shift + A) and to delete the last drug list added press Delete Drug Lists (or Ctrl + Shift + D).*						
6		**Drug List ID 1**			**Drug List ID 2**			
7	**RXCUI***	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	**Tier Level***	**Prior Authorization Required**	**Step Therapy Required**	
8	Required: Enter the RXCUI	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	Required: Select the Tier this drug is in, or select NA if this drug is not a part of this Drug List	Required if Tier Level is not NA: Select "Yes" if Prior Authorization is Required	Required if Tier Level is not NA: Select "Yes" if Step Therapy is Required	
9	405550	3	No	No	3	No	No	
10	405551	2	No	Yes	NA			
11	405552	1	No	No	1	No	No	
12	405553	1	No	No	1	No	No	

After completing the Drug Lists worksheet, navigate to the Formulary Tiers worksheet.

Formulary Tiers	Steps
HIOS Issuer ID	Enter the five-digit Health Insurance Oversight System (HIOS) Issuer ID.
State	Select the state in which the template will apply from the drop-down menu.
Generate Formulary IDs	Click **Create Formulary IDs** to create the formulary IDs. ◆ A pop-up dialog box prompts issuers to enter the number of formularies. ◆ After issuers enter the number of formularies, the message "Formulary IDs have been generated successfully" appears. Click **OK**. Automatically generated IDs consist of the state abbreviation, the letter "F," and a sequenced number (such as ALF001 or ALF002). ◆ Once completed, the formulary IDs appear in a drop-down menu in the *Formulary ID* column.
Formulary ID	Select the formulary ID from the drop-down menu. ◆ After issuers select a formulary ID, the template populates some cells and grays out those that do not apply. Grayed out cells cannot be edited. The MPMS Module will not process data entered in the cell before it was grayed out. ◆ Select only formulary IDs that link to a standard component ID in the Plans & Benefits Template.
Drug List ID	Select the appropriate drug list ID from the drop-down menu. The menu auto-populates with the drug list IDs from the Drug Lists worksheet. Issuers must complete the Drug Lists worksheet before proceeding.

Formulary Tiers	Steps
Number of Tiers	Select the number of tiers (1–7) from the drop-down menu. The number of tier levels in a formulary must correspond to the number of tiers in the associated drug list. Cost-sharing subgroups cannot be created in a tier. All drugs in each tier should have the same cost-sharing structure. The number of tiers selected must match all formulary IDs that associate with the same drug list ID.
Drug Tier ID	The template controls the *Drug Tier ID* column; do not edit it. The template populates this column based on the selection in Number of Tiers and grays out cells that do not apply.
Drug Tier Type	Click the drop-down menu and select **Click here to select** to open a dialog box. Choose a maximum of two drug types (one generic type and one brand type) for each tier. No additional tier type can be selected for **Zero Cost Share Preventive Drugs** or **Medical Service Drugs**. The drug tier type selections for a drug tier ID must match all formulary IDs that associate with the same drug list ID. ◆ If a tier contains preferred and non-preferred generic drugs, select only one tier type. Choose the tier type according to the majority of drugs in the tier. For example, if the tier contains 80 percent preferred generic and 20 percent non-preferred generic, choose the preferred generic tier type. The same applies for a tier with preferred and non-preferred brand drugs. ◆ Multiple tiers can have the same drug tier types, but each tier should have unique cost sharing. ◆ If the issuer has preferred and non-preferred specialty drugs, create two tiers and differentiate between them using cost sharing. For example, designate the first as **Preferred Brand, Specialty** and the second as **Non-Preferred Brand, Specialty**. Zero Cost Share Preventive Drugs: When issuers select **Zero Cost Share Preventive Drugs** for a tier, it becomes the only selectable tier type. Classify the **Zero Cost Share Preventive Drug** tier as Tier 1, if applicable, to represent the lowest-cost tier to the consumer. The *1 Month In Network Retail Pharmacy Copayment* and *1 Month In Network Retail Pharmacy Coinsurance* information is **$0** and **0 percent**, respectively, when issuers choose this tier type. Issuers can still edit the remaining pharmacy benefit types. If offering remaining pharmacy benefits, enter the subsequent cost-sharing values as **$0** and **0 percent**. Only include drugs that have an indication for preventive medicine in the **Zero Cost Share Preventive Drugs** tier. Issuers include drugs for prevention and treatment in the **Zero Cost Share Preventive Drugs** tier and an additional drug tier to communicate the dual indication. ◆ If offering a tier with preventive drugs that can incur cost sharing for different circumstances, issuers complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the *Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page. Medical Service Drugs: Issuers use this tier type to indicate that a formulary contains medical service drugs. The Centers for Medicare & Medicaid Services (CMS) recognizes that some state benchmarks contain medical service drugs in various categories and classes; a **Medical Service Drugs** tier helps identify these drugs in the formulary. When issuers select the **Medical Service Drugs** tier, no other tier type can be selected for the tier. When issuers pick this tier, the *1 Month In Network Retail Pharmacy Copayment* and *1 Month In Network Retail Pharmacy Coinsurance* are automatically set to **Not Applicable** and issuers cannot edit the remaining pharmacy benefit types.
Tier Cost Sharing	This section describes how to document the cost-sharing structure for each drug tier. The only columns that issuers must populate are *1 Month In Network Retail Pharmacy Copayment* and *1 Month In Network Retail Pharmacy Coinsurance*. Issuers must indicate whether each tier offers these types of pharmacy benefits but only complete the information for the other three pharmacy types if they apply to the given drug tier. The pharmacy benefits follow: ◆ *1 Month In Network Retail Pharmacy (Copayment & Coinsurance)* ◆ *1 Month Out of Network Retail Pharmacy Benefit Offered?* ◆ *1 Month Out of Network Retail Pharmacy (Copayment & Coinsurance)*

Formulary Tiers	Steps
	◆ *3 Month In Network Mail Order Pharmacy Benefit Offered?* ◆ *3 Month In Network Mail Order Pharmacy (Copayment & Coinsurance)* ◆ *3 Month Out of Network Mail Order Pharmacy Benefit Offered?* ◆ *3 Month Out of Network Mail Order Pharmacy (Copayment & Coinsurance)*.
Benefit Offered	Select **Yes** if the corresponding tier offers the pharmacy benefit. Otherwise, select **No**.
Copayment	Enter the copayment amount for the given pharmacy type. Round any copayments to the hundredths decimal place. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this benefit is not subject to the deductible). Use **Not Applicable**, not **No Charge**, for copayment if a coinsurance is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no copayment is charged (this benefit is subject to the deductible). ◆ **$X**—the consumer pays just the copay and the issuer pays the remainder of allowed charges (this benefit is not subject to the deductible). ◆ **$X Copay after deductible**—after the consumer meets the deductible, the consumer is responsible only for the copay (this benefit is subject to the deductible). ◆ **$X Copay with deductible**—after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a coinsurance. Issuers only select **Not Applicable** for coinsurance and copay if the drug tier type is **Medical Service Drugs**.
Coinsurance	Enter the coinsurance amount for the pharmacy type. Round any coinsurance to the hundredths decimal place. Choose from the following: ◆ **No Charge**—no cost sharing is charged (this benefit is not subject to the deductible). Use **Not Applicable**, not **No Charge**, for coinsurance if only a copay is charged. ◆ **No Charge after deductible**—after the consumer meets the deductible, no coinsurance is charged (this benefit is subject to the deductible). ◆ **X%**—the consumer pays just the coinsurance and the issuer pays the remainder of allowed charges (this benefit is not subject to the deductible). ◆ **X% Coinsurance after deductible**—after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this benefit is subject to the deductible). ◆ **Not Applicable**—the consumer pays only a copay. Issuers only select **Not Applicable** for copay and coinsurance if the drug tier type is **Medical Service Drugs**.

Complete cost-sharing fields in the Prescription Drug Template for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the *Benefit Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page.

CMS reviews tier placement to ensure that the formulary does not substantially discourage the enrollment of certain beneficiaries. When developing their formulary tier structure, issuers should use standard industry practices. Consider Tier 1 the lowest cost-sharing tier available, listing a **Zero Cost Share Preventive Drugs** tier first. List subsequent tiers in the formulary structure for higher cost-sharing tiers in ascending order. Place the **Medical Service Drugs** tier as the last tier for all formulary designs.

Under the Affordable Care Act, issuers must cover preventive services without requiring the consumer to pay a copayment or coinsurance or meet a deductible. For more information on covering preventive services, refer to the preventive health services web page on HealthCare.gov.

CMS recommends that issuers place preventive drugs in a separate **Zero Cost Share Preventive Drugs** tier in the Prescription Drug Template. Furthermore, list drugs covered for both prevention and treatment in a **Zero Cost Share Preventive Drugs** tier for prevention use at zero cost and include a distinct tier for those prescribed for treatment purposes. When a tier contains preventive drugs that can incur cost sharing for different circumstances, complete the cost-sharing fields for the most typical or most used benefit cost-share design. Describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the *Benefit Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page.

If the issuer has used all seven available tiers, include the **Zero Cost Preventive Drugs** in the lowest-cost tier and clearly identify that these drugs are available at zero cost sharing in the plan brochures and on the formulary web page; all drugs in the same tier should have the same cost sharing. Alternatively, if one of the seven tiers is a **Medical Service Drugs** tier, remove the **Medical Service Drugs** tier and add a **Zero Cost Preventive Drugs** tier as the first tier.

If the issuer offers a tier with cost sharing of zero that is not a preventive tier, select either **No Charge** for copayment and **Not Applicable** for coinsurance or **Not Applicable** for copayment and **No Charge** for coinsurance in the Formulary Tiers worksheet. Only use **Not Applicable** for copayment and coinsurance in a **Medical Service Drugs** tier.

The Prescription Drug Template does not capture minimum or maximum copay or coinsurance. Describe, in detail, any cost-sharing designs not captured in the Prescription Drug Template in the *Explanation* field of the Plans & Benefits Template, in the plan brochure, and on the formulary web page.

Issuers are now required to have four drug tiers for all standardized plan options (SPOs). Enter the cost sharing for generic drugs for Tier 1, the cost sharing for preferred brand drugs for Tier 2, the cost sharing for nonpreferred brand drugs for Tier 3, and the cost sharing for specialty drugs for Tier 4. The Zero Cost Share Preventive Drugs tier and the Medical Service Drugs tier may then be added in addition to the four tiers specified in this plan design, if so desired. If the issuer chooses to include the Zero Cost Share Preventive Drugs tier type, that tier type must be entered as Tier 1 for the associated formulary ID and if the issuer includes the Medical Service Drugs tier type, that tier type must be entered as the highest tier for the associated formulary ID. Finally, if the issuer chooses to include both the Zero Cost Share Preventive Drugs and the Medical Service Drugs tier types, then Zero Cost Preventive Drugs should be entered for Tier 1, Generic Drugs for Tier 2, Preferred Brand Drugs for Tier 3, Non-preferred Drugs for Tier 4, Specialty Drugs for Tier 5, and Medical Services Drugs for Tier 6.

After entering all data, click **Save** to prevent data loss. After completing the Prescription Drug Template, issuers must validate, finalize, and upload it into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML file of the template that will be uploaded to the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Prescription Drug section of the QHP Application Instructions.

Section 2G: Service Area

1. Introduction

In the Service Area section of the Marketplace Plan Management System (MPMS) Module, issuers identify the service areas associated with their qualified health plans (QHPs), stand-alone dental plans (SADPs), or both, by state and county. Issuers must submit the Service Area Template as part of their QHP Application.

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

Issuers must identify proposed service areas in their application to indicate the geographic coverage of each QHP, SADP, or combination and to demonstrate compliance with the county integrity requirements under 45 *Code of Federal Regulations* (CFR) 155.1055. The service area of a plan is the geographic area where it accepts members, if it limits membership based on where people live.

The U.S. Department of Health and Human Services (HHS) prefers only service areas covering full counties. If an issuer proposes a service area covering a partial county, the issuer must provide a partial county supplemental response.

The Service Area section of the QHP Application comprises three parts:

- A template for identifying the issuer's proposed service area and the included counties and ZIP Codes, if the issuer does not intend to cover the entire state.[1]
- A detailed Partial County Supplemental Response Form, if the issuer is proposing a plan covering a partial county.
- Written evidence from the appropriate Federally-facilitated Exchange (FFE) state regulator indicating that the state has approved the issuer's proposed plan to cover a partial county.

2. Data Requirements

To complete the template for this section, issuers need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer state
3. Names and IDs for proposed service areas to be associated with the issuer's QHPs or SADPs
4. Names of counties that the issuer is applying to cover if the issuer does not include an entire state in a service area
5. ZIP Codes in any county that the issuer is applying to cover if the issuer does not include an entire county in a service area.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Service Area Section
◆ Issuers submitting via the National Association of Insurance Commissioners' System for Electronic Rates & Forms Filing (SERFF) must use the same Service Area Template across all binders. ◆ Dual-product issuers must create two different service area IDs, one for medical plans and one for dental plans, regardless of whether the service area is intended to serve both plan types. ◆ Dual-product issuers must use the word "dental" in the service area name for their dental service area to distinguish the dental service area from the medical service area.

[1] The columns for these data appear in the Excel template when **Yes** is selected for Column E.

Tips for the Service Area Section
◆ If the issuer offers plans in the Individual and Small Business Health Options Program Markets, the issuer must create separate service area IDs for each market, regardless of whether the service area is intended to serve both markets. ◆ Issuers can make changes to their plan's service area after the initial submission deadline without first submitting a data change request (DCR) for Centers for Medicare & Medicaid Services (CMS) authorization. After the final submission deadline in the plan year 2027 QHP Data Submission and Certification Timeline bulletin, a DCR is required for any change to QHP data, including service area. ◆ *Service Area Names* must be identical within the same *Service Area ID*. ◆ *Service Area Names* must be unique across *Service Area IDs*.

Additional Resources
◆ There are supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Follow these steps to complete the Service Area Template.

When completing the template, note that only the following special characters are allowed in free text fields. Entering other special characters will result in validation errors when uploading the template to the MPMS Module.

Valid Special Characters for Free Text Fields in the Service Area Template						
( ) (parentheses)	- (hyphen)	, (comma)	. (period)	/ (slash)	\ (backslash)	& (ampersand)
$ (dollar sign)	+ (addition sign)	‘ ’ (apostrophe/ single quote)	_ (underscore)			

Service Area Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
Issuer State	Select the state in which the issuer intends to offer coverage using the drop-down menu.
Service Area ID	Click **Create Service Area IDs** at the top of the Service Area Template and enter the total number of desired service areas for the identified state. The template will generate and add the requested number of service area IDs to the *Service Area ID* drop-down menu. For example, if “3” is entered for the total number of service areas, the template automatically generates three service area IDs. If the proposed service area covers the entire state, request one service area. The service area ID consists of the state abbreviation plus an “S” and then a sequenced number (e.g., AZS001 or AZS002). Note: If the issuer submits via SERFF, click **Create Service Area IDs** and enter the total number of service area IDs the issuer needs across all binders and use the same Service Area Template across all binders. Each plan can only be associated with one service area ID, but a service area ID can be associated with multiple plans. In the first available blank row after the header (Row 13), use the drop-down menu to select a service area ID.

Service Area Template	Steps
Service Area Name	Enter a name for the service area selected. Note: It may be helpful to name the service area so that it identifies a plan characteristic, such as health maintenance organization (HMO), or the plan name. Dual-product issuers must use the word "dental" in the name for their dental service area to distinguish the dental service area from the QHP service area. The service area name will not display to the public on HealthCare.gov. However, the service area name will display in the Public Use Files.[2] Issuers will receive an error when validating the Service Area Template if the *Service Area Name* is not identical within the same *Service Area ID*. For example, the *Service Area Name* for county A must be identical for county B if both counties are included in AZS001. Issuers will also receive an error when validating the Service Area Template if the *Service Area Name* is not unique across *Service Area IDs*. For example, the *Service Area Name* of AZS001 must differ from the *Service Area Name* of AZS002. Similarly, issuers will receive an error when validating the Service Area Template if the *Service Area Name* is not identical within the same *Service Area ID*. For example, the *Service Area Name* of AZS001 must be identical across all instances of AZS001 when multiple counties are part of the same *Service Area ID*.
State	Choose from the following: ◆ **Yes**—if the service area includes the entire state. No additional information is required for the identified service area. Add service areas until all service areas have been identified. ◆ **No**—if the service area includes only certain counties in the state. In the next step, county information must be provided for the identified service area. Add service areas and counties as appropriate until all service areas have been identified. Note: The same service area ID cannot be used for both a service area that covers the entire state and a service area that covers only certain counties in the state.
County Name	Use the drop-down menu to select the name of each county included in the identified service area if the identified service area was indicated to not cover the entire state. If a service area includes multiple counties, a new row must be added for each new county using the same service area ID and service area name. If the issuer's service area counties are not in the drop-down menu, contact the Marketplace Service Desk by phone at 855-267-1515 or by email at CMS_FEPS@cms.hhs.gov.
Partial County	Choose from the following: ◆ **No**—if the service area includes the entire county. No additional information is required for the identified county. ◆ **Yes**—if the service area covers only part of the county. If **Yes** is selected, an informational box appears showing the HHS partial county policy. Select **OK**. A *Service Area ZIP Codes* column and a *Partial County Justification Filename* column will appear on the template.
Service Area ZIP Code	Enter the five-digit ZIP Code (e.g., 12345) the issuer proposes to cover in the partial county. If entering more than one ZIP Code, separate each ZIP Code with a comma.
Partial County Justification Filename	Save the Partial County Justification Form using the naming convention in Table B-1: 12345_AZ_service_area_partial_county.

See Figure 2G-1 for a sample completed Service Area Template.

[2] For more information regarding Public Use Files, visit https://www.cms.gov/marketplace/resources/data/public-use-files.

Figure 2G-1. Sample Service Area Template

	A	B	C	D	E	F	G
1	**2027 Service Area v16.0**	*All fields with an asterisk (*) are required*					
2	Validate	*To validate, press the Validate button or Ctrl + Shift + I. To finalize, press the Finalize button or Ctrl + Shift + F*					
3		*Click Create Service Area IDs button (or Ctrl + Shift + R) to Create Service Area IDs based on your state*					
4	Finalize	*Service Area IDs will populate in the drop-down box in Service Area ID column*					
5		*For each row, enter one County for that Service Area ID (unless the Service Area covers entire state)*					
6	**HIOS Issuer ID:***	12345					
7	**Issuer State:***	AZ					
8							
9	Create Service Area IDs						
10							
11	**Service Area ID***	**Service Area Name***	**State***	**County Name**	**Partial County**	**Service Area Zip Code(s)**	**Partial County Justification Filename**
12	**Required:** Enter the Service Area ID	**Required:** Enter the Service Area Name	**Required:** Does this Service Area cover the entire state?	**Required if State is "No":** Select the County - FIPS this Service Area covers	**Required if State is "No":** Does this Service Area include a partial county?	**Required if Partial County is "Yes":** Enter the zip codes in this county that are covered by this Service Area	**Required if Partial County is "Yes":** Enter the filename of the partial county justification file you are uploading to SERFF or HIOS
13	AZS001	Service Area One	Yes				
14	AZS002	Service Area Two	No	Mohave - 04015	No		
15	AZS003	Service Area Three	No	La Paz - 04012	Yes	85325, 85328	12345_AZ_service_area_partial_county
16	AZS004	Service Area Four	No	Yuma - 04027	No		

If the issuer requests to serve a partial county (i.e., if **Yes** is selected in Column E of the Service Area Template), the issuer must complete the following steps.

Partial County Justification Supplemental Response
HHS allows issuers to cover partial county service areas only in extraordinary circumstances. The issuer must submit a detailed supplemental response substantiating why they will not serve the entire county for each exception the issuer requests. The issuer must justify how the partial county service area is necessary, non-discriminatory, and in the best interests of consumers and the Exchange program, consistent with 45 CFR 155.1055.
Answer the questions on the Partial County Supplemental Response Form. If responses are not provided to each of these questions, the partial county request will be denied.
The issuer may request partial county service areas only if the issuer has received state authorization. If the issuer requests a partial county service area in an FFE state and submits the QHP Application via HIOS, the issuer must provide written evidence demonstrating that the appropriate state regulator has authorized the issuer's partial county service area. For example, the issuer might provide email correspondence with the state that lists the specific ZIP Codes in the partial county requested. If the issuer is in a state performing plan management functions, the issuer must submit a partial county supplemental response but does not need to provide evidence of state approval. If the state transmits the request, that will serve as evidence of state approval.
After completing the supplemental response, do the following: ◆ Combine the written evidence that the appropriate FFE state regulator has authorized the partial county service area and the partial county justification supplemental response into one PDF file. ◆ Name the PDF file using the naming convention in Table B-1: 12345_AZ_service_area_partial_county. Enter this file name in Column G, *Partial County Justification Filename*, of the Service Area Template.
Upload the completed Partial County Supplemental Response Form and evidence of state approval into the Service Area section of the MPMS Module.

After entering all data, click **Save** to ensure no data are lost. Once the Service Area Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML version of the template that will be uploaded to the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.

Template Validation and Submission Step	Step Description
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

When establishing service areas, issuers should consider existing health care delivery markets in the states in which they are applying to offer plans. If the distance people in a rural county travel to see a provider is consistent with state-permitted practices, it may not be necessary to have a contracted provider in all parts of a rural county. In such cases, an issuer might consider establishing a service area for the entire state to enable members in rural parts of the county to see providers in other ZIP Codes. Alternatively, an issuer might exclude an entire county from a service area if no providers are available in the excluded ZIP Codes.

A service area can be associated with multiple plans. For example, an issuer might have five plans and four service areas as follows: The first plan has a service area (SA001) that covers the entire state. The second and third plans have a service area (SA002) that covers counties A and B. The fourth plan has a service area (SA003) that covers counties C and D. The fifth plan has a service area (SA004) that covers counties A, B, C, and D.

A QHP or SADP must always be associated with a single service area ID and with a single network ID, but networks and service areas may be used for multiple QHPs or SADPs. Create one template for all service areas and identify each service area with a unique service area ID. Complete the Network ID Template and create a unique network ID for each network. The Plans & Benefits Template maps each plan to a specific service area ID and network ID as entered in the Service Area and Network ID Templates. Service area IDs and network IDs may both be used for multiple plans and do not have to correspond one to one. For example, an issuer may have a single state-wide network that is identified with a network ID and assigned to all of the issuer's plans but have two service area IDs that are each made up of half the state and each assigned to a different plan.

The Exchange does not require an issuer's service area to cover a complete rating area, but the issuer is bound by state service area requirements. Issuers should carefully review state guidance on this topic to ensure the proposed service areas comply with state requirements. Multiple rating areas are allowed within a service area as specified by the state. Separate service area IDs are not required, even if a service area is made up of multiple rating areas.

If an issuer is in a state performing plan management functions and the issuer files via SERFF, CMS strongly encourages the issuer to submit a Microsoft Excel (.XLSM) version of their Service Area Template.

This concludes the Service Area section of the QHP Application Instructions.

Section 2H: Network ID

1. Introduction

In the Network ID Template each of the issuer's provider networks—groups of providers providing services in an area—must be assigned to network IDs. This template is submitted in the Network ID section of the Marketplace Plan Management System (MPMS) Module.

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. List of provider networks.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Network ID Section
◆ The Network ID Template is submitted in the Network ID section of the MPMS Module. ◆ Dual-product issuers must create two different network IDs, one for medical plans and one for dental plans, regardless of whether the specific network is intended to serve both plan types. Dual-product issuers must use the word "dental" in the network area name for their dental network to distinguish the dental network from the medical network. ◆ Issuers submitting via the National Association of Insurance Commissioners' System for Electronic Rates & Forms Filing (SERFF) must use the same Network ID Template across all binders. ◆ Issuers who offer plans in the Individual and Small Business Health Options Program Markets must create separate network IDs for each market, regardless of whether the network is intended to serve both markets. ◆ The Network ID Template syncs to the Plans & Benefits Template. Each plan identified in the Plans & Benefits Template must list the network ID that is associated with it. ◆ Although a medical qualified health plan (QHP) or stand-alone dental plan (SADP) must always be associated with a single service area ID and with a single network ID, networks and service areas may be used for multiple QHPs or SADPs. Issuers should complete the Network ID Template and create a unique network ID for each network. When the Plans & Benefits Template is completed, it will map each plan to a specific service area ID and network ID as entered in the Service Area and Network ID Templates. ◆ Network IDs and service area IDs may both be used for multiple plans and do not have to correspond one to one (for example, an issuer may have a single statewide network that is assigned to all its plans and identified with a network ID but have two service area IDs, each made up of half the state and each assigned to a different plan). ◆ If specific providers are available for some products but not others, issuers should establish separate network IDs and map the plans to the applicable network IDs.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Follow these steps to complete the Network ID Template.

When completing the template, note that only the following special characters are allowed in free text fields. Entering other special characters will result in validation errors when uploading the template to the MPMS Module.

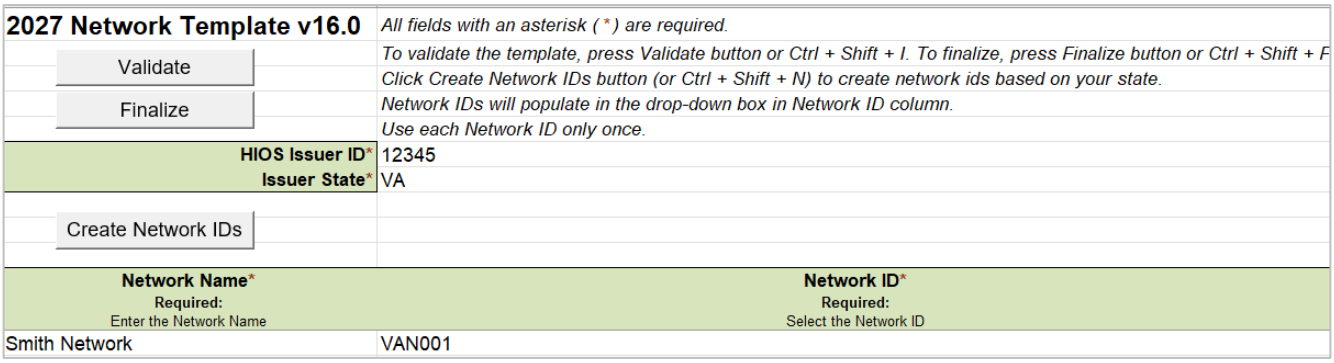
Valid Special Characters for Free Text Fields in the Network ID Template						
( ) (parentheses)	- (hyphen)	, (comma)	. (period)	/ (slash)	\ (backslash)	& (ampersand)
$ (dollar sign)	+ (addition sign)	‘ ’ (apostrophe/ single quote)	_ (underscore)			

Network ID Template	Steps
HIOS Issuer ID	Enter the five-digit HIOS Issuer ID.
State	Using the drop-down menu, select the state in which the proposed plan will be offered.
Generate Network IDs	Click **Create Network IDs**. Enter the number of networks when prompted and select **OK**. This button automatically generates the network IDs based on the number of networks specified. Note: Issuers who submit via SERFF should click **Create Network IDs** and enter the total number of network IDs the issuer needs across all binders and use the *same* Network ID Template across all binders.
Network Name	Enter a network name. Dual-product issuers must use the word “dental” in the dental network name to distinguish the dental network from the QHP network.
Network ID	Select a network ID from the drop-down menu. The network IDs consist of the state abbreviation, the letter “N,” and a sequenced number (such as MDN001 or MDN002). Dual-product issuers must create separate network IDs for their QHP and dental networks.

Repeat these steps for each additional network ID.

See Figure 2H-1 for a sample completed Network ID Template.

Figure 2H-1. Sample Network ID Template



After entering all data, click **Save** to ensure no data are lost. Once the Network ID Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Continue this process until all errors are resolved.
Finalize Template	Click **Finalize** in the template to create the .XML version of the template that will be uploaded to the Plan Validation Workspace in the MPMS Module.

Template Validation and Submission Step	Step Description
Save Template	**Save** the .XML template. The Centers for Medicare & Medicaid Services recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application in the Network ID section. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Network ID section of the QHP Application Instructions.

Section 2I: Essential Community Providers

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

In the Essential Community Providers (ECP) section of the Marketplace Plan Management System (MPMS) Module, qualified health plan (QHP) issuers must demonstrate that they have a sufficient number and geographic distribution of ECP facilities to ensure reasonable and timely access to a broad range of ECPs for low-income, medically underserved individuals, to comply with ECP standards under 45 *Code of Federal Regulations* (CFR) 156.235. Medical QHP and stand-alone dental plan (SADP) issuers must submit ECP data associated with a QHP and/or SADP. Please note that ECPs are facilities-based. Individual providers are not typically considered ECPs and are generally associated with network adequacy providers under 45 CFR 156.230 (please see the Network Adequacy (NA) section for more information about the individual or specialty providers).

2. Data Requirements

To complete this section, issuers will need the following:

1. HIOS Issuer ID
2. Issuer state
3. Completed Network ID Template
4. Completed Service Area Template
5. Completed Plans & Benefits Template
6. Identify as an Alternate ECP Standard or General ECP Standard Issuer
7. A list of ECPs in each of the proposed networks, including the ECP site name, street address of the location providing services, city, state, county, ZIP Code and the Facility Status and associated issuer network ID for each ECP facility.

3. Quick Reference

Key Changes for 2027
◆ Issuers will receive their ECP corrections in the Centers for Medicare & Medicaid Services (CMS) Feedback tab immediately upon submitting the Plan Attributes group. Issuers will also receive an email notification if the number of their ECP corrections changes following updates to the ECP reference data in the MPMS Module.
◆ Before submitting the Plan Attributes group in the MPMS Module, issuers can view their ECP calculation results (also known as ECP score) immediately after revising their ECP data and clicking the **Save and Calculate Results** button in the *ECP Calculations* area at the bottom of the *Select ECPs* page.
◆ Issuers can view all eligible ECPs in their state in the MPMS Module ECP UI. Issuers can download the "current list of available ECPs" for each applicable state by navigating to the *Select ECPs* tab in the ECP UI and clicking the hyperlink above the search bar.
◆ Issuers can enter additional, optional notes regarding an ECP facility's status to communicate important information to CMS that may aid CMS in its review of an ECP's eligibility.
◆ Issuers can now receive credit for newly qualified ECP categories added to existing ECP facilities on the Final ECP List as write-in categories.

Tips for the ECP Section
◆ Issuers operating in FFEs need to complete the Network ID Template and Service Area Template before beginning the ECP section of the MPMS Module.
◆ Issuers in states performing plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs) will need to wait for the state to transfer their Network ID Template through plan transfer. Once this is completed, issuers can update their network ID data in the MPMS Module.

Tips for the ECP Section
◆ Issuers operating in State-based Exchanges (SBEs) will submit their completed NA Template (which will include ECP data in the ECP tab for SBE issuers only) via the System for Electronic Rates & Forms Filing (SERFF). ◆ Issuers must only include providers in the ECP section of the MPMS Module that are not at known risk for potential contract termination for the upcoming plan year. ◆ The ECP Change Report reflects all the ECPs that have been added, removed, or changed since publication of the Final Plan Year (PY) 2026 ECP List last year. CMS will update this change report each time it updates the MPMS Module ECP Reference Data throughout the QHP Application submission season, which will be no less than monthly. This ECP Change Report will be available on the Essential Community Providers webpage of the QHP certification website. ◆ There is a limited exception to the provider network requirement for SADPs that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers as determined by CMS; this exception is not available to medical QHP issuers. ▪ Under this limited exception, an area is considered "prohibitively difficult" for the SADP issuer to establish a network of dental providers based on attestations from state departments of insurance (DOIs) with at least 80 percent of their counties classified as counties with extreme access considerations where at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Marketplace issuers, or significant geographic limitations impacting consumer access to dental providers. ▪ CMS will not accept requests for this limited exception directly from SADP issuers. Once an eligible state DOI submits an attestation to CMS that the DOI considers the area to be prohibitively difficult to establish a network of dental providers, CMS will review the attestation to determine if an exception will be granted. CMS will notify the SADP issuer directly if it qualifies for this limited exception. SADP issuers that qualify for this limited exception will not be required to use a provider network or submit ECP data.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are no templates for this section. ◆ NEW: The HHS Rolling Draft ECP List website has a searchable map of qualified ECPs.

4. Detailed Section Instructions

For the best user experience in the ECP section, begin by linking or importing a complete Network ID Template and Service Area Template. The ECP user interface will allow issuers to start ECP data entry before the templates are linked, but issuers must link the templates to the application to complete the ECP section. Issuers operating in states performing plan management functions and SBE-FP states can only assign network IDs after the state transfers the issuer's Network ID Template from SERFF to HIOS.

Issuers must respond to the two questions on the *Essential Community Providers (ECP) Introduction* screen before entering ECP data. Note that issuers will be unable to change their response to either question after saving. Please ensure the responses are accurate before clicking on the **Save and Next** button.

Question: Are you an Alternate ECP Standard Issuer?

- Only issuers that qualify as an Alternate ECP Standard issuer as described under 45 CFR 156.235(b) should respond **Yes**.
- General ECP Standard Issuers should respond **No**.

Question: Do you want to import the ECPs you entered on last year's application into this year's application?

- Select **Yes** to import network ID(s), ECPs, and associated data from the prior year. This option will pre-populate ECPs selected last year.
  - Issuers that select **Yes** will see eligible ECPs submitted in the prior year for inclusion in their upcoming plan year's provider network(s). Additionally, ECPs with a facility status of "contract

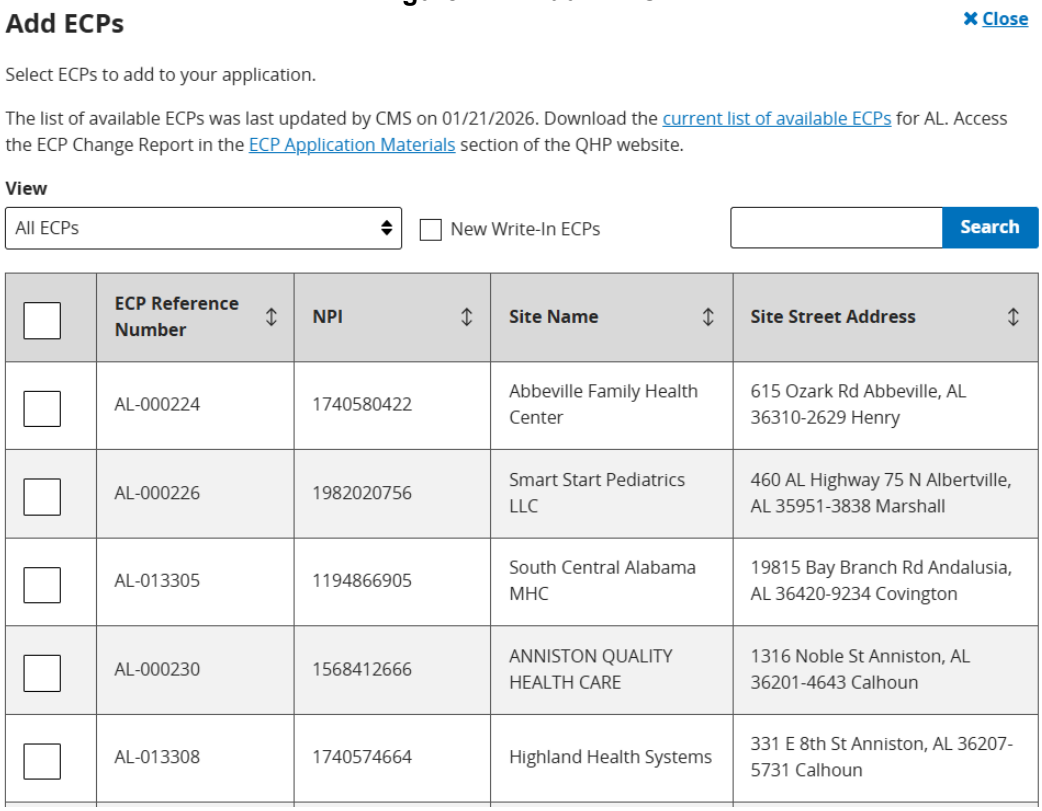
executed" will import with this status. Eligible ECPs with other facility statuses will be imported as incomplete with some of their prior year's details pre-completed. ECPs that are no longer eligible on the Final Plan Year ECP List or the MPMS Module ECP Reference Data will not be imported. For this reason, issuers should review and update all ECPs whose facility status or recruitment activity has changed in the new plan year.

- Select **No** to start with a blank provider network. This option will not import any data from last year and start with no pre-populated ECPs.
  - Issuers that select **No** will not automatically transfer data of ECPs from the issuer's prior year network. Although issuers may select this option for a clear slate, it is recommended that returning issuers select **Yes** to save time by importing the prior year's provider data and make necessary/applicable changes for the plan year.

After responding to the two questions, click the **Save and Next** button.

For issuers that did not import ECPs and/or need to add additional ECPs to their networks, click on the **Add ECPs** button. The *Add ECPs* pop up screen (Figure 2I-1) displays identifying information about each ECP facility, including ECP details (ECP reference number and National Provider Identifier [NPI]) and Site Details (site name and address).

Figure 2I-1. Add ECPs



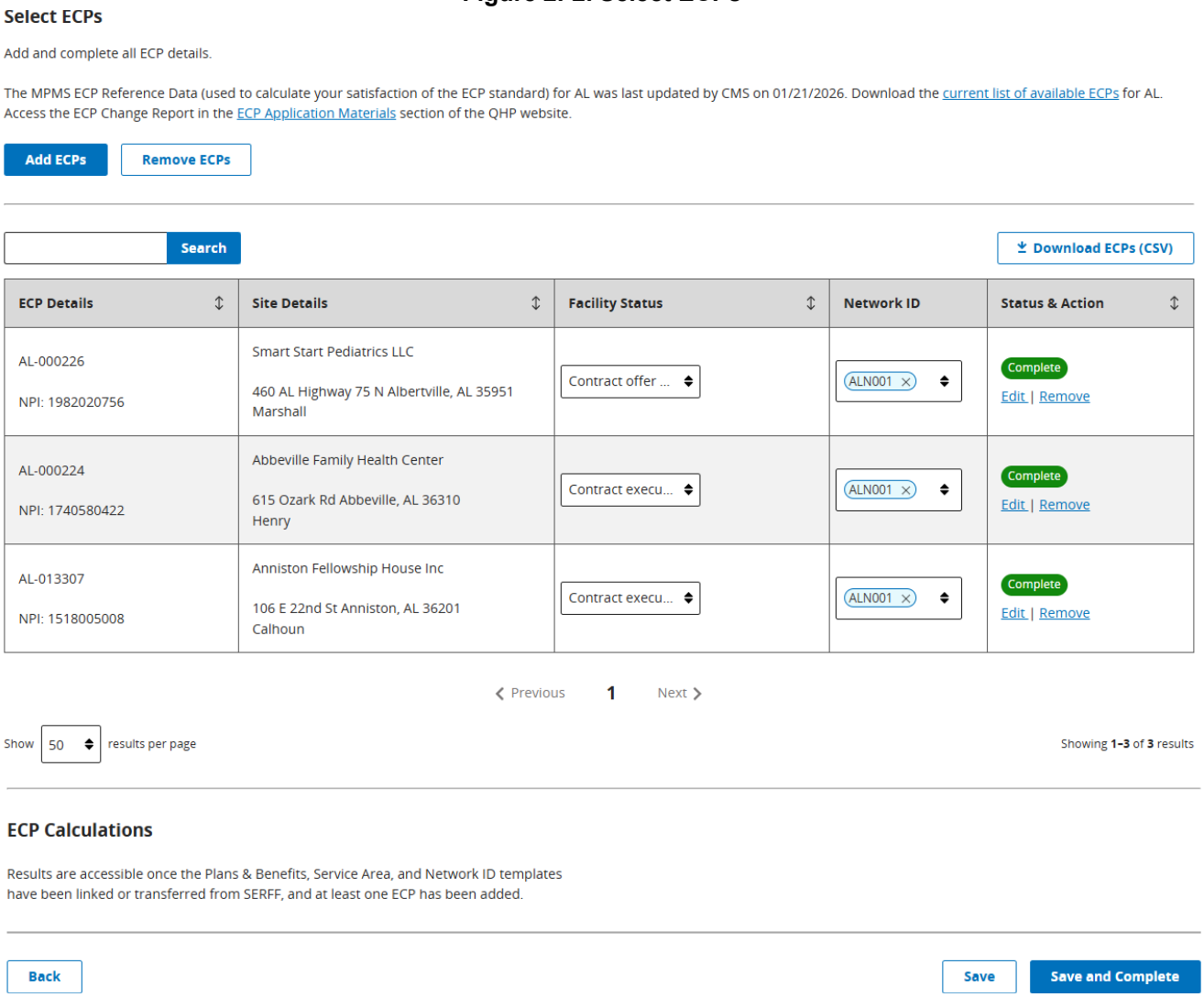
The following table details the actions for completing the *Add ECPs* pop up screen.

Add ECPs Screen	Steps
Filter ECPs	The *Add ECPs* table can be filtered to facilitate data entry. To see the available ECPs in the MPMS Module, as shown in Figure 2I-1 *Add ECPs* table, click the **Add ECPs** button from the *Select ECPs* screen (Figure 2I-2). To apply filters, select the dropdown menu on the top left of the *Add ECPs* screen (Figure 2I-1). From the dropdown options, the issuer can choose an ECP requirement or ECP category to automatically filter the table, displaying only the ECPs that meet the selected criteria, such as family planning providers or mental health facilities. Depending on the issuer's selection of the application's product offering (e.g., QHPs only, SADPs only, QHP & SADP), the drop-down menu will display applicable ECP filter options. For example, issuers only offering SADPs will only see ECPs filter options pertaining to dental categories in their state. The *Add ECPs* table includes a sorting functionality, allowing the user to click the arrow to the right of each column header to sort any column in ascending or descending order. Users can also search and filter for ECPs in the *Add ECPs* table using the search bar on the right of the screen (Figure 2I-1). For each ECP, the *Add ECPs* table will display the following searchable information: ECP Details (which displays the ECP Reference Number and NPI) and Site Details (which displays Site Name and Site Street Address).
Add ECPs	To select the applicable ECPs to your QHP Application, click inside the checkbox to the left of each ECP facility. Once selected, the box will be highlighted in blue. To deselect this ECP, select the box again, and the row will be deselected. Continue selecting all applicable ECPs until finished. To select all ECPs in the *Add ECPs* table, click the box to the left of the ECP Details column header and a check mark appears in the box and in all the checkboxes in each subsequent row. This action will select all available ECPs in the *Add ECPs* table, not just those displayed on the current page. To deselect all available ECPs from the *Add ECPs* table, click the checkbox in the header row again. To complete and close the *Add ECPs* table, click the **Add ECPs** button at the bottom of the screen; all selected ECPs will be inserted into the *Select ECPs* table (Figure 2I-2).

For issuers that selected **Yes** to import ECPs, the *Select ECPs* screen (Figure 2I-2) will display a table that is pre-populated with the prior year's data. All issuers can download the "current list of available ECPs" for their state by navigating to the *Select ECPs* tab in the ECP UI and clicking the hyperlink above the search bar.

Select those ECP facilities located within the service area and state in which the issuer intends to operate. Include only those providers located within the service area and state in which the issuer intends to operate. Issuers may find the following information helpful for locating the specific ECP: ECP reference number, organization name, NPI, and ECP category. Issuers may also refer to the ECP lists on the QHP certification website for additional information.

Figure 2I-2. Select ECPs



Within the *Select ECPs* table, each row displays a Status & Action status in the last column. The statuses are:

- **Complete**: All required information and/or fields are complete
- **Incomplete**: More details are required or there are fields missing information. These fields must be addressed for successful data submission.

The actions are:

- **Edit**: Add ECP information or make changes (Figure 2I-3)
- **Remove**: Delete the ECP facility from your list

Issuers must do the following for each ECP facility in the *Select ECPs* table:

1. Review the imported ECP, network IDs, and facility status for accuracy and update them as needed.
    a. For issuers operating in states performing plan management functions and SBE-FP states, selection and corrections to the associated network IDs can be made only after the state transfers the issuer's Network ID Template from SERFF to HIOS.

2. Add any recruited ECPs that were not part of the prior year's network(s). Enter the following required information:
    a. Facility status
    b. Associated network IDs
    c. All required facility details
3. Remove any ECPs that are no longer under contract for the upcoming plan year, have ended/terminated, or are non-renewed.
4. Review and update the facility status of all ECPs selected. Identify all ECP facilities which may have closed, relocated outside the service area, no longer provide medical/dental services, are no longer actively pursuing pre-contract negotiations, etc. as needed.

Table 2I-1 lists the ECP facility status types and how each impacts the ECP calculations toward satisfaction of ECP requirements.

Table 2I-1. Facility Status Types

Facility Status	Description and Status Impact
Contract executed	Issuer has already contracted with this provider for the upcoming plan year. ECPs imported from prior year with this status will automatically import with the same information and default to "Contract Executed." Status **counts** toward the ECP Standard (i.e., all ECP requirements).
Contract offer made, awaiting response	Issuer has offered a contract and is waiting for response. Status **counts** toward the ECP requirement to: ◆ Offer a contract in good faith to at least one ECP in each ECP category in each county in the service area and ◆ Offer a contract in good faith to all available Indian health care providers in the plan's service area. Status **does not count** toward the satisfaction of the following ECP requirements: ◆ Contracts with at least 35% of available ECPs in each plan's service area to participate in the plan's provider network ◆ Contracts with at least 35% of available Family Planning Providers in each plan's service area to participate in the plan's provider network (not applicable to SADP applicants) ◆ Contracts with at least 35% of available Federally Qualified Health Centers (FQHCs) in each plan's service area to participate in the plan's provider network. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Pre-contract negotiations in progress (contract offer not made yet)	Issuer and ECP facility are still developing contract terms and conditions. Status **does not count** toward the ECP Standard but provides justification for the ECP requirement. Please continue to recruit providers and maintain a record of your recruitment activities. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Offer rejected	ECP facility rejected the issuer's contract offer for the upcoming plan year. Status **counts** toward the ECP requirement to: ◆ Offer a contract in good faith to at least one ECP in each ECP category in each county in the service area and ◆ Offer a contract in good faith to all available Indian health care providers in the plan's service area.

Facility Status	Description and Status Impact
	Status **does not count** toward the satisfaction of the following ECP requirements: ◆ Contracts with at least 35% of available ECPs in each plan's service area to participate in the plan's provider network ◆ Contracts with at least 35% of available Family Planning Providers in each plan's service area to participate in the plan's provider network (not applicable to SADP applicants) ◆ Contracts with at least 35% of available FQHCs in each plan's service area to participate in the plan's provider network. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Contract not offered due to no response following issuer outreach	ECP facility has not responded to repeated contract offers or attempts. Status **does not count** towards the satisfaction of the ECP Standard but provides explanation for not contracting with the ECP. Issuers should continue to conduct outreach efforts via multiple channels to reach the ECP's contracting personnel. Issuers should make multiple good faith attempts to reach out to this provider, including calling at different times during the day, on different days of the week, and combining phone calls with emails and letters. Consider sending a recruiter to the provider's location as an expression of your strong interest in contracting with this facility. CMS does not consider an issuer who reached out to a provider only once at the beginning of the QHP certification cycle to have made a good faith effort. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Exclusivity contract prohibits us from contracting with facility	ECP facility is contractually prevented from contracting with other issuers. Issuer should not use this status if ECP is rejecting offer due to contract terms and conditions. Status **does not count** toward the satisfaction of the ECP Standard but provides an explanation for not contracting with the ECP. CMS will investigate this status. If this status is verified, CMS will update/remove the ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If the ECP is removed, issuers will not be expected to offer a contract to this ineligible ECP facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Facility closed	ECP facility is no longer in business. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP. CMS will investigate closure. If the closure is confirmed, CMS will remove the ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If the ECP is removed, issuers will not be expected to offer a contract to this closed facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
No medical services provided	ECP facility does not provide medical services. Only applicable to ECPs with medical ECP categories. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP. CMS will investigate the status. If the status is verified, CMS will update/remove ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If there was a ECP category change, CMS will make applicable changes as needed—see Write-in ECP Categories section below. If the ECP is removed, issuers will not be expected to offer a contract to this removed facility once the MPMS Module and the ECP Tools are updated.

Facility Status	Description and Status Impact
	The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
No dental services provided	ECP facility does not provide dental services. Only applicable to dental ECPs with dental categories. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP. CMS will investigate the status. If the status is verified, CMS will update/remove ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If there was a ECP category change, CMS will make applicable changes—see Write-in ECP Categories section below. If the ECP is removed, issuers will not be expected to offer a contract to this removed facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Not licensed or certified by the state	ECP facility fails to satisfy licensing or certification requirements. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP. CMS will investigate the status. If the status is verified, CMS will update/remove ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If the ECP is removed, issuers will not be expected to offer a contract to this facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Facility has relocated outside the service area	ECP facility's address has moved or relocated outside the service area. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP that was previously in issuer's service area. Issuers can also remove this facility from their list of selected facilities instead of selecting this status. (By removing facility from issuer's selected ECPs, it will not be populated in future year applications and imports). CMS will investigate this status and the facility's address change. If the relocation is verified to be within the same county, CMS will note the ECP's address change for next year and update as applicable. If the relocation is outside the county, CMS will change the ECP to a Write-in ECP. If the ECP is removed, issuers will not be expected to offer a contract to this removed facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.
Facility has one or more incorrect ECP categories	One or more of the ECP categories displayed in the MPMS Module ECP UI for the ECP facility is not correct. Status **does not count** toward the satisfaction of ECP requirements but provides CMS with additional information about the facility. CMS will investigate the status. If the status is verified, CMS will update/remove the applicable ECP categories from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. CMS may make applicable Write-in ECP Categories changes, as needed.

Facility Status	Description and Status Impact
Facility has no interest in contracting with commercial insurance	ECP facility cites this specific reason for not engaging in contract negotiations with the issuer. Status **does not count** toward the satisfaction of ECP requirements but provides an explanation for not contracting with the ECP. CMS will investigate the status. If the status is verified, CMS will update/remove the ECP from the MPMS Module Reference Data and ECP Tools used to calculate an issuer's ECP score. If the ECP is removed, issuers will not be expected to offer a contract to this removed facility once the MPMS Module and the ECP Tools are updated. The MPMS Module will automatically import valid ECPs from prior year with this facility status as incomplete; issuers are required to review facility status for current plan year and complete all required fields.

An issuer can duplicate an ECP facility so it can be added to two or more networks if the facility status varies by network. To enable this functionality, click on the **Save and Duplicate** button (Figure 2I-3).

Figure 2I-3. Edit ECP Details

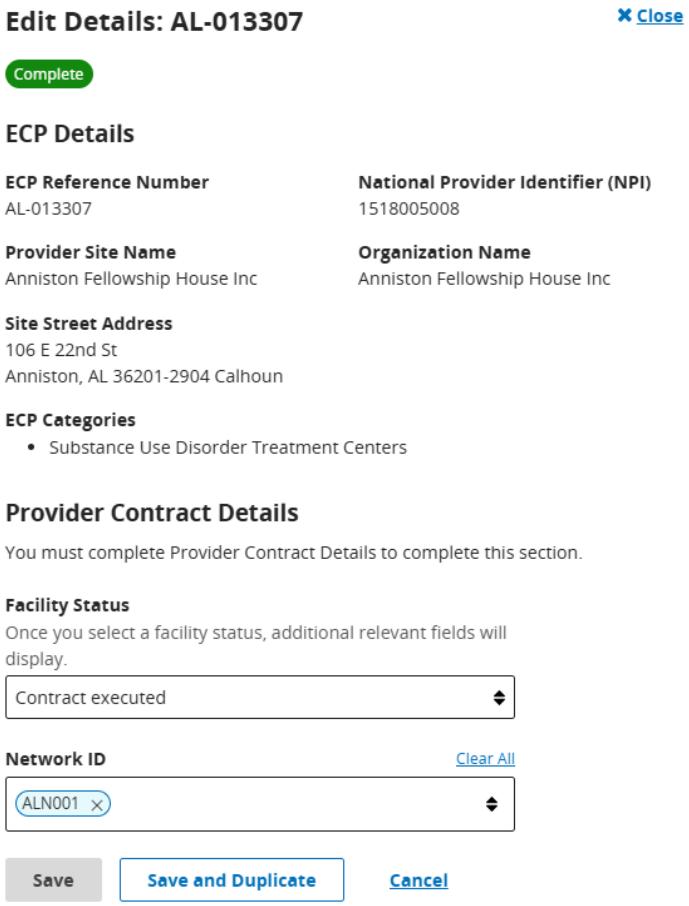


Table 2I-2 details the data elements that the issuer may need to provide to complete the ECP UI. Depending on the Facility Status selection, the issuer may need to provide some or all the following information regarding a provider.

Table 2I-2. Data Elements Needed to Complete ECP UI

Provider Details	Steps
Contract Offer Date	Enter the date on which the issuer made a contract offer to the ECP facility. This date cannot be a future date and must be on or after October 1 of the previous calendar year.
Last Date of Contact	Enter the date on which the issuer last contacted the ECP. This date cannot be a future date and must be on or after October 1 of the previous calendar year.
Point of Contact Name	Enter the name of the individual at the facility who provided the Facility Status information.
Point of Contact Email	Enter the email address of the individual at the facility who provided the Facility Status information.
Information Source	Provide the information source through which the issuer learned of the facility's changed status.
Additional notes (Optional)	Provide additional information (such as comments, justifications, clarifications, context affecting the facility, or notes from the facility or point of contact, etc.) to CMS on the issuer's outreach to this ECP facility. (Note: there is a limit of 600 characters.)
Save	Press the **Save** button when finished making selections and then select close (upper right corner) to return to the application.

Write-in ECPs

Write-in ECPs are qualified ECP facilities available for contracting that CMS approved after the Final PY2027 ECP List cutoff (August 13, 2025). These facilities are listed on the PY2027 Available ECP Write-in List on the Essential Community Providers webpage of the QHP Certification website. Write-in ECPs count toward the satisfaction of ECP requirements if issuers contract with them. However, if issuers do not select these Write-in ECPs, they will not be included in the denominator of the ECP calculation and, therefore, will not be penalized for not including them.

As with previous years, available ECP Write-ins for PY2027 QHP certification are available within the ECP UI. These ECP Write-ins can be found by checking the **New Write-in ECPs** checkbox in the *Add ECPs* pop up screen (Figure 2I-1). General ECP Standard issuers may only select write-ins listed in the PY2027 Available ECP Write-in List, which has been uploaded for selection within the ECP UI.

Alternate ECP Standard issuers should use the custom *Write-in ECP* screen (See Figures 2I-4a and 4b) to submit ECPs in Health Professional Shortage Areas (HPSAs) or low-income ZIP Codes that the issuer directly employs or contracts with through a single contracted medical group. CMS does not expect these ECPs to submit an ECP application form to be included on the Available ECP Write-in List because such ECPs are either employees of the issuer or practicing in a single contracted medical group and typically are unavailable to contract with other issuers. To access the custom ECP Write-ins, issuers should select the **Write-in ECP** button on the *Select ECPs* screen of the MPMS Module ECP UI. The *Write-in ECP* pop-up screen will appear allowing the issuer to enter required information about the custom write-in facility. General ECP Standard issuers cannot add custom Write-in ECPs to their networks.

Write-in ECP Categories

Starting in PY2027, issuers can now receive credit for newly approved ECP categories added to existing ECPs on the Final ECP List. These new ECP category additions, also referred to as an ECP write-in category, will not count toward satisfaction of the ECP requirement if the issuer did not already contract with that existing ECP.

- An example: An ECP that is on the Final ECP List and MPMS Module ECP Reference Data as a FQHC is designated as contract executed with an issuer. Later, CMS identifies this ECP is also a family planning provider (after the publication of the Final ECP List) and adds this new ECP category to the MPMS Module ECP Reference Data as an ECP write-in category. The issuer contracting with this ECP would then additionally receive credit for this ECP toward satisfaction of the family planning provider threshold requirement and category per county – family planning provider requirement once the issuer resubmits ECP data in the MPMS Module. Conversely, an issuer not contracting with this ECP would not be penalized for this ECP toward the family planning provider threshold and category per county –

family planning provider requirements but may be penalized for the original ECP category which is the Overall ECP Threshold, FQHC ECP Threshold, and Category per County – FQHC requirements.

Figure 2I-4a. Write-in ECP, Part 1

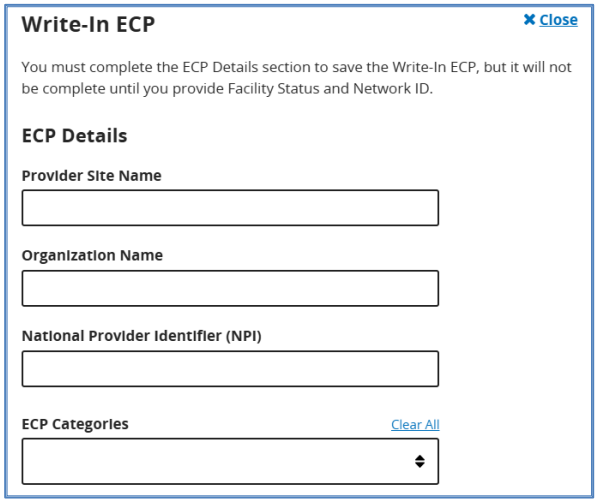
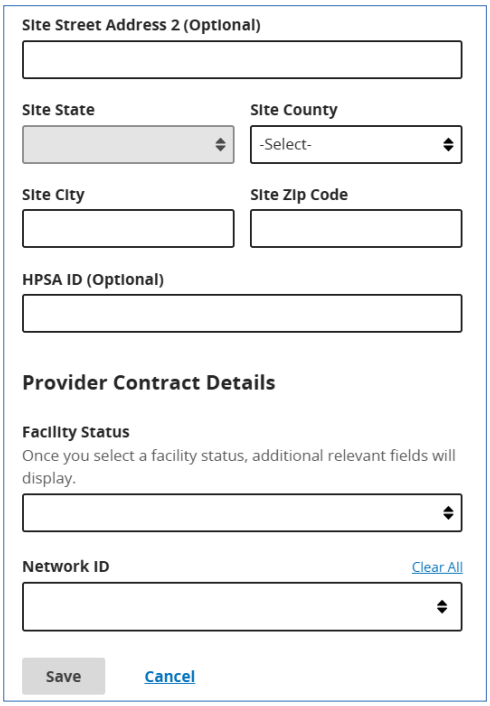


Figure 2I-4b. Write-in ECP, Part 2



To complete the information on the *Write-in ECP, A*lternate Standard issuers enter the following:

Write-in ECP	Required Information
Provider Site Name	Enter the ECP facility site name.
Organization Name	Enter the ECP's organization name.
NPI	Enter the facility's NPI.
ECP Category	Select the appropriate ECP category for each facility. Multiple ECP categories for each ECP may be selected, as applicable.
Site Street Address 1	Enter the site street address of the ECP.
Site Street Address 2	Enter additional street address information.
Site State	The ECP's state is prepopulated.
Site County	Select the ECP's site county from the drop-down list
Site City	Enter the ECP's site city.
Site ZIP Code	Enter the ECP's site ZIP Code. For Alternate ECP Standard issuers, all ECPs must be located in an HPSA or low-income ZIP Code.
HPSA ID (Optional)	Enter the HPSA designation ID, if applicable. For Alternate ECP Standard issuers, all ECPs must be located in an HPSA or low-income ZIP code.
Facility Status	Use the drop-down list to select a facility status for each ECP.
Network IDs	Use the drop-down list to select the network IDs for the networks to which the facility belongs.
Save	When the data entry is complete, press the **Save** button.

Once all applicable ECPs have been added/selected and updated, click the **Save and Complete** button from the *Select ECPs* screen (Figure 2I-2). Issuers will immediately be notified if any missing data is not entered. Issuers will be unable to submit the Plan Attributes group until all missing data is entered.

ECP Calculations

Once all ECP data elements are entered, issuers may view their ECP calculation results immediately after entering or revising their ECP data in the *ECP Calculations* area at the bottom of the Select ECPs page. Click on the "+" to expand the *ECP Calculation Results* space (see Figure 2I-5). Issuers may revise their ECP data and view updated calculations by clicking on the **Save and Calculate Results** button (Figure 2I-6).

Figure 2I-5. Expand the ECP Calculations

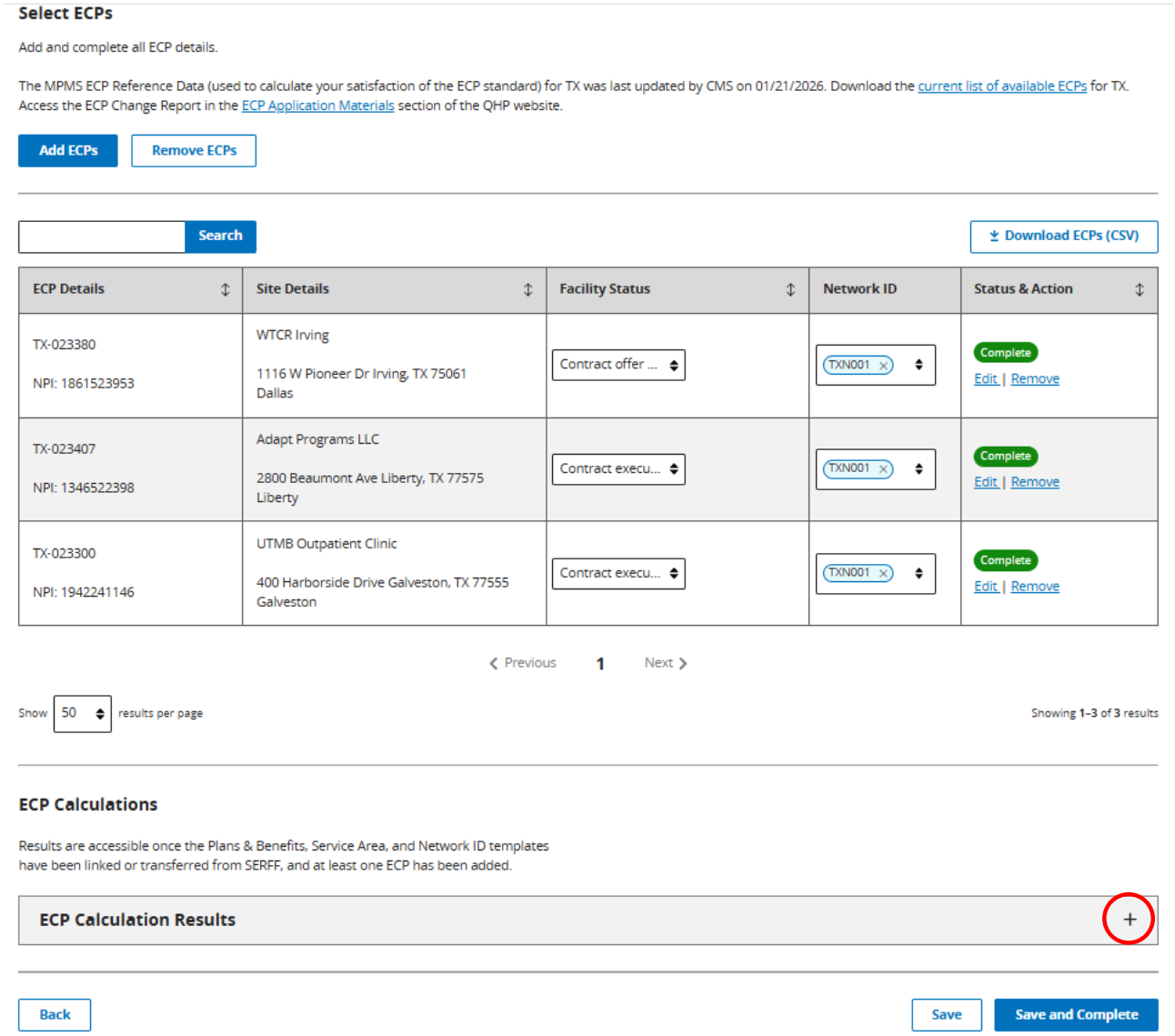
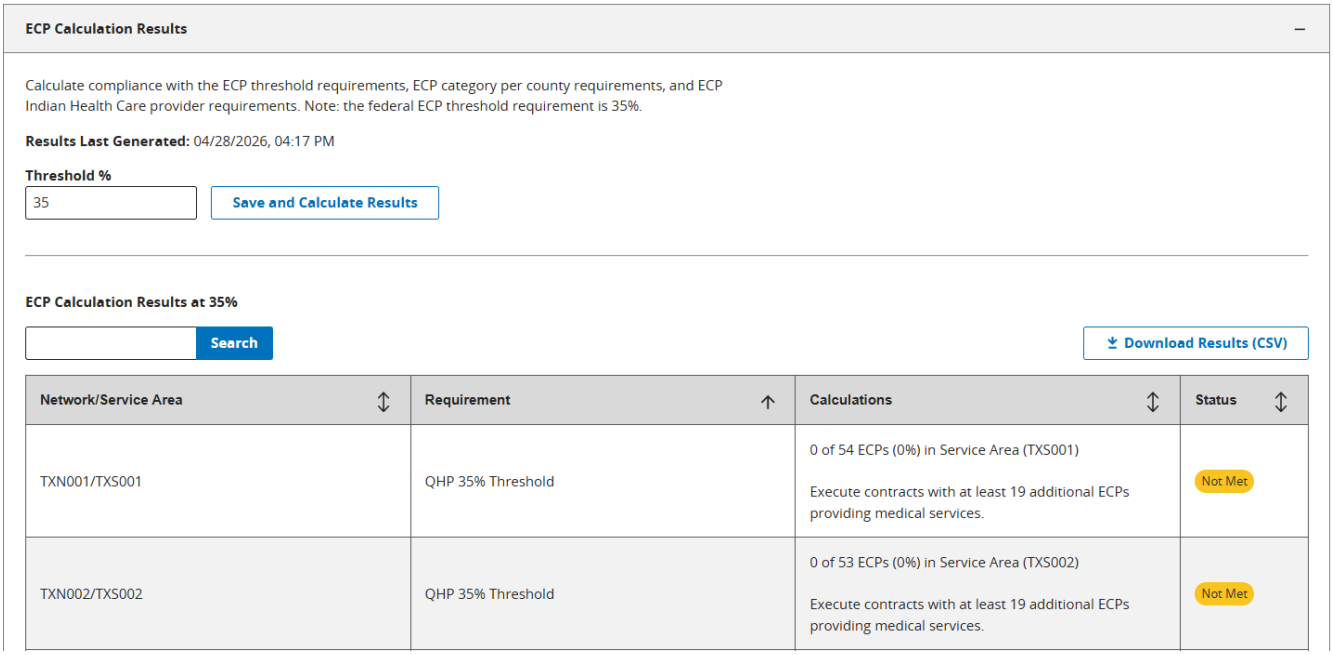


Figure 2I-6. Refresh ECP Results



Issuers in SBE-FP states will need to download their ECP data by clicking on the **Download ECPs (CSV)** button (Figure 2I-2.) on the *Select ECPs* screen and then upload this file as a supporting document into SERFF. This will allow state DOIs to review their ECP data. Issuers in FFEs and states performing plan management functions will review their ECP review results directly in the MPMS Module.

This concludes the ECP section of the QHP Application Instructions.

Section 2J: Network Adequacy

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

In the Network Adequacy (NA) section of the Marketplace Plan Management System (MPMS) Module, qualified health plan (QHP) issuers must demonstrate that they have a sufficient number and geographic distribution of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay. QHP issuers must submit provider data in each network associated with a QHP (Figure 2J-1).

2. Data Requirements

To complete this section, issuers will need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer state
3. Completed Network ID Template
4. A list of providers in each of the networks. When completing the NA Template, providers outside the service area may be included to satisfy time and distance (T&D) requirements, even if they are across state lines. If a provider is in-network and enrollees can access services from the provider within the requisite T&D standards for the respective county type designation, include the provider first name and provider last name, or facility name, National Provider Identifier (NPI), provider grouping, specialty type of individual provider or facility, telehealth service availability (only for individual providers), street address of the location providing services, city, state, county, ZIP code, and appointment scheduling provider phone number.
5. NA Justification Form (as applicable). After each round of reviews, issuers will retrieve a partially populated NA Justification Form from the MPMS Module with information regarding their deficient network, county, and specialty combinations. Issuers with deficiencies must complete and return their CMS-generated NA Justification Form to avoid receiving a deficiency. Once issuers have completed their portions of the NA Justification Form, they will submit the completed form to the MPMS Module by the required deadline. CMS will accept only the official NA Justification Form in Excel format and does not accept individually customized supplemental response forms as a substitute for the official form.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the NA Section
◆ For PY2027, the NA General Acute Care Hospital List will be updated and uploaded to the MPMS Module. Additionally, it can be found on the QHP certification website.
◆ Complete the Issuer Information section on the ***User Control*** tab before creating and entering data into the other tabs.
◆ Do not change the file names on NA files after finalizing the template. This file-naming convention helps CMS identify each issuer's NA Template. If the file name is changed, CMS may issue a required correction.
◆ Complete the Network ID Template before completing the NA Template.
◆ Issuers must only include providers on the NA Template that are not at known risk for potential contract termination or non-renewal for the upcoming plan year.

Tips for the NA Section
◆ Dual issuers (i.e., issuers that offer both a medical QHP and a stand-alone dental plan (SADP) under the same issuer ID) must enter both their medical QHP and their SADP provider data in the same NA Template. Otherwise, if the dual issuer mistakenly enters and submits their provider data in two separate NA Templates, the MPMS Module will retain only the most recently submitted template and will overwrite the previously submitted NA Template associated with the same issuer ID. For example, if a dual issuer submits their SADP provider data in a NA Template then submits a separate NA Template containing its medical QHP provider data, the MPMS Module will overwrite the issuer's SADP NA Template and retain only the dual issuer's medical QHP NA Template.
◆ All medical QHPs and SADPs operating on the FFE, including issuers in states performing plan management functions, and State-Based Exchange on the Federal Platform (SBE-FP) states, will submit their completed NA Template via the MPMS Module.
◆ NA Justifications are only required when at least one element of the NA standard is not met. Issuers that do not meet all elements of the NA standards are issued a correction notice and a partially populated NA Justification Form for the issuer to retrieve, complete, and submit via the MPMS Module. Issuers with required corrections must complete and return their CMS-generated NA Justification Form.
◆ SADPs that qualify for the limited exception and that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers as determined by CMS, will not be required to submit a NA Template. Under this limited exception, an area is considered "prohibitively difficult" for the SADP issuer to establish a network of dental providers based on attestations from state departments of insurance (DOIs) with at least 80 percent of their counties classified as counties with extreme access considerations, meaning that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Marketplace issuers, or significant geographic limitations impacting consumer access to dental providers.
◆ CMS will not be accepting requests for this limited exception directly from SADP issuers. Once an eligible state DOI submits to CMS an attestation that the state considers the area to be prohibitively difficult to establish a network of dental providers, CMS will review the attestation to determine if an exception will be granted. CMS will notify the SADP issuer directly if they qualify for this limited exception. SADP issuers that qualify for this limited exception will not be required to use a provider network or submit a NA Template.
◆ Issuers complete the NA Template by including all providers in their network in the *NA Provider* tab, using the *Taxonomy Codes* tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for T&D standards.
◆ Providers in another state that are part of the network may be included if they are located within the T&D allowed for reasonable access.
◆ Issuers should reference the *Taxonomy Codes* tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for T&D standards.

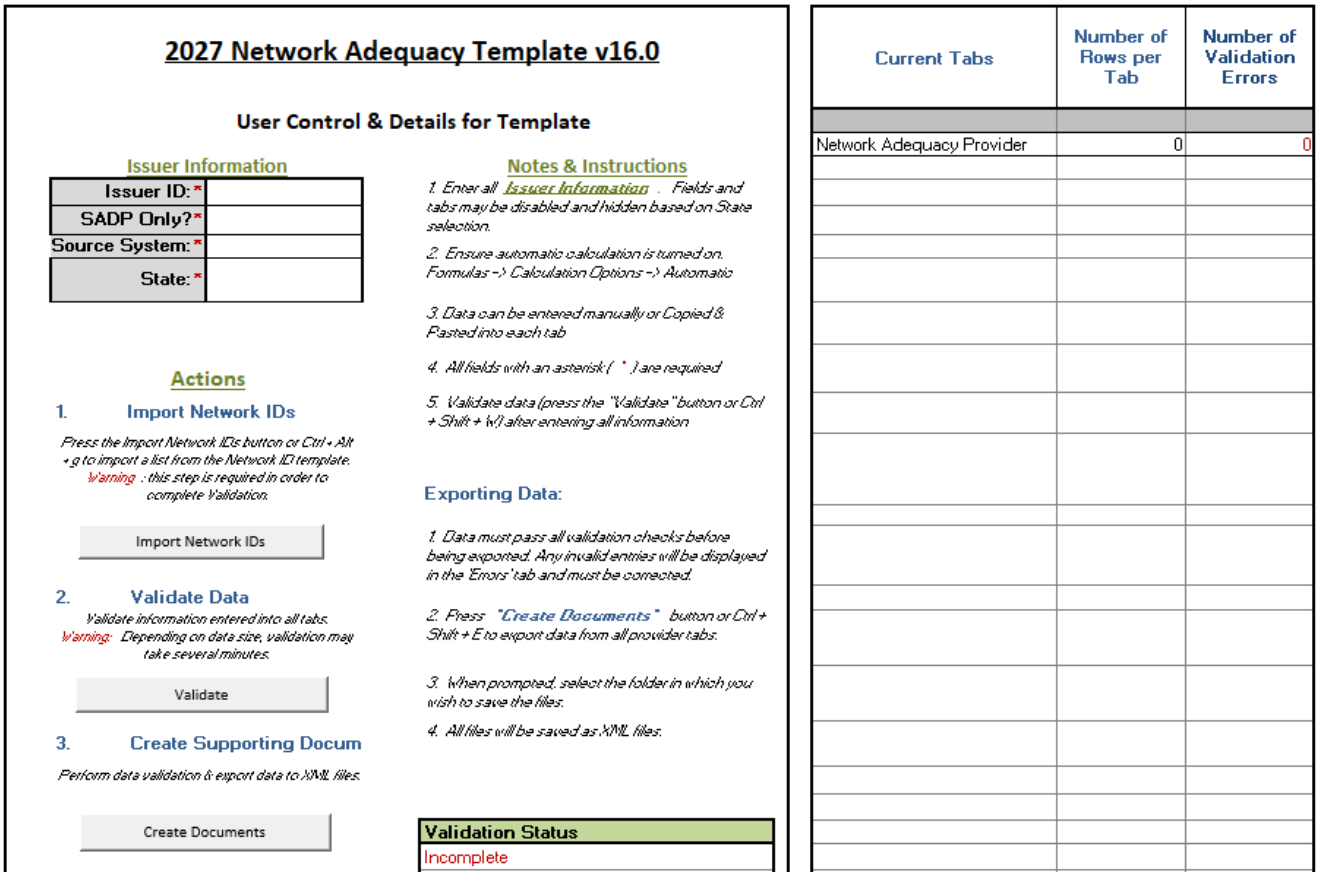
Additional Resources
◆ There are supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

4. Detailed Section Instructions

Existing issuers should navigate to the Application Tools section in the MPMS Module, select Application Materials, and download the data from the prior year's template directly into the current year's NA Template. New issuers download a blank NA Template from the QHP certification website and populate it according to the following instructions and guidelines. All issuers must upload the NA Template into the Plan Validation Workspace and verify that no errors exist.

Use the NA Template to identify each provider and any networks to which the provider belongs. Download the NA Template and save a local copy, then ensure macros are enabled before completing the template. Complete all required fields, which are identified with an asterisk (*).

Figure 2J-1. Sample User Control Tab



User Control Tab	Steps
Issuer ID	Enter the five-digit HIOS Issuer ID.
SADP Only	Choose from the following: ◆ **Yes**—if the issuer only submits SADPs. ◆ **No**—if the issuer submits QHPs.
Source System	Select the name of the system used to submit the QHP Application: ◆ **HIOS**—if the issuer is in an FFE state. ◆ **SERFF**—if the issuer is in a state performing plan management functions or an SBE-FP.
State	Use the drop-down menu to select the state in which the issuer is applying to offer QHPs.

Import Network IDs: Click **Import Network IDs** to import data from the Network ID Template (please refer to Section 2H: Network ID for detailed instructions on this template). Once the Network ID Template is imported, it will automatically populate networks into the *Network IDs* field as a drop-down list on the *NA Provider* tab (Figure 2J-2).

Follow these instructions and guidelines to determine the appropriate providers to include in the NA Template.

- Include a list of all the providers in each of the proposed networks, even those outside of the immediate geographic area meeting T&D requirements. Such providers must meet the following requirements:
  - Be appropriately licensed, accredited, or certified to practice in their state, as applicable, and
  - Must offer in-person services at a brick-and-mortar location. Stand-alone telehealth or virtual-only providers are not allowed to be submitted on the NA Template at this time. If a provider offers both in-person and telehealth or virtual services, issuers should select “Yes” in the “Does the Provider offer

Telehealth" column of the *NA Providers* tab of the NA Template for that provider. To count toward T&D standards, a provider must provide in-person care at least one day per week at each location. Issuers should remove any rows that indicate the provider is offering care solely in a telehealth or virtual setting, as such providers do not count toward an issuer's satisfaction of the T&D standards.

- Include only providers not at known risk for potential contract termination or non-renewal for the upcoming plan year.
- Reference the ***Taxonomy Codes*** tab of the NA Template to crosswalk provider taxonomy codes to provider specialty types and categories for T&D standards.
- For Cardiac Surgery Programs (facility specialty type code 041), Cardiac Catheterization Services (facility specialty type code 042), and Critical Care Services – Intensive Care Units (ICUs) (facility specialty type code 043), issuers must report within their NA submissions the respective facilities that filter into these facility specialty types. Since these are services rather than facility types, there are no specific taxonomy codes that align completely with these specialty codes. When the NA Template is uploaded to the MPMS Module, the provider data must be validated before the template can be linked to the application. A detailed list and descriptions of these MPMS Module provider validations are available on the NA webpage of the QHP certification website.

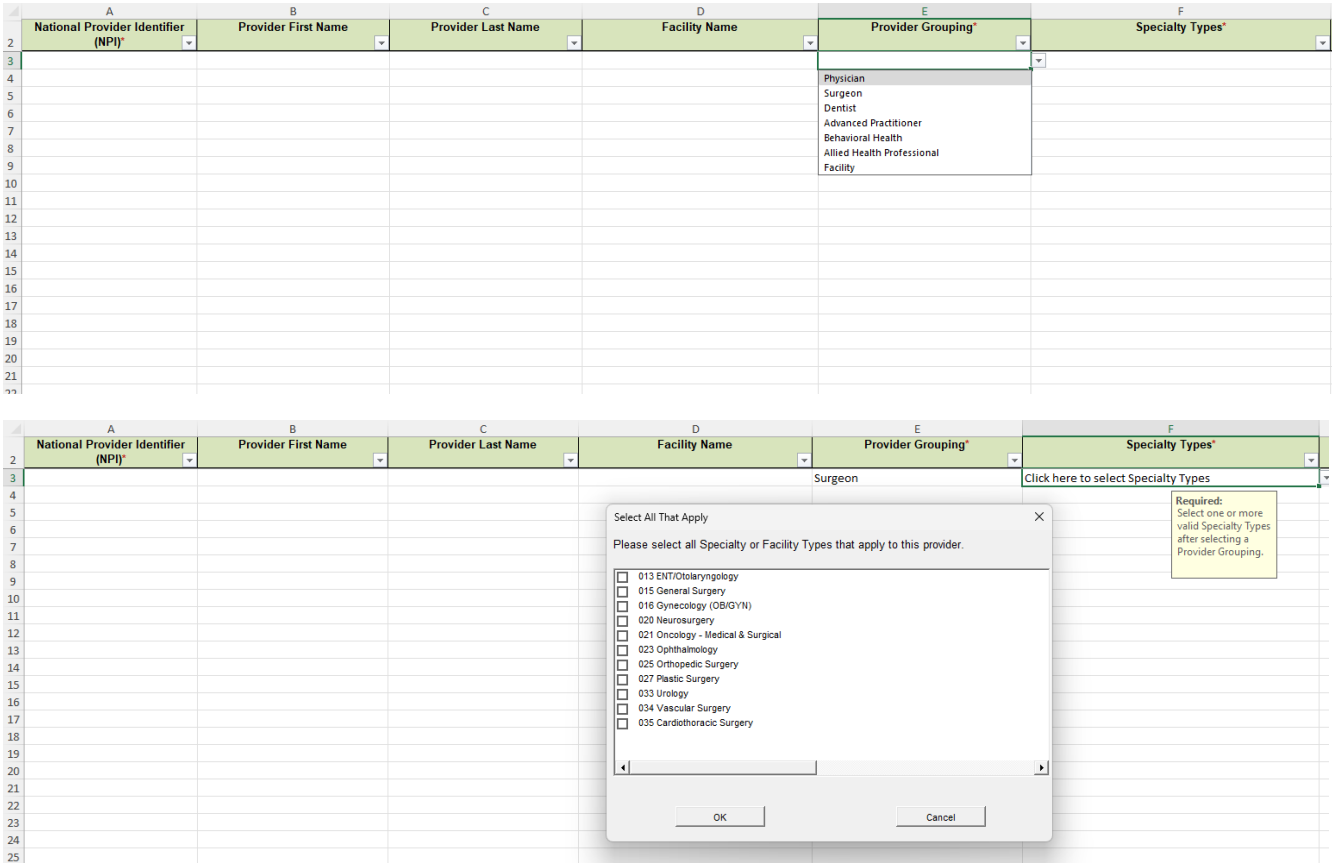
To complete the *NA Provider* tab, follow the steps in the tables.

NA Provider Tab	Steps
National Provider Identifier (NPI) (required)	Enter the provider's 10-digit NPI. Issuers should contact providers directly to acquire their NPIs. For NA purposes, issuers must report each individual provider under their unique practitioner NPI and each provider facility under their site-specific facility NPI. The parent organization-level NPI should not be reported. Issuers should only include providers in the NA Template after obtaining their NPI. CMS no longer accepts dummy entries for the *NPI* field. Ensure that the NPI is valid and active in the NPPES database.
Provider First Name (required if provider grouping selection reflects anything other than facility)	Enter the individual provider's first name. An individual practitioner's name should be entered into only the *Provider First Name* field and the *Provider Last Name* field for individual provider specialty types. An individual practitioner's name should not be entered into the *Provider First Name* field, the *Provider Last Name* field, or the *Facility Name* field for any facility provider specialty types. Similarly, a provider facility's name should not be entered into any of the name fields for an individual provider specialty type, except when a facility (such as a hospital) with whom the issuer has contracted directly employs a physical therapist, occupational therapist, speech therapist, or emergency medicine physician and the practitioner is available to provide services at in-network costs. In such cases, the name of the facility should be entered into the *Facility Name* field for these four specific individual provider specialty types when the issuer is unable to contract directly with the individual practitioner. To count toward T&D standards, a provider must provide in-person care at least one day per week at each location. Issuers should remove any rows that indicate the provider is offering care solely in a telehealth or virtual setting, as such providers do not count toward an issuer's satisfaction of the T&D standards.
Provider Last Name (required if provider grouping selection reflects anything other than facility)	Enter the individual provider's last name. An individual practitioner's name should be entered into only the *Provider First Name* field and the *Provider Last Name* field for individual provider specialty types. An individual practitioner's name should not be entered into the *Provider First Name* field, the *Provider Last Name* field, or the *Facility Name* field for any facility provider specialty type. Similarly, a provider facility's name should not be entered into any of the name fields for an individual provider specialty type, except when a facility (such as a hospital) with whom the issuer has contracted directly employs a physical therapist, occupational therapist, speech therapist, or emergency medicine physician and the practitioner is available to provide services at in-network costs. In such cases, the name of the facility should be entered into the *Facility Name* field for these four specific individual provider specialty types when the issuer is unable to contract directly with the individual practitioner. To count toward T&D standards, a provider must provide in-person care at least one day per week at each location. Issuers should remove any rows that indicate the provider is offering care solely in a telehealth or virtual setting, as such providers do not count toward an issuer's satisfaction of the T&D standards.

NA Provider Tab	Steps
Facility Name (required if provider grouping selection reflects facility)	Enter the facility name. An individual practitioner's name should not be entered into the *Facility Name* field for any provider facility specialty types, unless it is part of the name of the facility. Instead, a provider's facility name should be entered into only the *Facility Name* field for facility provider specialty types. When a facility (for example, a hospital) with whom the issuer has contracted has directly employed a physical therapist, occupational therapist, speech therapist, and/or an emergency medicine physician and the practitioner is available to provide services at the facility to enrollees at an in-network cost, the issuer should list the provider facility with whom it has contracted in the *Facility Name* field for these four specific individual provider specialty types when the issuer is unable to contract directly with the individual practitioner. To count toward T&D standards, a provider must provide in-person care at least one day per week at each location. Issuers should remove any rows that indicate the provider is offering care solely in a telehealth or virtual setting, as such providers do not count toward an issuer's satisfaction of the T&D standards
Provider Grouping (required)	Select a provider grouping using the following options: **Physician**, **Surgeon**, **Dentist, Advanced Practitioner**, **Behavioral Health**, **Allied Health Professional**, or **Facility**.
Specialty Type (s) (required)	After selecting a provider grouping, select all specialty types offered by the respective provider at the identified provider location. ◆ The template does not allow direct entry into this field. However, data may be copied and pasted into the template if the specialty type names match how they appear in the *Specialty Types* tab data, such as **001 General Practice**. Errors will appear if pasted data do not exactly match the specialty type format used in the *NA Provider* tab. ◆ To enter more than one specialty type for a provider, each specialty type must be separated by a comma and a space. Such specialty selections must comply with the Provider Classification and Specialty Framework and the Physician Specialty and Subspecialty Compatibility Matrices that are available on the NA webpage of the QHP certification website. ◆ Do not include provider specialties except those in which the provider is actively practicing and providing services. ◆ If the specialty type is not listed in the *Specialty Types* tab, do not list the provider. CMS does not accept specialties that do not fall within the defined Specialty Types lists.
Does this provider offer Telehealth? (required)	For the purpose of this data collection and reporting, the term "telehealth" is defined as "professional consultations, office visits, and office psychiatry services through brief communication technology–based service/virtual check-in, remote evaluation of pre-recorded patient information, and inter-professional internet consultation." From the drop-down menu, select **Yes** or **No** to indicate whether the provider offers telehealth services. If the issuer has reached out to the provider and is awaiting a response, select **Requested information from provider and awaiting their response**.
Street Address (required)	Enter the provider's street address. If the provider has multiple locations, enter each street address in a separate row. Do not enter a PO Box or any terms that indicate a provider is offering care solely in a telehealth or virtual setting, as such entries cannot be geocoded for T&D analysis. To count toward T&D standards, a provider must provide in-person care at least one day per week at each location. All providers with such entries in the address field will be excluded from T&D analysis. Issuers must not report an individual provider as practicing at more than 10 unique locations or a provider facility as operating at more than 10 unique locations within their NA Template. A validation error in the Plan Validation Workspace within the MPMS Module will result if an issuer exceeds this limit. CMS has relaxed this validation error to generate a validation warning (that does not block data entry) for the following specialties that can sometimes reasonably exceed 10 unique addresses for a single NPI: 037 Emergency Medicine, 049 Physical Therapy, 050 Occupational Therapy, 051 Speech Therapy, and 080 Urgent Care.
Street Address 2	Enter additional street address information, if applicable.
City (required)	Enter the city where the provider is located.
State (required)	Enter the state where the provider is located or select the state using the drop-down menu.
County (required)	Enter the county where the provider is located or select the county using the drop-down menu. A list of accepted county names is available on the *County Names* tab of the NA Template. Do not include the Federal Information Processing Standards code when entering the county name.

NA Provider Tab	Steps
ZIP Code (required)	Enter the ZIP Code where the provider is located. ZIP Codes must include either five (12345) or nine (12345-6789) digits.
Appointment Scheduling Provider Phone Number	Enter the provider's phone number. The phone number will be included in the Provider Population File for Appointment Wait Time Secret Shopper Surveys.
Network IDs (required)	When entering network IDs, use the same network IDs as those assigned in the Network ID Template and the Plans & Benefits Template. Issuers that offer both medical QHPs and SADPs (i.e., dual issuers) must create separate network IDs for their medical and dental plans but should enter all their provider data for both QHPs and SADPs into the same NA Template. Using the drop-down menu, issuers should select all network IDs that correspond to the networks in which the provider is included. If a provider is in multiple networks, issuers should select all networks in the same record.

Figure 2J-2. Sample NA Provider Tab



Reference information is provided in the four tabs listed below:

- The *Specialty Types* tab contains the specialty/facility types that can be added into the NA Template.
- The *Taxonomy Code Guidance* tab provides important information related to populating the *NA Provider* tab.
- The *Taxonomy Codes* tab contains the taxonomy codes that correspond to provider specialty types listed within the *Specialty Types* tab. The *Taxonomy Codes* tab may be used as a guide for the provider taxonomy types required for inclusion in submissions. The *Taxonomy Codes* tab also has columns to show which taxonomy codes crosswalk into each T&D specialty type.
- The *County Names* tab contains the county names that are used and accepted in the NA Template.

- The *Errors* tab displays any validation errors identified when the issuer attempts to validate the NA Template.
  1. Column A—Tab: Indicates the tab that produced the error.
  2. Column B—Cell: Indicates the cell location for the specific error and creates a hyperlink that allows the issuer to navigate to the exact cell in the correct tab.
  3. Column C—Validation Error Message: Describes the error.

After entering all data, click **Save** to ensure no data are lost. Once the NA Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** on the *User Control* tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, the message "No validation errors were identified. Validation is complete." will display, indicating that the template may be finalized.
Errors	Errors will appear on the *Errors* tab, which shows the data element, cell location, and validation error message for each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Create Documents	Once all validations are complete, click **Create Documents** on the *User Control* tab to create a separate .XML file for each tab in the workbook and compress all files into one .ZIP file.
Save Template	**Save** the .ZIP file and template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .ZIP file for easier reference.
Upload and Link Template	**Upload** the saved .ZIP file in the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for additional guidance on how to complete these steps.

After uploading the necessary NA files and linking them to the application, any NA Justifications Forms must also be uploaded. Completed NA Justification Forms must be submitted in the NA section in the MPMS Module.

Supporting Documents	Steps
NA Justification Form	◆ If a required correction for not meeting one or more of the NA standards is received, all required fields in the prepopulated NA Justification Form generated by CMS must be completed. This form can be retrieved from the MPMS Module. Refer to the MPMS User Guide. ◆ The completed NA Justification Form should be saved in the required .XLSM format and uploaded into the NA section of the MPMS Module by the required deadline for each submission round. Do not rename the NA Justification Form. ◆ CMS will use market data to confirm the availability of practicing providers/facilities within the established T&D standard. If CMS has confirmed a provider supply shortage, issuers will be allowed an expanded T&D standard. The Alternative Access Standards will be applied automatically after the NA Template is submitted in the MPMS Module. Issuers will also be able to access the current Alternative Access Standards for T&D on the NA webpage of the QHP certification website. ◆ On the *Monitoring & T&D Justification* tab of the NA Justification Form, issuers must answer the five-service area monitoring questions at the top of the worksheet for CMS to consider any barriers reported within the *Primary Reasons on Record for Unmet Standard* column. A fifth question has been added where issuers must provide the URL to their Out-of-Network policy. ◆ On the *Monitoring & T&D Justification* tab of the NA Justification Form, issuers must provide the primary reasons for not meeting the standard related to each correction.

Supporting Documents	Steps
	◆ On the *Recruitment Activity* tab of the NA Justification Form, CMS requires issuers to include at least one entry that identifies the provider recruitment activities for the network, county, and specialty combinations for which required corrections were received, including any ongoing, concluded, and unsuccessful activities. This additional provider recruitment data will inform next steps that may be required of the issuer as part of a compliance plan. ◆ Issuers with deficiencies must complete and return their CMS-generated NA Justification Form to avoid receiving required corrections. ◆ All required fields in the NA Justification Form must be completed before submission. Incomplete justifications will not be accepted. ◆ After completing the form, click the **Click Here to Validate this Tab** button on the *Monitoring & T&D Justification* tab. This will verify that all required fields have been completed and that the form is ready for submission to the MPMS Module. ◆ After issuers submit the completed NA Justification Form, CMS will send additional corrections via the MPMS Module if further corrections are required.

This concludes the NA section of the QHP Application Instructions.

Section 2K: Plan ID Crosswalk

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

The Plan ID Crosswalk Template crosswalks plan year (PY) 2026 qualified health plan (QHP) plan ID and service area combinations to PY2027 QHP plan IDs. These data facilitate re-enrollment transactions from the Centers for Medicare & Medicaid Services (CMS) to issuers for enrollees in the Individual Market who did not actively select a different QHP or terminated their coverage during Open Enrollment. These instructions apply to QHP and stand-alone dental plan (SADP) issuers that offered Individual Market plans on the Exchange during PY2026.

2. Data Requirements

To complete this section, issuers need the following:

1. Health Insurance Oversight System (HIOS) Issuer ID
2. Issuer's state
3. Market coverage
4. Completed Plans & Benefits Template
5. Completed Service Area Template
6. Completed State Authorization Form.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Plan ID Crosswalk Section
◆ Submit the Plan ID Crosswalk Template, justifications if needed, and state authorization in the Marketplace Plan Management System (MPMS) Module. Submit separate Plan ID Crosswalk Templates in the MPMS Module for SADPs.
◆ New issuers do not need to submit Plan ID Crosswalk Templates unless they will receive plans from a discontinuing issuer, which is a rare situation. However, to complete their application, new issuers must complete the questions in the Plan ID Crosswalk application section and submit the Plan Crosswalk application group in the MPMS Module.
◆ Issuers must provide alternative plans to crosswalk enrollees who age off child-only plans and alternatives for those who age off or otherwise lose eligibility for catastrophic plans.
◆ CMS has deferred the Federally-facilitated Small Business Health Options Program's (FF-SHOP's) ability to auto-renew employees. Do not submit a Plan ID Crosswalk Template for FF-SHOP plans.
◆ The 2024 U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters requires Exchanges to ensure that a consumer whose current year QHP is no longer available be auto re-enrolled into a QHP that has the most similar network compared to the enrollee's current QHP and that meets the other requirements that also apply to plan crosswalk at 45 CFR 155.335(j). Therefore, issuers should consider network ID when selecting crosswalk plans, if possible, along with product ID and plan type as has been required in prior years.[1]

Additional Resources
◆ There are supporting documents for this section.
◆ There are instructional videos for this section.
◆ There are templates for this section.

[1] For a complete list of plan crosswalk rules, refer to 45 CFR 155.335(j).

4. Detailed Section Instructions

Issuers must submit evidence (such as a signed State Authorization form or an email confirmation) that their state has authorized their Plan ID Crosswalk Template in the MPMS Module along with the completed template by no later than the deadline for the initial application submission.

States can review the Plan ID Crosswalk Template for compliance with the Affordable Care Act (ACA) market reforms and individually determine how they will review the Plan ID Crosswalk Template. For example, a state could review the submitted Plan ID Crosswalk Template for consistency with state and federal requirements and that it matches the expectations of its form filing reviews.

CMS does not send Plan ID Crosswalk Templates to states, but state regulators can ask the issuer to provide this template in addition to the issuer's QHP Application (as part of the National Association of Insurance Commissioners' [NAIC's] System for Electronic Rates & Forms Filing [SERFF] binder, for example).

Issuers in states that do not enforce the ACA market-wide requirements should submit the authorization form to their state's department of insurance and CMS's Compliance and Enforcement Division (formfiling@cms.hhs.gov) to obtain the necessary authorization for submission.

In the MPMS Module, returning issuers can generate prepopulated Plan ID Crosswalk Templates to submit as part of their QHP Application. The prepopulated templates import an issuer's plan IDs and associated service areas and network IDs from the prior plan year. Refer to the MPMS User Guide for details on how to generate prepopulated Plan ID Crosswalk Templates. New issuers are not required to submit Plan ID Crosswalk Templates in the MPMS Module to complete their application unless they will receive plans from a discontinuing issuer, which is a rare situation. Although new issuers may not need templates, they must complete the questions in the Plan ID Crosswalk application section and submit the Plan Crosswalk application group in the MPMS Module.

The following steps outline how to complete the Plan ID Crosswalk Template, beginning with the *2026 Plan Crosswalk* tab.

2026 Plan Crosswalk Tab	Steps
Import 2026 Plans & Benefits and Service Area Template	Note: A prepopulated Plan ID Crosswalk Template generated in the MPMS Module imports the issuer's plan IDs and associated service areas and network IDs from PY2026. Refer to the MPMS User Guide for details on how to generate a prepopulated Plan ID Crosswalk Template in the MPMS Module. For issuers who manually import PY2026 data: Click **Import 2026 Plans & Benefits and Service Area Template** to import the completed templates. The template prompts the user to select the completed 2026 Plans & Benefits and Service Area Templates. Before importing, save these templates in the same folder; both must be uploaded at the same time. To select both files, click one template, then press and hold **Ctrl** on Windows or **Cmd** on macOS while clicking on the other template, then click **Open**. Select exactly one of each type of template. The Plan ID Crosswalk Template will populate a list of PY2026 plan IDs and their associated service areas and network IDs on the *2026 Plan and Service Area Data* tab. Review this tab for accuracy. After the PY2026 plan and service area data have been imported, the *2026 Plan Crosswalk* tab will be populated with all applicable issuer information and a row for each PY2026 plan ID.
HIOS Issuer ID	Ensure the template accurately populated the five-digit HIOS Issuer ID.
Issuer State	Ensure the template accurately populated the state where the issuer is offering coverage.
Market Coverage	Ensure the template accurately populated the market coverage from the drop-down menu. The FF-SHOP Exchange no longer allows auto-renewals; this field is hard coded to **Individual**.

2026 Plan Crosswalk Tab	Steps
Dental Only	Ensure the template accurately indicates whether this Plan ID Crosswalk Template is for dental-only plans. Choose from the following: ◆ **Yes**—this template is for SADPs only. ◆ **No**—this template is for QHPs.
Crosswalk Level	Choose the level at which the user would like to crosswalk each PY2026 plan from the drop-down menu. Select from the following options: ◆ **Crosswalking to the same plan ID:** Crosswalking the PY2026 plan to the same plan ID for PY2027 with no service area changes. ◆ **Crosswalking at the plan ID level:** No service area changes but using a different PY2027 plan ID to reflect the same plan. ◆ **Crosswalking at the plan ID and county coverage level:** The issuer's service area changed for the upcoming year and the PY2026 plan needs to be crosswalked to two or more PY2027 plan IDs. Note: If the PY2026 plan covered the entire state, the plan must be crosswalked to PY2027 plan IDs for every county in the state. ◆ **Crosswalking at the ZIP Code level for one or more counties:** The service area changed for the upcoming year and the PY2026 plan needs to be crosswalked to two or more PY2027 plan IDs for the same county. This option requires issuers to pick the counties from the PY2026 plan's service area to crosswalk at the ZIP Code level. The remaining PY2026 service area will be crosswalked at the county level. Note: Do not crosswalk at the ZIP Code level unless necessary. ◆ **Discontinue with no crosswalk:** A PY2026 plan is being discontinued with no re-enrollment option for its enrollees. ◆ **Plan withdrawn prior to certification:** Remove PY2026 plans withdrawn from the Exchange before certification from the Plan ID Crosswalk Template. Optionally, select this option if the PY2026 plan ID listed on the template was withdrawn or not approved by the state or the Federally-facilitated Exchange (FFE) to be offered on the Exchange in PY2027.
Counties Crosswalked at ZIP Code Level	Select the counties in the PY2026 plan's service area to crosswalk at the ZIP Code level from the pop-up menu.

To complete the information on the *2027 Plan Crosswalk* tab, follow the steps in the table below.

2027 Plan Crosswalk Tab	Steps
Create "2027 Crosswalk Tab"	Click **Create "2027 Crosswalk Tab."** This action creates the *2027 Plan Crosswalk* tab. The first four columns—*2026 HIOS Plan ID*, *County Name*, *Service Area ZIP Codes*, and *Crosswalk Level*—and the last column—*2026 Network ID*—auto-populate based on the issuer's entries in the *2026 Plan Crosswalk* tab. If issuers crosswalk at the plan ID, county level for one or more plans, a row will appear for each county that plan covered in PY2026. If issuers crosswalk at the ZIP Code level for specific counties covered by a PY2026 plan, a row will appear for each combination of plan ID, county, and ZIP Code. Click **Create "2027 Crosswalk Tab"** only after completion of the *2026 Plan Crosswalk* tab. A *2027 Plan Crosswalk* tab cannot be changed after creation. To make changes, issuers must click **Create "2027 Crosswalk Tab"** again to clear all data and begin a new copy of the *2027 Plan Crosswalk* tab. Issuers can copy and paste previously entered information into a separate workbook and then into a new copy to save previous work when changes require replacing the *2027 Plan Crosswalk* tab.
Crosswalk Reason	Choose the reason for the crosswalk from the drop-down menu. Certain options are only available for specific crosswalk levels.

2027 Plan Crosswalk Tab	Steps
	Table 2K-1 details crosswalk reason entries for each crosswalk level: ◆ **Renewing exact same product/plan combination (same PY2026 plan ID):** Crosswalking this plan ID/service area to the exact same HIOS Plan ID. The template auto-populates the *PY2027 Plan ID* field with the PY2026 plan ID. Use the same HIOS Plan ID if the same plan was offered the previous plan year and remains available for the upcoming 2027 plan year. Issuers must comply with the "same plan" standards as defined in 45 CFR 144.103. ◆ **Renewing exact same product/plan combination (different PY2027 plan ID):** Crosswalking this plan ID/service area to the same product/plan combination but with a different HIOS Plan ID for PY2027. If possible, use the same HIOS Plan ID if the previous year's same plan ID/service area combination remains available. Issuers continuing a plan but wishing to crosswalk to a different HIOS Plan ID must obtain approval from their state regulatory authority before submitting the Plan ID Crosswalk Template. Issuers must comply with the "same plan" standards as defined in 45 CFR 144.103. ◆ **Renewing product; renewal in a different plan within product:** Renewing this product but crosswalking this plan ID/service area to a different plan in the product offered on the FFE. With this option, issuers must use the same product ID embedded in the plan's 2026 plan ID. ◆ **Continuing product; no plan available in the particular service area under that product; enrollment in a different product:** Continuing this product in PY2027 but no longer offering any plans in part of the service area covered by the product in PY2026 and crosswalking to a plan in a different product offered on the FFE. Select this reason for the portion of the service area where issuers no longer offer any plans under that product. With this option, issuers must crosswalk the PY2026 plan ID to a PY2027 plan ID with a different product ID. ◆ **Continuing product; no plan available in the particular service area under that product; no enrollment option:** Continuing a PY2026 product with no plan under this product available to crosswalk to for this plan/service area combination. Do not enroll such plans into a plan offered off the Exchange. Selecting this option will disable the *2027 HIOS Plan ID* field. ◆ **Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product**: No silver plan is available in the enrollee's product in a particular service area and the enrollee is being enrolled in a silver plan in another product. ◆ **Discontinuing product; enrollment into a different product:** This PY2026 product is discontinued for PY2027 and enrollees in this plan and the associated service area will be re-enrolled in a plan under a different product offered on the FFE. The entered PY2027 plan ID must have a different product ID, and issuers cannot enter the discontinued PY2026 product ID for any other row under the PY2027 plan ID. Crosswalk any discontinued PY2026 plan to an available plan in a different product, if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if issuers do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, CMS will crosswalk the discontinued plan to another product issuers offer under the same HIOS Issuer ID. ◆ **Discontinuing product; no enrollment option:** Discontinuing a PY2026 product for PY2027 without an enrollment option on the FFE for PY2026 enrollees in this plan ID/service area combination. Do not enroll pertinent plans into a plan offered off the Exchange. Selecting this option disables the *PY2027 Plan ID* field. Under this option, issuers cannot enter the discontinued PY2026 product ID for any other row under the PY2026 plan ID. Crosswalk any discontinued PY2026 plan to an available plan in a different product if one exists. In accordance with the hierarchy established in 45 CFR 155.355(j)(2), if issuers do not provide a crosswalk for a discontinued plan but still offer products in the same service areas, CMS will crosswalk the discontinued plan to another product issuers offer under the same HIOS Issuer ID.

2027 Plan Crosswalk Tab	Steps
2027 HIOS Plan ID	Enter the PY2027 plan ID to crosswalk enrollees to for the row's PY2026 plan ID/service area. This field is auto-populated when issuers choose **Renewing exact same product/plan combination (Same 2026 Plan ID)** under *Crosswalk Reason*. This field is disabled when issuers choose **Discontinuing product; no enrollment option** or **Continuing product; no plan available in the particular service area under that product; no enrollment option** under *Crosswalk Reason*. Note: Only enter PY2027 plan IDs for plans offered on the Exchange and listed in the 2027 QHP Application. CMS will not accept any PY2027 plan IDs for plans sold only off the Exchange.
Is the PY2027 Plan a Catastrophic or Child-Only Plan?	This field will default to **No**. Please select **Yes** if crosswalking to a catastrophic or child-only plan.
PY2027 Plan ID for Enrollees Losing Eligibility for Catastrophic or Child-Only Plan	If issuers respond **Yes** to *Is the 2027 Plan a Catastrophic or Child-Only Plan?*, this field will allow issuers to enter a PY2027 plan ID. Enrollees who no longer meet the criteria for continued eligibility in these plans will be crosswalked to the PY2027 plan ID entered in this field.
Associated Policy Form Numbers and NAIC SERFF Tracking Numbers for Form Filings	Complete the following optional data fields if directed to do so by the issuer's state regulator: ◆ *PY2026 Plan ID*—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ *PY2027 Plan ID*—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings. ◆ *PY2027 Plan ID (Catastrophic or Child-Only)*—Associated Policy Form numbers and NAIC SERFF tracking numbers for Form Filings.

See Figure 2K-1 for a sample completed Plan ID Crosswalk Template.

Figure 2K-1. Sample Plan ID Crosswalk Template

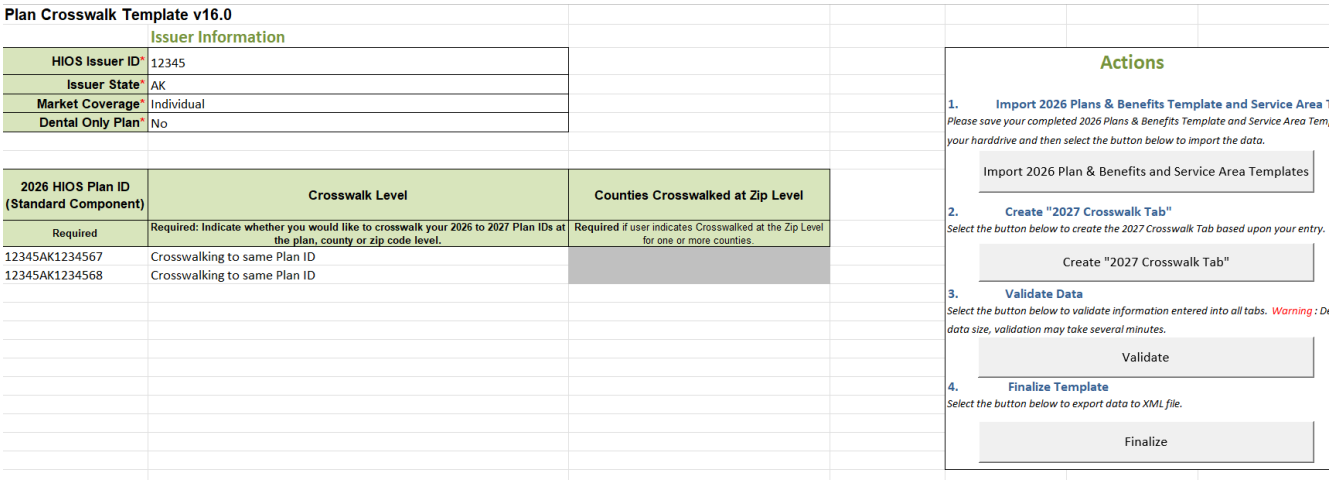


Table 2K-1 lists the crosswalk reason and PY2027 plan ID entry options for each crosswalk level.

Table 2K-1. Crosswalk Level, Reason for Crosswalk, and PY2027 Plan ID Entry Options

Crosswalk Level	Crosswalk Reason	2027 HIOS Plan ID
Crosswalking to same plan ID	Renewing exact same product/plan combination (auto-populated) (same PY2026 plan ID)	Template auto-populates field with PY2026 plan ID
Crosswalking at the plan ID level	Renewing exact same product/plan combination (different PY2027 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2026 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2026 plan ID
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product	Plan ID with different product ID from PY2027 plan ID
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2026 plan ID
Crosswalking at the plan ID and county coverage level	Renewing exact same product/plan combination (same PY2026 plan ID)	Template auto-populates field with PY2026 plan ID
	Renewing exact same product/plan combination (different PY2027 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2026 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2026 plan ID
	Continuing product; no silver plan available in the particular service area under that product, enrollment in a silver plan under a different product	Plan ID with different product ID from PY2027 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2026 plan ID
	Discontinuing product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
Crosswalking at the ZIP Code level for one or more counties	Renewing exact same product/plan combination (same PY2026 plan ID)	Template populates field with PY2026 plan ID
	Renewing exact same product/plan combination (different PY2027 plan ID)	Different plan ID
	Renewing product; renewal in a different plan within product	Plan ID with same product ID as PY2026 plan ID
	Continuing product; no plan available in the particular service area under that product; enrollment in a different product	Plan ID with different product ID from PY2026 plan ID
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
	Continuing product; no silver plan available in the particular service area under that product; enrollment in a silver plan under a different product	Plan ID with different product ID from PY2027 plan ID
	Discontinuing product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
	Discontinuing product; enrollment into a different product	Plan ID with different product ID from PY2026 plan ID

Crosswalk Level	Crosswalk Reason	2027 HIOS Plan ID
Discontinue with no crosswalk	Discontinuing product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
	Continuing product; no plan available in the particular service area under that product; no enrollment option	*PY2027 HIOS Plan ID* field is disabled
Plan withdrawn prior to certification	Plan suppressed; no enrollment option	*PY2027 HIOS Plan ID* field is disabled

After completing the Plan ID Crosswalk Template, issuers must validate, finalize, and upload it into the MPMS Module for further validation.

Template Validation	Step Description
Validate Template	Click **Validate** on the *2026 Plan Crosswalk* tab. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** on the *2026 Plan Crosswalk* tab to create the .XML version of the template that will be uploaded to the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. Refer to the MPMS User Guide for details on how to complete these steps.

Issuers must submit their Plan ID Crosswalk Templates, justifications (if necessary), and state authorization via the MPMS Module. The MPMS User Guide contains detailed instructions on how to use the Plan Validation Workspace, complete the sections of an application, and submit the application.

This concludes the Plan ID Crosswalk section of the QHP Application Instructions.

Section 2L: Accreditation

1. Introduction

The instructions for this section apply to the following issuer type:

- QHP

See Appendix D for additional information.

In the Accreditation section of the Marketplace Plan Management System (MPMS) Module, issuers enter information to satisfy the accreditation qualified health plan (QHP) certification requirement (Figure 2L-1). Issuers can provide information for an accredited product in the Commercial, Medicaid, or Exchange markets. These instructions apply only to those issuers that are filing via the Health Insurance Oversight System (HIOS) to offer a QHP on the Federally-facilitated Exchange (FFE).

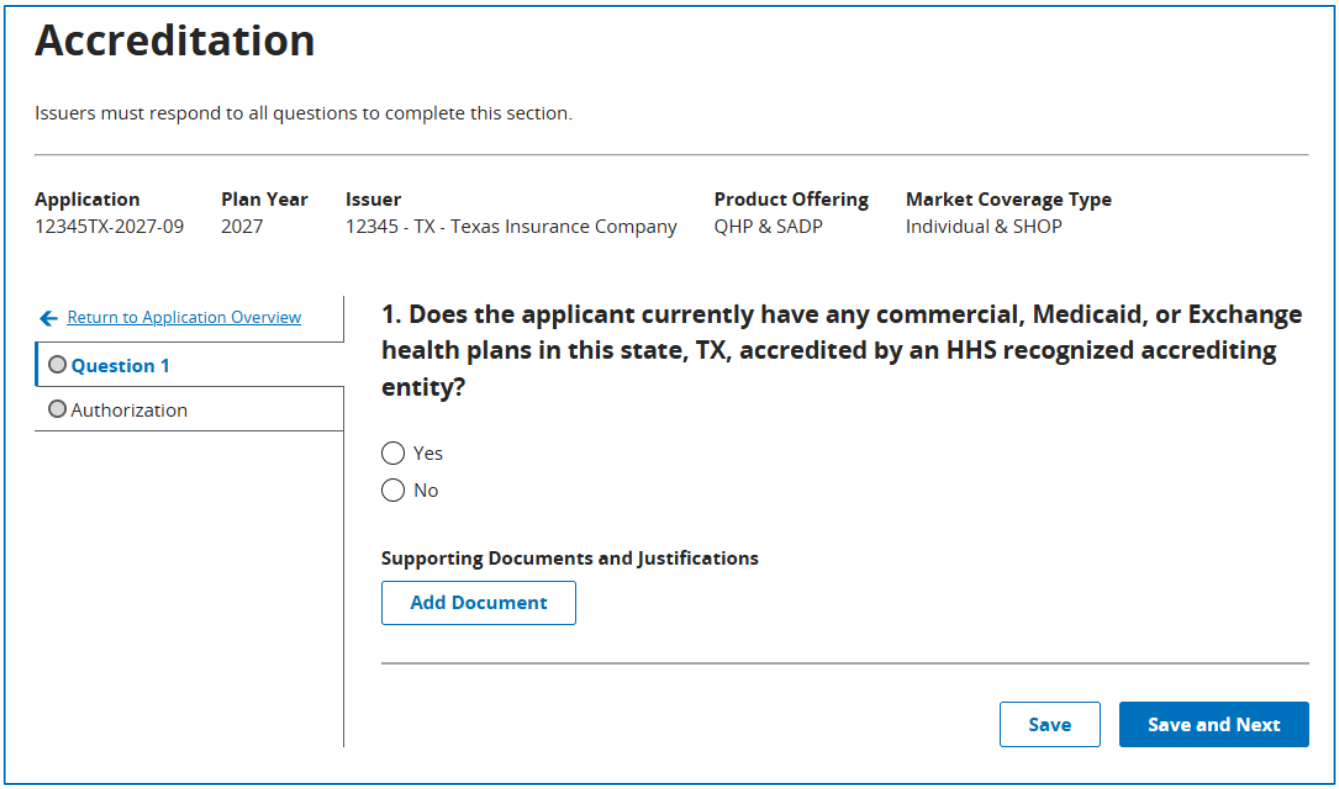
If the issuer is in a state performing plan management functions or a State-based Exchange on the Federal Platform, the issuer must comply with the requirements for accreditation data collection specified by its state.

2. Data Requirements

To complete this section, issuers need the following:

- Information about which accrediting entity the issuer is accredited by—the National Committee for Quality Assurance (NCQA), URAC, or the Accreditation Association for Ambulatory Health Care (AAAHC).

Figure 2L-1. Accreditation Application Section



3. Quick Reference

Key Changes for 2027
◆ Issuers in FFE states and states performing plan management functions required to submit Quality Improvement Strategy (QIS) documents will no longer submit their QIS documents in the Accreditation section. Instead, issuers will submit this information in the new Issuer Quality group within the MPMS Module.

Tips for the Accreditation Section
◆ Only provide information on accredited products in the same state and for the same legal entity that submits the QHP Application. ◆ Provide accrediting entities with the legal issuer name and the HIOS Issuer ID used in the QHP Application to ensure the HIOS Issuer ID is included in the data file the accrediting entity provides to the Centers for Medicare & Medicaid Services (CMS).

Additional Resources
◆ There are optional supporting documents for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

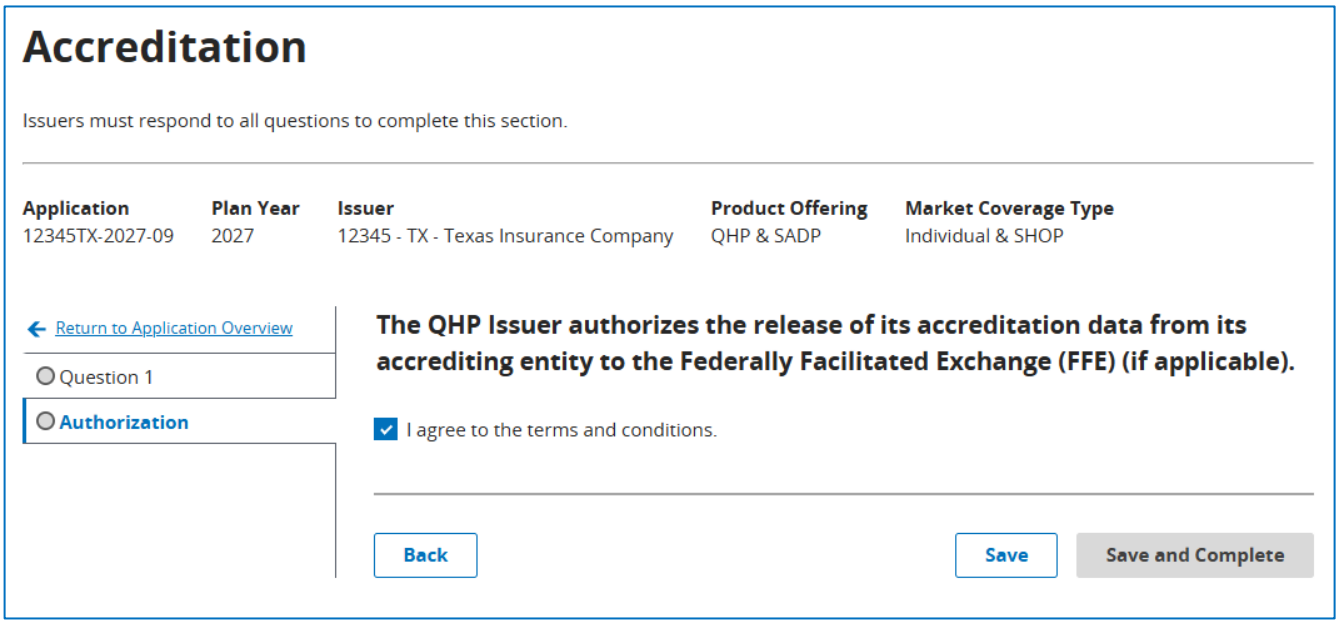
If the answer to the accreditation question (Question 1 in the MPMS Module) is **Yes**, an additional section appears for issuers to select an accrediting entity from the list.

Accreditation Question	Steps
Does the applicant currently have any Commercial, Medicaid, or Exchange health plans in this state, [state of issuer identified], accredited by an HHS-recognized accrediting entity?	Choose from the following: ◆ **Yes**—issuers have existing health plan accreditations on any products in the Exchange, Commercial, or Medicaid market from NCQA, URAC, or AAAHC. Dual-product issuers with an accredited medical plan select **Yes**. Proceed to the next step. ◆ **No**—not accredited by NCQA, URAC, or AAAHC.

Accreditation Responses	Steps
If the issuer responds **Yes** to the accreditation question, the issuer must select the accrediting entity.	Choose from the following. Issuers accredited by multiple entities select all that apply: ◆ **NCQA**—accredited by NCQA. ◆ **URAC**—accredited by URAC. ◆ **AAAHC**—accredited by AAAHC.
Irrespective of whether the issuer responds **Yes** or **No** to the accreditation question, proceed to the Authorization.	All issuers must respond to the Terms and Conditions attestation regardless of whether accredited. Note: Unaccredited issuers are strongly encouraged to schedule a review of their QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). Issuers do not need to be accredited in their initial year of QHP certification but must be accredited 90 days before the first day of Open Enrollment when entering any subsequent year of QHP certification.

After responding to the accreditation question, issuers must complete the Terms and Conditions attestation (Figure 2L-2), regardless of their response.

Figure 2L-2. Authorization for All Issuers



In addition to responding to Question 1, issuers can upload copies of relevant accreditation certificates into the MPMS Module.

Accreditation Certificate	Step Description
Scan Certificate	**Scan** each accreditation certificate (one per accredited market type). Issuers accredited by NCQA who do not have a copy of their accreditation certificate can obtain a copy of their survey results through the NCQA Interactive Survey System (ISS). Log in to ISS, click on the *Results* tab, view the survey results, and print the results screen.
Name File	**Save** the accreditation certificate using the naming convention in Table B-1: [Issuer ID]_[Name of Accrediting entity] (e.g., 12345_NCQA.pdf).
Upload Certificate	**Upload** the saved files in the Accreditation section of the MPMS Module. Refer to the MPMS User Guide for further instruction.

Issuers in their initial year of QHP certification must schedule (or plan to schedule) a review of their QHP policies and procedures with a recognized accrediting entity (i.e., AAAHC, NCQA, or URAC). Issuers do not need to be accredited in their initial year of QHP certification but **must** be accredited 90 days before the first day of Open Enrollment when entering any subsequent year of QHP certification.

Issuers entering their second year (or later) of QHP certification must be accredited by a recognized accrediting entity 90 days prior to Open Enrollment on the policies and procedures applicable to its Exchange products or receive Commercial or Medicaid health plan accreditation granted by one of the recognized accrediting entities.

Second-year issuers that immediately pursued Exchange certification after their initial year of certification and have an accreditation status of "scheduled" or "in process" upload documentation from their accrediting entity indicating their completion of the policies and procedures review and that they have scheduled for or are in the process of completing additional review.

Issuers entering their fourth year (or later) of QHP participation must have Exchange health plan accreditation 90 days prior to Open Enrollment with one of the following statuses:

1. AAAHC—Accredited
2. NCQA—Accredited or Provisional
3. URAC—Full or Conditional.

Note: Issuers who were previously QHP certified but did not pursue certification in the preceding year and are pursuing certification in the current year will be held to the second-year accreditation standard (i.e., issuers must be accredited 90 days prior to Open Enrollment). If issuers go on to pursue certification the following year, they will be considered a third-year issuer, and so forth.

Note: CMS reviews issuers that crosswalk enrollees to a new HIOS Issuer ID for accreditation based on their cumulative years of certification. Therefore, issuers must ensure that the receiving HIOS Issuer ID issuer is appropriately accredited. For example, if Issuer A participated for 3 consecutive years and is crosswalking all their plans to Issuer B who has only participated for 1 year, Issuer B would now be considered a fourth-year issuer and must meet the requirements for issuers in their fourth year (or later) of participation.

This concludes the Accreditation section of the QHP Application Instructions.

Section 2M: Transparency in Coverage

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

This document provides instructions for qualified health plan (QHP) issuers submitting Transparency in Coverage data for plan year (PY) 2027.[1]

Issuers submitting a QHP Application for PY2027 must make accurate and timely disclosures of transparency reporting information to the appropriate Exchange, the Secretary of the U.S. Department of Health and Human Services, and the state insurance commissioner and make the information available to the public.[2,3] These instructions apply to issuers applying for QHP certification in Federally-facilitated Exchanges (FFEs) in PY2027, including issuers in states performing plan management functions and State-based Exchanges on the Federal Platform (SBE-FPs). This includes:

- On-Exchange medical QHPs
- On-Exchange stand-alone dental plans (SADPs)
- Off-Exchange-only SADPs seeking QHP certification
- Small Business Health Options Program (SHOP) QHPs.

Note: Issuers in a State-based Exchange (SBE) state that is not on the federal platform are not required to submit Transparency in Coverage data at this time.

Exchange Type	Transparency in Coverage Reporting Required?
FFE	Yes
State performing plan management functions	Yes
SBE (using own IT platform)	No
SBE-FP (using federal IT platform)	Yes

2. Data Requirements

To complete this section, the following are needed:

1. Information on whether the issuer was on the Exchange in 2025
2. Health Insurance Oversight System (HIOS) Issuer ID and all PY2027 plan IDs
3. Number of PY2025 claims received, denied, and resubmitted
4. Number of PY2025 pre-service benefit requests received, denied, and resubmitted.
5. Number of PY2025 internal and external appeals
6. Claims Payment Policy and Other Information URL (“Transparency in Coverage URL”).

To apply for PY2027 QHP certification (except in an SBE state not on the federal platform), the issuer must submit a Transparency in Coverage Template that includes all on-Exchange PY2027 plan IDs. The QHP Application cannot be submitted without this template. However, only certain on-Exchange QHPs and SADPs will report numerical Transparency in Coverage claims data for dates of service from January 1, 2025, through December 31,

[1] Office of Management and Budget Control Number CMS-10572.

[2] Section 2715A of the Public Health Service (PHS) Act extends the transparency reporting provisions under Section 1311(e)(3) to non-grandfathered groups and issuers offering group or individual coverage, except for a plan not offered on an Exchange.

[3] The implementation of the transparency reporting requirements under Section 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into Section 715(a)(1) of the Employee Retirement Income Security Act and Section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

2025. Off-Exchange SADP issuers and on-Exchange issuers not on the Exchange in PY2025 should complete the template indicating reporting requirements are not applicable. See Table 2M-1 for more information.

- The Transparency in Coverage Template must include all on-Exchange PY2027 plan IDs and a separate Transparency in Coverage Template must be submitted for each unique HIOS Issuer ID. Only report claims data for plan IDs that were offered on the Exchange in PY2025 and will be offered on the Exchange again in PY2027. Claims for plan IDs that were offered on the Exchange in PY2025 but will no longer be offered on the Exchange in PY2027 must be included within the total claims counts on the *Issuer Level* tab of the template. If a PY2027 plan ID was not offered on the Exchange in PY2025 but will be offered on the Exchange in PY2027, include it in the *Plan Level* tab of the template and indicate that PY2025 claims data is not applicable for that plan ID by entering **N/A** in the relevant fields. See Table 2M-1 for a summary of Transparency in Coverage reporting requirements.

If a QHP has enrollment both on and off the Exchange, the issuer is required to report claims data only for the on-Exchange enrollees.

Table 2M-1. Summary of Transparency in Coverage Reporting Requirements

Plan Type	Transparency in Coverage Template Required?	Transparency in Coverage Claims Data Required?	Transparency in Coverage URL Required?
On-Exchange QHP that was offered in PY2025	Yes	Yes. Do not include or count claims data for off-Exchange QHP enrollment.	Yes
On-Exchange SADP that was offered in PY2025	Yes	Yes. Do not include claims data for off-Exchange SADP enrollment.	Yes
Off-Exchange SADP that was offered in PY2025	Yes	No. Do not include claims data associated with any off-Exchange plans or plan IDs.	No
On-Exchange QHP that was not offered in PY2025	Yes	No. Note as N/A in the template.	Yes
On-Exchange SADP that was not offered in PY2025	Yes	No. Note as N/A in the template.	Yes

3. Quick Reference

Key Changes for 2027

- Issuers must now report the number of issuer-level pre-service benefit requests received and denied.
- Issuers must now report the number of issuer-level pre-service benefit requests which were internally or externally appealed and the number of internal or external pre-service benefit requests which were overturned on appeal.
- Issuers must now differentiate plan-level claims received, denied, and resubmitted by whether they were claims for behavioral health services (behavioral health-only) or non-behavioral health services.
- Issuers must now differentiate, for each plan-level reason for a denied claim, whether those claims were for in- or out-of-network services.

Tips for the Transparency in Coverage Section

- Issuers applying to offer on-Exchange plans for PY2027 that did not offer on-Exchange plans in PY2025 must still submit a Transparency in Coverage Template.
- Issuer level data for returning issuers must be non-zero numeric values for in- and out-of-network claims received and denied but can be zero for issuer level in- and out-of-network claims appealed and resubmitted.
- Do not include off-Exchange only plans in the Plan Level tab of the Transparency in Coverage Template.
- Required data elements are identified by an asterisk (*) next to the field name.
- Complete a separate template for each unique HIOS Issuer ID.

Tips for the Transparency in Coverage Section
◆ Use only the tabs provided in the Transparency in Coverage Template. Do not add additional tabs, rows, or columns. ◆ Enter all on-Exchange plan level data in the Plan Level Data tab. One plan ID should be captured in each row. Each plan ID listed should be a distinct 14-character ID. ◆ Check the templates for completeness and data validity before submitting by clicking Validate on the Issuer Level Data tab. ◆ For issuers that submit via the System for Electronic Rates & Forms Filing (SERFF), one identical Transparency in Coverage Template containing all plan IDs should be submitted in each submission binder. For example, if an issuer submits an Individual Market binder and a SHOP Market binder, both the Individual Market plan IDs and the SHOP Market plan IDs should be included in one Transparency in Coverage Template and submitted in each binder. Note that this is different from the process used for other templates submitted as part of the QHP Application and certification process, wherein each binder should include a unique template.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Perform the following steps to complete the Transparency in Coverage Template (see Figure 2M-1 and Figure 2M-2).

Note for issuers that submit via SERFF: Issuers should complete only one Transparency in Coverage Template containing all necessary information and submit that template in all SERFF binders. Include the same Transparency in Coverage Template across all SERFF binders. The Marketplace Plan Management System (MPMS) Module will return a validation error upon submission of the Transparency Data group if different Transparency in Coverage Templates are identified across SERFF binders. For example, if an issuer has an Individual Market SERFF binder with 3 on-Exchange plan IDs and a SHOP Market SERFF binder with 7 on-Exchange plan IDs, the issuer should submit an identical Transparency in Coverage Template that contains all 10 on-Exchange plan IDs in both SERFF binders.

4.1 Defining and Reporting a Claim

For all claims data fields on the *Issuer Level* and *Plan Level* tabs, the following definitions apply:

- A claim is any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of service will be counted as 10 claims).
- A pre-service benefit request refers to any request from an enrollee or provider for coverage of care that is submitted prior to the delivery of said care that meets the definition of "pre-service claim" as defined at 29 *Code of Federal Regulations* (CFR) 2560.503-1(m)(2).
- An in-network provider is any provider, such as a hospital, physician, or pharmacy, that is contracted to be part of the issuer's network (such as a health maintenance organization [HMO] or preferred provider organization [PPO]).
- An out-of-network provider is any provider, such as a hospital, physician, or pharmacy, that is not contracted to be part of your network (such as an HMO or PPO).
- Non-behavioral health claims refer to payments for services related to medical or surgical diagnosis, including medical and pharmacy point of sales. Do not include behavioral health claims or payments for

benefits associated with mental health or substance use disorders.[4] Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health:

- Analgesics
- Anesthetics
- Antibacterials
- Anticonvulsants
- Antidementia Agents
- Antiemetics
- Antifungals
- Antigout
- Antimigraine Agents
- Antimyasthenic Agents
- Antimycobacterials
- Antineoplastics
- Antiparasitics
- Antiparkinson Agents
- Antipasticity Agents
- Antivirals
- Blood Glucose Regulators
- Blood Products and Modifiers
- Cardiovascular Agents
- Central Nervous System Agents
- Dental and Oral Agents
- Dermatological Agents
- Electrolytes/Minerals/Metals/Vitamins
- Gastrointestinal Agents
- Genetic or Enzyme or Protein Disorder: Replacement, Modifiers, Treatment
- Genitourinary Agents
- Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal)
- Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary)
- Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins)
- Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers)
- Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid)
- Hormonal Agents, Suppressant (Adrenal)
- Hormonal Agents, Suppressant (Pituitary)
- Hormonal Agents, Suppressant (Thyroid)
- Immunological Agents
- Inflammatory Bowel Disease Agents
- Metabolic Bone Disease Agents
- Ophthalmic Agents
- Otic Agents
- Respiratory Tract/Pulmonary Agents
- Skeletal Muscle Relaxants
- Sleep Disorder Agents.

- Behavioral health-only claims refer to payments for services, including pharmacy claims and pharmacy point of sales related to behavioral health. This includes mental health and substance use disorder claims or payments for benefits associated with mental health or substance use conditions as classified in the current versions of the DSM and the ICD and applicable federal or state guidelines. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as

[4] Mental health claims or payments for benefits associated with mental health conditions as classified in the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD.

behavioral or mental health according to the current version of the DSM. Use the following USP drug categories to count pharmacy claims for behavioral health:

- Anti-addiction/Substance Abuse Treatment Agents
- Antidepressants
- Antipsychotics
- Anxiolytics
- Bipolar Agents.

Additionally, when calculating claim counts:

- Include those for all QHPs that fall under the reporting HIOS Issuer ID. Submit a separate template for each HIOS Issuer ID, if applicable.
- When reporting claims, calculate claim counts by dates of service (DOS) and report claims data with a single numerical value.
- Include pediatric vision claims and pediatric dental claims.

4.2 Issuer Level Data Tab

Figure 2M-1. Transparency in Coverage Template

*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting

Plan Year 2027 v7.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2025?*	
SADP Only?*	
Issuer HIOS ID*	
Issuer Level Data	
Number of Issuer Level Pre-Service Benefit Requests Received in Calendar Year 2025*	
Number of Issuer Level Pre-Service Benefit Requests Denied in Calendar Year 2025*	
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2025 That Were Also Received in Calendar Year	
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	
Number of Issuer Level Internal Appeals of Pre-Service Benefit Determinations Filed in Calendar Year 2025*	
Number of Issuer Level Internal Appeals of Pre-Service Benefit Determinations Overturned from Calendar Year 2025 Appeals*	
Number of Issuer Level External Appeals of Pre-Service Benefit Determinations Filed in Calendar Year 2025*	
Number of Issuer Level External Appeals of Pre-Service Benefit Determinations Overturned from Calendar Year 2025 Appeals*	
Number of Issuer Level Internal Appeals of Claims Filed in Calendar Year 2025*	
Number of Issuer Level Internal Appeals of Claims Overturned from Calendar Year 2025 Appeals*	
Number of Issuer Level External Appeals of Claims Filed in Calendar Year 2025*	
Number of Issuer Level External Appeals of Claims Overturned from Calendar Year 2025 Appeals*	
Notes:	

The values submitted on the *Issuer Level* tab must include claims for all QHPs in 2025, including QHPs not returning to the Exchange in 2027. Therefore, the sum of plan level claims values reported elsewhere in the template may be less than the issuer level claims values reported.

If the issuer was not on the Exchange in 2025 or will offer only off-Exchange SADPs for 2027, please mark **N/A** for all claims data fields.

General Information	Steps
Was this issuer on the Exchange in 2025?*	Enter **Yes** or **No** to indicate whether or not this issuer was on the Exchange in 2025. ◆ If **Yes**, the issuer must fill out claims and appeals data. ◆ If **No**, the issuer must enter **N/A** in the claims and appeals data fields. ◆ If the issuer offers only off-Exchange SADPs, enter **No**.

General Information	Steps
Issuer HIOS ID*	Enter the **five-digit HIOS Issuer ID**. Submit a separate template for each HIOS Issuer ID, if applicable.
SADP Only?*	Select **Yes** or **No** from the drop-down menu to indicate whether the issuer offers only SADPs.

Issuer Level Data	Steps
Number of Issuer Level Pre-Service Benefit Requests Received in Calendar Year 2025*	Enter the number of issuer level requests the issuer received that requested prospective coverage of care or services, such as requests for prior authorization. ◆ Requests that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one request in this category.
Number of Issuer Level Pre-Service Benefit Requests Denied in Calendar Year 2025*	Enter the number of issuer level requests the issuer received that requested prospective coverage of care or services, such as requests for prior authorization that the issuer subsequently denied. ◆ Count denied requests based on their final adjudication. ◆ Include all denials in the total number of requests denied in calendar year 2025, including: ▪ Pediatric vision and dental request denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Duplicate requests.
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of issuer level claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Claims that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial, and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims.
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Enter the number of issuer level claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. Do not include out-of-network claims.

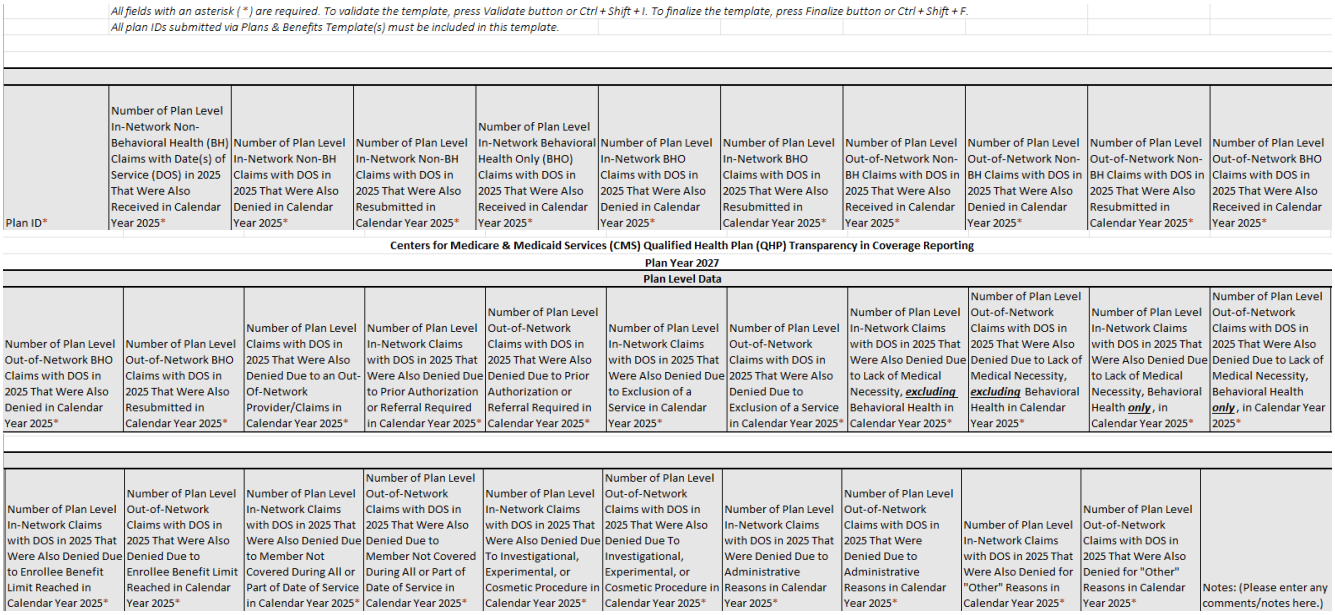
Issuer Level Data	Steps
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of issuer level claims resubmissions received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. Do not include out-of-network claims.
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of issuer level claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. ◆ Claims that were pended or initially denied and subsequently resubmitted for any reason should only be counted as one claim in this category. For example, each of the following counts as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial, and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include in-network claims.
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Enter the number of issuer level claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission

Issuer Level Data	Steps
	▪ Denials caused by incorrect billing ▪ Duplicate claims. Do not include in-network claims.
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of issuer level claims resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. Do not include in-network claims.
Number of Issuer Level Internal Appeals of Pre-Service Benefit Requests Filed in Calendar Year 2025*	Enter the number of requests for internal appeals involving adverse pre-service benefit determinations the issuer received from or on behalf of consumers pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse pre-service benefit determination reviewed with respect to a prospective denial of coverage, in whole or in part, for a service or treatment. Include appeals regarding pre-service benefit requests received in calendar year 2025. Do not include appeals that were subsequently withdrawn. Note: CMS expects the number of issuer level internal appeals reported here to be less than the *Number of Issuer Level Pre-Service Benefit Requests Received in Calendar Year 2025*.
Number of Issuer Level Internal Appeals of Pre-Service Benefit Requests Overturned from Calendar Year 2025 Appeals*	Enter the number of final pre-service benefit determinations adverse to consumers that were overturned on request for internal review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request internal review to have a pre-service benefit determination reviewed with respect to a prospective denial of coverage, in whole or in part, for a service or treatment.
Number of Issuer Level External Appeals of Pre-Service Benefit Requests Filed in Calendar Year 2025*	Enter the number of requests for external appeals of final adverse pre-service benefit determinations sent by or on behalf of consumers to an external review organization pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse pre-service benefit determination (or final internal adverse pre-service benefit determination) reviewed by an independent third-party reviewer. Include appeals regarding pre-service benefit requests received in calendar year 2025. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals of Pre-Service Benefit Requests Overturned from Calendar Year 2025 Appeals*	Enter the number of final pre-service benefit determinations adverse to consumers that were overturned on request for external review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse pre-service benefit determination (or final internal adverse pre-service benefit determination) reviewed by an independent third-party reviewer.

Issuer Level Data	Steps
Number of Issuer Level Internal Appeals of Claims Filed in Calendar Year 2025*	Enter the number of requests for internal appeals involving adverse claims determinations the issuer received from or on behalf of consumers pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse claim determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment or a rescission of coverage. Include appeals regarding services with DOS in 2025 that the issuer received, fully adjudicated, and completed in 2025. Do not include appeals that were subsequently withdrawn. Note: CMS expects the number of issuer level internal appeals reported here to be less than the sum of the *Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and the *Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*.
Number of Issuer Level Internal Appeals of Claims Overturned from Calendar Year 2025 Appeals*	Enter the number of final claims determinations adverse to consumers that were overturned on request for internal review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request internal review to have an adverse determination reviewed with respect to a denial of payment, in whole or in part, for a service or treatment or a rescission of coverage.
Number of Issuer Level External Appeals of Claims Filed in Calendar Year 2025*	Enter the number of requests for external appeals of final adverse claims determinations sent by or on behalf of consumers to an external review organization pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals regarding services with DOS in 2025 that the issuer received, fully adjudicated, and completed in 2025. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals of Claims Overturned from Calendar Year 2025 Appeals*	Enter the number of final claims determinations adverse to consumers that were overturned on request for external review, in whole or in part, pursuant to 45 CFR 147.136. Consumers request an external appeal to have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

4.3 Plan Level Data Tab

Figure 2M-2. Transparency in Coverage Template—Plan Level Tab



All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.
All plan IDs submitted via Plans & Benefits Template(s) must be included in this template.

Plan ID*	Number of Plan Level In-Network Non-Behavioral Health (BH) Claims with Date(s) of Service (DOS) in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level In-Network Non-BH Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level In-Network Non-BH Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level In-Network Behavioral Health Only (BHO) Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level In-Network BHO Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level In-Network BHO Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*

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Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2025*

Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Denied Due to Administrative Reasons in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Denied Due to Administrative Reasons in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025*	Notes: (Please enter any comments/notes here.)

Issuers must include all on-Exchange plan IDs that are present in their PY2027 QHP Application in the Transparency in Coverage Template. If a plan is off-Exchange or did not exist in PY2025, enter **N/A** in all Plan

Level data fields. All other on-Exchange plans (including SADPs, except for SADPs offered by SADP-only issuers when reporting the *Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2025*) must enter a numerical value in all fields; 0 is acceptable.

Note: Report all reasons a claim is denied. A claim can be denied for more than one reason. Therefore, the sum of the reasons why claims were denied may either be equal to or greater than the sum of the *Number of In-Network Plan Level Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and *Number of Out-of-Network Plan Level Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025.*

PY2027 Plan Data	Steps
2027 On-Exchange Plan ID*	Enter the **14-character PY2027 on-Exchange plan ID** on the *Plan Level Data* tab. The plan ID is composed of the five-digit HIOS Issuer ID, the two-character state abbreviation, and the seven unique digits for the plan (e.g., 12345AZ1234567). If there is more than one PY2027 plan ID to report for a single HIOS Issuer ID, add each plan line by line in the *Plan Level Data* tab. All plan variants should be rolled up to one plan ID or line in the template. For example: ◆ Reported claims for 12345AZ1234567 would include claims that fall under this plan ID from members on all associated plan variants: ▪ 12345AZ1234567-01: 100 claims ▪ 12345AZ1234567-02: 500 claims ▪ 12345AZ1234567-03: 200 claims ▪ 12345AZ1234567-04: 50 claims. Reporting for plan ID 12345AZ1234567 should be entered as one plan ID in one row of the template with a total of 850 claims (100 + 500 + 200 + 50) for the applicable data field.
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of plan level non-behavioral health claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Claims that were pending or initially denied for additional information and subsequently paid for any reason should only be counted once.[5] For example, the following each count as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.

[5] For example, if one of an issuer's plans were to receive 20,000 claims and deny 3,000 of those claims, the issuer would further report the reasons for the 3,000 denials in one or more of 10 denial categories:

1. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025
2. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2025
3. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025
4. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Including Behavioral Health in Calendar Year 2025
5. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2025
6. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025
7. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025
8. Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025
9. Number of Plan Level Claims with DOS in 2025 That Were Also Denied for Administrative Reasons in Calendar Year 2025
10. Number of Plan Level Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025.

In this example, the issuer would only report that 3,000 plan-level claims were denied but could report more than 3,000 denial reasons in the 10 reporting categories if any claims were denied for more than one reason.

PY2027 Plan Data	Steps
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Footnote 5) (Plan Level Claims Denied)*	Enter the number of plan level non-behavioral health claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the sum of the *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and the *Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* because individual claims may be denied for more than one reason.
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of plan level non-behavioral health claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.

PY2027 Plan Data	Steps
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of plan level behavioral health-only claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 5, should only be counted once. For example, the following each count as one claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Footnote 5) (Plan Level Claims Denied)*	Enter the number of plan level behavioral health-only claims the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the sum of the *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and the *Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* because individual claims may be denied for more than one reason.
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of plan level behavioral health-only claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an in-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied).

PY2027 Plan Data	Steps
	◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of plan level non-behavioral health claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 5, should only be counted once. For example, the following each count as one claim: ◆ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ◆ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include in-network claims. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Footnote 5) (Plan Level Claims Denied)*	Enter the number of plan level non-behavioral health claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission ▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the sum of the *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and the *Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* because individual claims may be denied for more than one reason.

PY2027 Plan Data	Steps
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of plan level non-behavioral health claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. The total issuer level claims resubmitted data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Enter the number of plan level behavioral health-only claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. Claims that were pending or initially denied for additional information and subsequently paid for any reason, as shown in Footnote 5, should only be counted once. For example, the following each count as one claim: ◆ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. ◆ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include in-network claims. The total issuer level claims received data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Footnote 5) (Plan Level Claims Denied)*	Enter the number of plan level behavioral health-only claims the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider that the issuer subsequently denied. ◆ Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: ▪ An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim because it lacks medical necessity. ▪ An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. ◆ Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. ◆ Include all denials in the total number of claims denied in calendar year 2025, including: ▪ Pediatric vision and dental denials, including for SADPs ▪ Denials because of ineligibility ▪ Denials caused by incorrect submission

PY2027 Plan Data	Steps
	▪ Denials caused by incorrect billing ▪ Duplicate claims. The total number of plan level claims denied in the specified calendar year should also be accounted for in the 10 Plan Level Claims Denial categories. Note: CMS expects the sum of the 10 Plan Level Claims Denial categories to be greater than or equal to the sum of the *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* and the *Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025* because individual claims may be denied for more than one reason.
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Enter the number of plan level behavioral health-only claim resubmissions the issuer received that asked for a payment or reimbursement by or on behalf of an out-of-network health care provider. ◆ Any claim that is resubmitted one or more times after the initial submission should be counted as one resubmitted claim, regardless of the outcome of the claim. This means that all of the following should count as one resubmission: ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied, resubmitted, approved (i.e., resubmitted on three occasions, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied, resubmitted, denied (i.e., resubmitted on two occasions, ultimately denied) ▪ A claim that was submitted, denied, resubmitted, approved (i.e., resubmitted on only one occasion, ultimately approved) ▪ A claim that was submitted, denied, resubmitted, denied (i.e., resubmitted on only one occasion, ultimately denied). ◆ Regardless of who initiates the resubmission—the issuer, the enrollee, or someone resubmitting on behalf of the enrollee—any claim that is resubmitted one or more times after initial submission should be counted as one resubmitted claim. ◆ Duplicate claims do not count as resubmitted claims if the duplicates are denied for being repetitious of a previously received claim that has been or is in the process of being adjudicated. The total issuer level claims resubmitted data may include plans not offered in 2027. Therefore, the plan level claims total may not total the issuer level claims.

The claim denial reporting instructions for the *Denial Reason* fields on the *Plan Level* tab are different from the instructions for claim denial reporting on the *Issuer Level* tab and total denied claims counts on the *Plan Level* tab. For the Denial Reason fields, rather than reporting denied claims based on their final adjudication, report each incidence of the following denials that occur throughout the life of a claim. For example:

> If an in-network claim is denied for lacking a prior authorization and being an excluded service, then resubmitted and denied again for lacking a prior authorization and being an excluded service, it will count twice toward *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025* and twice toward *Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025*.

This guidance applies to all following plan level fields.

PY2027 Plan Data	Steps
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for non-emergency-related claims for service that required prior authorization, preauthorization, referral, prior approval, or precertification, from when a claim was first received to its final adjudication. Issuers should include the following claims (individual claim line of service items):

PY2027 Plan Data	Steps
(Plan Level Claims Denied)*	◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied. ◆ Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for non-emergency-related claims for service that required prior authorization, preauthorization, referral, prior approval, or precertification, from when a claim was first received to its final adjudication. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied. ◆ Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification.
Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of plan level denials the issuer issued for claims for service from outside the plan's network of health care providers if the plan has a closed network, from when a claim was first received to its final adjudication. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied for point of service benefits provided by someone (e.g., health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plan's (HMO or closed network plans) network. Do not include in-network claims.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims for excluded or non-covered services. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because certain services, tests, treatments, admissions, supplies, etc., are excluded, not covered, or limited under the plan, including claims denied because a drug is not on the formulary.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims for excluded or non-covered services. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because certain services, tests, treatments, admissions, supplies, etc., are excluded, not covered, or limited under the plan, including claims denied because a drug is not on the formulary.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health, in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these related to a medical or surgical diagnosis, from when a claim was first received to its final adjudication.

PY2027 Plan Data	Steps
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health, in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these related to a medical or surgical diagnosis, from when a claim was first received to its final adjudication.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health-only, in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat illness, injury, condition disease, or the symptoms of these related to behavioral or mental health, from when a claim was first received to its final adjudication. If a plan is off-Exchange, an SADP offered by an issuer offering only SADPs, and/or a plan that did not exist in PY2025, enter **N/A**. All other on-Exchange plans, including SADPs offered by an issuer offering both SADPs and QHPs, must enter a numerical value in this field; 0 is acceptable.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health-only, in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat illness, injury, condition disease, or the symptoms of these related to behavioral or mental health, from when a claim was first received to its final adjudication. If a plan is off-Exchange, an SADP offered by an issuer offering only SADPs, and/or a plan that did not exist in PY2025, enter **N/A**. All other on-Exchange plans, including SADPs offered by an issuer offering both SADPs and QHPs, must enter a numerical value in this field; 0 is acceptable.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims denied due to the beneficiary reaching their benefit limit. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because a beneficiary has reached or exceeded the benefit limit for their plan. This item refers to any annual limit on benefits (including monetary limits, cost maximums, quantity limits, visit limits, etc.).
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims denied due to the beneficiary reaching their benefit limit. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because a beneficiary has reached or exceeded the benefit limit for their plan. This item refers to any annual limit on benefits (including monetary limits, cost maximums, quantity limits, visit limits, etc.).
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims denied due to beneficiary enrollment status. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because of the beneficiary's enrollment status.

PY2027 Plan Data	Steps
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims denied due to beneficiary enrollment status. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because of the beneficiary's enrollment status.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims denied because the procedure was investigational, cosmetic, or experimental. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because the procedure for which the claim is submitted is considered investigational, cosmetic, or experimental.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims denied because the procedure was investigational, cosmetic, or experimental. Issuers should include the following claims (individual claim line of service items): ◆ Total number of claims denied because the procedure for which the claim is submitted is considered investigational, cosmetic, or experimental.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for Administrative Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level claims the issuer denied for administrative reasons. Issuers should include the following claims (individual claim line of service items): ◆ Duplicate Claim ◆ Missing/Insufficient Information ◆ Untimely Claim Filing ◆ Billing Provider Not Approved ◆ Coordination of Benefit ◆ Inconsistent Procedure Code/Diagnosis ◆ Workers Comp/Liability Issue ◆ Paid by Auto or Other Insurance ◆ Unable to identify patient.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for Administrative Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level claims the issuer denied for administrative reasons. Issuers should include the following claims (individual claim line of service items): ◆ Duplicate Claim ◆ Missing/Insufficient Information ◆ Untimely Claim Filing ◆ Billing Provider Not Approved ◆ Coordination of Benefit ◆ Inconsistent Procedure Code/Diagnosis ◆ Workers Comp/Liability Issue

PY2027 Plan Data	Steps
	◆ Paid by Auto or Other Insurance ◆ Unable to identify patient.
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan level denials the issuer issued for claims rejected for reasons other than those specified in the above categories, from when a claim was first received to its final adjudication.
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of out-of-network plan level denials the issuer issued for claims rejected for reasons other than those specified in the above categories, from when a claim was first received to its final adjudication.

4.4 Transparency in Coverage Template Submission for Issuers Not Subject to Reporting Requirements

To apply for PY2027 QHP certification, the issuer must submit a Transparency in Coverage Template that includes all the issuer's on-Exchange PY2027 plan IDs. The QHP Application cannot be submitted without this template. However, the following issuers are not required to submit Transparency in Coverage data as described in the *Issuer Level Data* tab (Figure 2M-3) and *Plan Level Data* tab (Figure 2M-4):

- Issuers with no PY2025 on-Exchange plans
- Off-exchange certified SADPs.

Off-Exchange-only SADP issuers that are not seeking certification are not required to submit a Transparency in Coverage Template and do not have a data reporting requirement at this time.

This section describes how to submit the Transparency in Coverage Template without reporting numerical transparency data. Issuers must submit their **HIOS Issuer ID** in the *Issuer Level Data* tab (Figure 2M-3) and all **PY2027 plan IDs** in the *Plan Level Data* tab (Figure 2M-4). **N/A** must be entered in all other data fields as indicated below.

4.4.1 Issuers with No Data Reporting Requirement—Issuer Level Data Tab

General Information	Expected Value
Was this issuer on the Exchange in 2025?*	No
Issuer HIOS ID*	Enter the **five-digit HIOS Issuer ID**.

Issuer Level Data	Expected Value
Number of Issuer Level Pre-Service Benefit Requests Received in Calendar Year 2025*	**N/A**
Number of Issuer Level Pre-Service Benefit Requests Denied in Calendar Year 2025*	**N/A**
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**

Issuer Level Data	Expected Value
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	**N/A**
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	**N/A**
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Issuer Level Internal Appeals of Pre-Service Benefit Requests Filed in Calendar Year 2025*	**N/A**
Number of Issuer Level Internal Appeals of Pre-Service Benefit Requests Overturned from Calendar Year 2025 Appeals*	**N/A**
Number of Issuer Level External Appeals of Pre-Service Benefit Requests Filed in Calendar Year 2025*	**N/A**
Number of Issuer Level External Appeals of Pre-Service Benefit Requests Overturned from Calendar Year 2025 Appeals*	**N/A**
Number of Issuer Level Internal Appeals of Claims Filed in Calendar Year 2025*	**N/A**
Number of Issuer Level Internal Appeals of Claims Overturned from Calendar Year 2025 Appeals*	**N/A**
Number of Issuer Level External Appeals of Claims Filed in Calendar Year 2025*	**N/A**
Number of Issuer Level External Appeals of Claims Overturned from Calendar Year 2025 Appeals*	**N/A**

Figure 2M-3. Sample Data Template With No Reporting Requirement—Issuer Level Tab

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2027 v7.0

Validate

Finalize

General Information	
Was this Issuer on the Exchange in 2025?*	No
SADP Only?*	No
Issuer HIOS ID*	12345
Issuer Level Data	
Number of Issuer Level Pre-Service Benefit Requests Received in Calendar Year 2025*	N/A
Number of Issuer Level Pre-Service Benefit Requests Denied in Calendar Year 2025*	N/A
Number of Issuer Level In-Network Claims with Date(s) of Service (DOS) in 2025 That Were Also Received in Calendar Year 2025*	N/A
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	N/A
Number of Issuer Level In-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	N/A
Number of Issuer Level Out-of-Network Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	N/A
Number of Issuer Level Internal Appeals of Pre-Service Benefit Determinations Filed in Calendar Year 2025*	N/A
Number of Issuer Level Internal Appeals of Pre-Service Benefit Determinations Overturned from Calendar Year 2025 Appeals*	N/A
Number of Issuer Level External Appeals of Pre-Service Benefit Determinations Filed in Calendar Year 2025*	N/A
Number of Issuer Level External Appeals of Pre-Service Benefit Determinations Overturned from Calendar Year 2025 Appeals*	N/A
Number of Issuer Level Internal Appeals of Claims Filed in Calendar Year 2025*	N/A
Number of Issuer Level Internal Appeals of Claims Overturned from Calendar Year 2025 Appeals*	N/A
Number of Issuer Level External Appeals of Claims Filed in Calendar Year 2025*	N/A
Number of Issuer Level External Appeals of Claims Overturned from Calendar Year 2025 Appeals*	N/A
Notes:	
Please enter any comments/notes here.	

4.4.2 Issuers with No Reporting Requirement—Plan Level Data Tab

Plan Level Data	Expected Value
2027 On-Exchange Plan ID*	Enter the **14-character PY2027 plan ID** on the *Plan Level Data* tab. The issuer must include all on-Exchange plan IDs present in its QHP Application (do not include plan IDs for off-Exchange–only plans) on the *Plan Level Data* tab.
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Non-Behavioral Health Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	**N/A**
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Behavioral Health-Only Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**

Plan Level Data	Expected Value
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Excluding Behavioral Health in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health only, in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for Administrative Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for Administrative Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**

Plan Level Data	Expected Value
Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**
Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025 (Plan Level Claims Denied)*	**N/A**

Figure 2M-4. Sample Data Template With No Reporting Requirement—Plan Level Tab

*All fields with an asterisk (*) are required. To validate the template, press Validate button or Ctrl + Shift + I. To finalize the template, press Finalize button or Ctrl + Shift + F.*
All plan IDs submitted via Plans & Benefits Template(s) must be included in this template.

Plan ID*	Number of Plan Level In-Network Non-Behavioral Health (BH) Claims with Date(s) of Service (DOS) in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level In-Network Non-BH Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level In-Network Non-BH Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level In-Network Behavioral Health Only (BHO) Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level In-Network BHO Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level In-Network BHO Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level Out-of-Network Non-BH Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Received in Calendar Year 2025*
12345AZ1234567	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting
Plan Year 2027
Plan Level Data

Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Denied in Calendar Year 2025*	Number of Plan Level Out-of-Network BHO Claims with DOS in 2025 That Were Also Resubmitted in Calendar Year 2025*	Number of Plan Level Claims with DOS in 2025 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, ***excluding*** Behavioral Health in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health ***only***, in Calendar Year 2025*
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Enrollee Benefit Limit Reached in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due to Member Not Covered During All or Part of Date of Service in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied Due To Investigational, Experimental, or Cosmetic Procedure in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Denied Due to Administrative Reasons in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Denied Due to Administrative Reasons in Calendar Year 2025*	Number of Plan Level In-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025*	Number of Plan Level Out-of-Network Claims with DOS in 2025 That Were Also Denied for "Other" Reasons in Calendar Year 2025*	Notes: (Please enter any comments/notes here.)
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

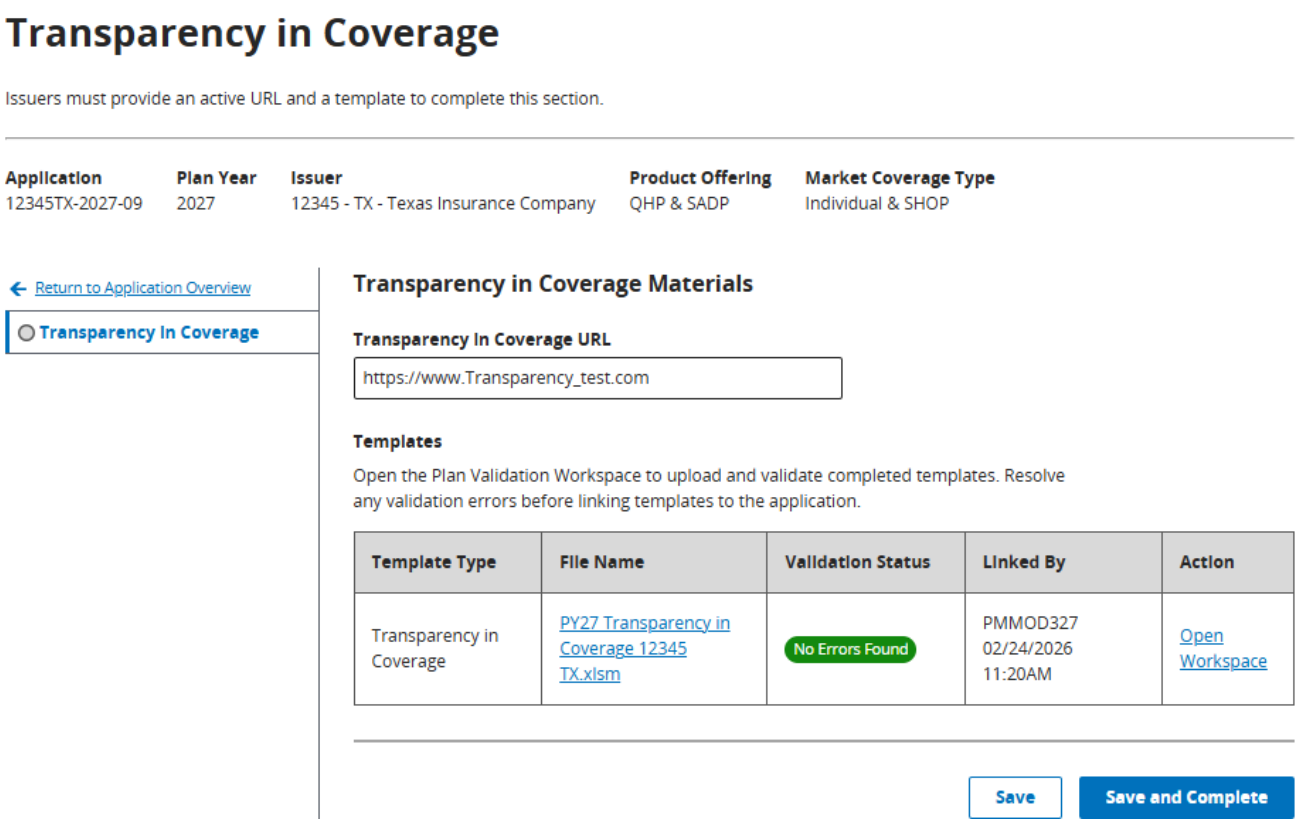
After you have entered all data, click **Save** to ensure no data are lost. Once the Transparency in Coverage Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the *Issuer Level Data* tab of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved.
Finalize Template	Click **Finalize** in the top left of the *Issuer Level Data* tab of the template to create the .XML file of the template that will need to be uploaded to the Plan Validation Workspace in the MPMS Module. Issuers that submit via SERFF will upload their Transparency in Coverage Template in their SERFF binders.
Save Template	**Save** the .XML template. CMS recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module, link the validated template to the issuer's application and complete submission of the Transparency in Coverage URL. Issuers that submit via SERFF will submit the Transparency in Coverage Template in their SERFF binders and the Transparency in Coverage URL in the MPMS Module. Refer to the MPMS User Guide for details on how to complete these steps.

5. Claims Payment Policy and Other Information URL

Issuers applying for PY2027 QHP certification, including issuers offering off-Exchange SADPs, must submit a Transparency in Coverage URL in the MPMS Module (Figure 2M-5). Although SERFF issuers will submit their Transparency in Coverage Template in SERFF, the Transparency in Coverage URL must be submitted in the MPMS Module.

Figure 2M-5. MPMS Submission Screen for Transparency in Coverage URL



Although a URL submission is required to apply for PY2027 QHP certification, issuers are required to submit an active URL that directs to a compliant claims payment policy website only if they offer on-Exchange QHPs and SADPs.

Other issuers (e.g., issuers with only off-Exchange SADP offerings) are not required to submit a URL directing to compliant claims payment policies.

The information below provides an overview of the information the issuer must include on the Transparency in Coverage URL's web page and examples of how it might be explained.

PY2027 URL Contents	Minimum Requirements
Claims Payment Policies & Other Information URL	Enter the active and easily accessible URL. Ensure it meets the following requirements: ◆ It can be viewed and accessed directly from the plan's public website via a clearly identifiable link or tab on the issuer's home or marketplace plan landing page without requiring an individual to create or access an account or enter a policy number. ◆ An individual can easily discern which information applies to each plan the issuer offers. The URL is the web address on the issuer website that directs consumers to the page on the issuer's website they can use to view pertinent information about the issuer's practices. All URLs should be live and compliant when they are submitted, with one URL for a landing page or a single page with one or more links providing the information indicated below. If the issuer has

PY2027 URL Contents	Minimum Requirements
	unique HIOS Issuer IDs in the same state and the Transparency in Coverage information is the same across the HIOS Issuer IDs, the same URL may be submitted for all HIOS Issuer IDs. Note: If the URL or website content refers to the plan year, it should refer to the plan year of the current application submission, not the plan year of the claims data.
Out-of-network liability and balance billing	Description: ◆ Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or the amount remaining on a deductible. Provide: ◆ An explanation of what balance billing is. ◆ Information regarding whether a consumer may have financial liability for out-of-network services. ◆ Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act. ◆ Information regarding whether a consumer may be balance billed. Specific dollar amounts for out-of-network liability or balance billing do not need to be included. Example of Acceptable Consumer-Facing Language: Out-of-network services are from doctors, hospitals, and other health care professionals that have not contracted with your plan. A health care professional who is out of your plan network can set a higher cost for a service than professionals who are in your health plan network. Depending on the health care professional, the service could cost more or not be paid for at all by your plan. Charging this extra amount is called balance billing. In cases like these, you will be responsible for paying for what your plan does not cover. Balance billing may be waived for emergency services received at an out-of-network facility.
Enrollee claim submission	Description: ◆ An enrollee submits a claim instead of the provider, requesting payment for services received. Provide: ◆ General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, indicate this here. ◆ A time limit to submit a claim, if applicable. If there is no time limit imposed for claim submission, specify that there is no time limit to submit a claim. If the issuer's time limits vary by state, list out the states and their corresponding time limits. ◆ Active links that route directly to any applicable forms. All forms must be easily identifiable and publicly accessible. ◆ Describe how an enrollee can submit a claim if the issuer does not require any forms. List any identifying information such as name, member number, and other information that an enrollee should include for successful claim submission. ◆ The physical mailing address or email address where an enrollee can submit a claim, and a customer service phone number. Example of Acceptable Consumer-Facing Language: A claim is a request to an insurance company for payment of health care services. Usually, providers file claims with us on your behalf. If you received services from an out-of-network provider, and if that provider does not submit a claim to us, you can file the claim directly. There are time limits on how long you have to submit claims, with details on the limit by state below. You can also check your specific plan's claims filing time limit information to determine the specific time limit for submitting your claim. Enrollee medical claim submission and claim filing time limit information: State (Maximum Claim Filing Time Limit) VT, NH, CT (90 Days) CA (90 Days) WA (180 Days) To file a claim, follow these steps: 1. Complete a claim form **[Include link to Claim Form]**. 2. Attach an itemized bill from the provider for the covered service. 3. Make a copy for your records.

PY2027 URL Contents	Minimum Requirements
	4. Mail your claim to the address below. [Company Name] [P.O Box 1234] [City, State, ZIP Code] 5. Alternatively, you can send the information by email to **[claims-submissions@companyname.com]** or by fax to **[123-456-7890]**.
Grace periods and claims pending	Description: ◆ QHP issuers must provide a grace period of 3 consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least 1 full month's premium during the benefit year. During the grace period, the issuer must provide an explanation of the 90-day grace period for enrollees with premium tax credits, pursuant to 45 CFR 156.270(d). Provide: ◆ An explanation of what a grace period is. ◆ An explanation of what claims pending is. ◆ An explanation that the issuer will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period. Example of Acceptable Consumer-Facing Language: You are required to pay your premium by the scheduled due date. If you do not do so, your coverage could be canceled. For most individual health care plans, if you do not pay your premium on time, you will receive a 30-day grace period. A grace period is a time period when your plan will not terminate even though you did not pay your premium. Any claims submitted for you during that grace period will be pended. When a claim is pended, that means no payment will be made to the provider until your delinquent premium is paid in full. If you do not pay your delinquent premium by the end of the 30-day grace period, your coverage will be terminated. If you pay your full outstanding premium before the end of the grace period, we will pay all claims for covered services you received during the grace period that are submitted properly. If you have an individual HMO plan in [state], we will pay your claims during the 30-day grace period; however, your benefits will terminate if your delinquent premium is not paid by the end of that grace period. If you are enrolled in an individual health care plan offered on the *Health Insurance Marketplace* and you receive an advance premium tax credit, you will get a 3-month grace period, and we will pay all claims for covered services that are submitted properly during the first month of the grace period. During the second and third months of that grace period, any claims you incur will be pended. If you pay your full outstanding premium before the end of the 3-month grace period, we will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If you do not pay all of your outstanding premium by the end of the 3-month grace period, your coverage will terminate, and we will not pay for any pended claims submitted for you during the second and third months of the grace period. Your provider may balance bill you for those services.
Retroactive denials	Description: ◆ A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment. Provide: ◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable. ◆ Ways to prevent retroactive denials when possible, such as paying premiums on time. Example of Acceptable Consumer-Facing Language: A retroactive denial is the reversal of a claim we have already paid. If we retroactively deny a claim we have already paid for you, you will be responsible for payment. Some reasons why you might have a retroactive denial include having a claim that was paid during the second or third month of a grace period or having a claim paid for a service for which you were not eligible. You can avoid retroactive denials by paying your premiums on time and in full and making sure you talk to your provider about whether the service performed is a covered benefit.

PY2027 URL Contents	Minimum Requirements
	You can also avoid retroactive denials by obtaining your medical services from an in-network provider.
Recoupment of overpayments	Description: ◆ If the issuer overbills an enrollee for a premium, the enrollee may use recoupment of overpayments to obtain a refund. Provide: ◆ Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact. Example of Acceptable Consumer-Facing Language: If you believe you have paid too much for your premium and should receive a refund, please call the member service number on the back of your ID card.
Medical necessity and prior authorization timeframes and enrollee responsibilities	Description: ◆ Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. ◆ Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit. Provide: ◆ An explanation that some services may require prior authorization and may be subject to review for medical necessity. ◆ Any ramifications should the enrollee not follow proper prior authorization procedures. ◆ A timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable. If the issuer's timeframe for response varies by state, list out the states and their corresponding timeframes. Example of Acceptable Consumer-Facing Language: We must approve some services before you obtain them. This is called prior authorization or preservice review. For example, any kind of inpatient hospital care (except maternity care) requires prior authorization. If you need a service that we must first approve, your in-network doctor will call us for the authorization. If you don't get prior authorization, you may have to pay up to the full amount of the charges. The number to call for prior authorization is included on the ID card you receive after you enroll. Please refer to the specific coverage information you receive after you enroll. We typically decide on requests for prior authorization for medical services within 72 hours of receiving an urgent request or within 15 days for non-urgent requests. These timeframes may vary by state.
Drug exception timeframes and enrollee responsibilities (not required for SADPs)	Description: ◆ Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c). Provide: ◆ An explanation of the internal exceptions process for people to obtain non-formulary drugs. ◆ An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or independent review organization (IRO). ◆ Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. ◆ Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact. Example of Acceptable Consumer-Facing Language: Sometimes our members need access to drugs that are not listed on the plan's formulary (drug list). These medications are initially reviewed by [plan name] through the formulary exception review process. The member or provider can submit the request to us by faxing the Pharmacy Formulary Exception Request form **[Include Form Link]**. If the drug is denied, you have the right to an external review.

PY2027 URL Contents	Minimum Requirements
	If you feel we have denied the non-formulary request incorrectly, you may ask us to submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). We must follow the IRO's decision. An IRO review may be requested by a member, member's representative, or prescribing provider by mailing, calling, or faxing the request: [Request Form Link] [Address] [Phone] [Fax]. For initial standard exception review of medical requests, the timeframe for review is 72 hours from when we receive the request. For initial expedited exception review of medical requests, the timeframe for review is 24 hours from when we receive the request. For external review of standard exception requests that were initially denied, the timeframe for review is 72 hours from when we receive the request. For external review of expedited exception requests that were initially denied, the timeframe for review is 24 hours from when we receive the request. To request an expedited review for exigent circumstance, select the "Request for Expedited Review" option in the Request Form.
Explanation of benefits (EOB)	Description: ◆ An EOB is a statement the issuer sends an enrollee that lists the medical treatments or services the issuer paid for on an enrollee's behalf, what the issuer paid, and the enrollee's financial responsibility pursuant to the terms of the policy. Provide: ◆ An explanation of what an EOB is. ◆ Information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims). ◆ How a consumer should read and understand the EOB. Example of Acceptable Consumer-Facing Language: Each time we process a claim submitted by you or your health care provider, we explain how we processed it on an Explanation of Benefits (EOB) form. The EOB is not a bill. It explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid, and any balance you're responsible for paying the provider. Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider.
Coordination of benefits (COB)	Description: ◆ COB allows an enrollee who is covered by more than one plan to determine which plan pays first. Provide: ◆ An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services). Example of Acceptable Consumer-Facing Language: Coordination of benefits (COB) is required when you are covered under one or more additional group or individual plans, such as one sponsored by your spouse's employer. An important part of coordinating benefits is determining the order in which the plans provide benefits. One plan provides benefits first. This is called the primary plan. The primary plan provides its full benefits as if there were no other plans involved. The other plans then become secondary. Further information about COB can be found in your benefit booklet.

Once the Transparency in Coverage URL is entered, click the **Save** button to ensure no data are lost.

This concludes the Transparency in Coverage section of the QHP Application Instructions.

Section 2N: Quality Improvement Strategy

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP

See Appendix D for additional information.

In the Quality Improvement Strategy (QIS) section of the Marketplace Plan Management System (MPMS) Module, issuers submit their Implementation Plan, Progress Reports, Progress Report Closeout forms, and Modification Summary Supplement forms. This section applies to qualified health plan (QHP) issuers on the Federally-facilitated Exchanges (FFEs), including states performing plan management functions, that meet the requirements to submit QIS documents. Specific requirements for which QHP issuers are required to submit QIS documents may be found on the Marketplace Quality Initiatives website.

2. Data Requirements

Information about submission criteria and supporting documentation can be found in Appendix B.

QIS requirements and instructions for how to complete the QIS form are located in the QIS Technical Guidance and User Guide available on the Quality Improvement Strategy (QIS) website.

3. Quick Reference

Key Changes for 2027
◆ Issuers in FFE states and states performing plan management functions must submit their QIS documents in the Issuer Quality group within the MPMS Module. QIS documents uploaded in the System for Electronic Rates & Forms Filing (SERFF) will be ignored and only those documents uploaded in the MPMS Module will be evaluated. ◆ Issuers in State-based Exchange on the Federal Platform states will continue to submit their QIS documents via SERFF.

Tips for the Quality Improvement Strategy Section
◆ All newly-eligible QIS issuers will submit an Implementation Plan form. ◆ Continuing issuers will be required to submit a Progress Report form. ◆ Some issuers will also be required to submit a Progress Report Closeout form or Modification Summary Supplement form.

Additional Resources
◆ There is a supporting document for this section. ◆ There are no instructional videos for this section. ◆ There are no templates for this section.

4. Detailed Section Instructions

In the MPMS Module, issuers should navigate to the Quality Improvement Strategy section in the QHP Application to upload all required QIS documents.

QIS Supporting Documents	Steps
Name File	**Save** the QIS documents using the naming convention in Table B-1: If submitting an Implementation Plan: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_IP; If submitting a Progress Report: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_PR; If submitting a Modification Summary: [5-digit HIOS Issuer ID]_[Issuer Name]_QIS_MS.
Upload Document	**Upload** the saved files in the Quality Improvement Strategy section of the MPMS Module. Refer to the MPMS User Guide for further instruction.

This concludes the Quality Improvement Strategy section of the QHP Application Instructions.

Section 2O: Rates Table

1. Introduction

In the Rates Table section of the Marketplace Plan Management System (MPMS) Module, issuers enter rate information for each plan they offer in a rating area. If the issuer offers both medical and dental plans and submits its Qualified Health Plan (QHP) Application in the Health Insurance Oversight System (HIOS), a single Rates Table Template must be submitted that contains rate data for all submitted plans (QHPs and stand-alone dental plans [SADPs]).

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

1. HIOS Issuer ID
2. Plan IDs.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the Rates Table Section
◆ Use separate worksheets in the Rates Table Template for medical plans and dental plans. ◆ Use separate worksheets for Individual Market plans and Small Business Health Options Program (SHOP) plans. ◆ For Individual Market plans, the rate effective date must be January 1, 2027. ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (January 1, April 1, July 1, and October 1). Each worksheet is bound to a separate effective date range. If the issuer submits SHOP trended quarterly rates, a separate worksheet must be submitted for each date range that a set of rates will be effective. ◆ If the issuer submits in HIOS, a single Rates Table Template that contains rate data for all the issuer's plans (QHPs and SADPs, Individual and SHOP markets) must be submitted in the MPMS Module. If the issuer submits via the System for Electronic Rates & Forms Filing, this requirement does not apply. ◆ Issuers must have Unified Rate Review (URR) data linked to the MPMS Module prior to submitting the Plan Rates group.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

Complete the Rates Table Template using the steps outlined below to provide rate information. All required fields must be completed to validate the template.

Rates Table Template	Steps
HIOS Issuer ID	Enter the five-digit **HIOS Issuer ID**.
Rate Effective Date	Enter the rate effective date as **mm/dd/yyyy**. For Individual Market plans, the rate effective date must be **01/01/2027**. ◆ For SHOP plans with trended quarterly rates, the rate effective date must correspond with the calendar quarters (**01/01/2027**, **04/01/2027**, **07/01/2027**, and **10/01/2027**). Each worksheet in the Rates Table Template is bound to a separate effective date range. If the issuer submits SHOP trended quarterly rates, a separate worksheet must be submitted for each date range that a set of rates will be effective. ◆ If the issuer submits a SHOP quarterly rate change, the issuer must submit the entire template with updated worksheets for the effective date range of the quarterly rate change during the applicable data change submission window. The issuer may submit rate changes that would apply for the next quarter or any subsequent quarter in the remaining plan year. The issuer must not change or delete rates from the template for any current or previous quarter during the data change window. For example, during the submission for updated second-quarter SHOP rates, the first-quarter rates must match the original submission that contained the rates offered during the first quarter. For SHOP medical plans, the changes must be consistent with the revised index rates that are submitted in the corresponding URR Template.
Rate Expiration Date	Enter the rate expiration date as **mm/dd/yyyy**. ◆ For Individual Market plans, the rate expiration date must be **12/31/2027**. ◆ For SHOP plans, the rate expiration date must correspond with the calendar quarters (**03/31/2027**, **06/30/2027**, **09/30/2027**, and **12/31/2027**).
Rating Method	Select whether the plans on the worksheet use **Age-Based Rates** or **Family-Tier Rates**. Note: Only issuers in states that do not permit rating for age or tobacco use and that establish uniform family tiers and corresponding multipliers or issuers entering rates for SADPs are eligible to select **Family-Tier Rates**. A list of states that use family-tier rating is available on the State Specific Rating Variations page.
Add Sheets	Click **Add Sheet** to add additional worksheets for the following: ◆ To separate SHOP plans with different rate effective and expiration dates. All plans on a single worksheet must have the same rate effective and rate expiration dates. ◆ To separate Individual Market plans and SHOP plans. ◆ To separate medical plans and dental plans. ◆ To separate plans that use age-based rating and family-tier rating. ◆ To separate by rating area.
Plan ID	Enter the 14-character alphanumeric **HIOS-generated plan ID** (e.g.,12345AZ1234567) that identifies the plan associated with the rates in that row.
Rating Area	Select the **rating area** from the list. The rating area is the geographic area where the rates in the row are valid. Rating areas are defined by each state. A list of rating areas for each state is available on the State Specific Geographic Rating Areas page. If a set of rates is allowed to be offered in more than one rating area, issuers can elect to assign the set of rates to multiple rating areas within a template worksheet.
Tobacco	If the issuer uses age-based rates, select from the following to indicate whether rates vary based on tobacco use: ◆ **Tobacco User/Non-Tobacco User**—if rates differ for tobacco and non-tobacco users. If this option is selected, rates must be entered for non-tobacco and tobacco users. Market rules require QHP tobacco rates to be no more than 1.5 times higher than the corresponding non-tobacco rate within a single age band.[1] QHPs rating by tobacco use may not apply tobacco rating to individuals aged 0–20, for whom the sale and use of tobacco products is prohibited under federal law. For each underage tobacco age band (0–14, 15, 16, 17, 18, 19, and 20), enter the same rate values under *Individual (non-*

[1] 42 U.S.C. 300gg—Fair Health Insurance Premiums.

Rates Table Template	Steps
	tobacco) Rate and *Individual Tobacco Rate*. This entry will prevent application of unique tobacco rating to an underage enrollee. To offer Small Group Market medical plans (including SHOP QHPs) with tobacco rating, the issuer must offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the Public Health Service (PHS) Act and indicate the wellness program on its Plans & Benefits Template. If the issuer does not offer such a wellness program, the small-group market medical plan cannot rate for tobacco use. ◆ **No Preference**—if the rate applies to tobacco and non-tobacco users. No separate rates are submitted for tobacco and non-tobacco users.
Age	If the issuer uses age-based rates, the template will automatically generate a row for each age band from 0–14 through 64 and over. ◆ If the issuer elects to rate by tobacco use and enters the non-tobacco rates first for the underage age bands of 0–14 through 20, the worksheet will auto-populate the tobacco rate for each band with the non-tobacco rate. ◆ If the issuer is in a state that does not permit rating for age or tobacco use and that establishes uniform family tiers (and corresponding multipliers) or is entering rates for an SADP using Family-Tier Rates as the rating method, skip to Family Tier.
Individual Rate	◆ Enter the individual rate that applies to the plan ID. Market rules limit individual rate variation based on age to no more than three times the 21-age rate. In addition, QHPs may not have a 0–20 age rate higher than the 21-age rate and must follow the federal age-rating curve or the state's age-rating curve if it is within the 1:3 market rule. A list of states using state-specific age curve variations is available on the State Specific Rating Variations page. Note: QHPs and SADPs must enter a value above $0.00 for all age bands under the Individual Rate column unless the plan is a child-only offering, indicated with a value of **Allows Child-Only** under *Child-only Offering* in the Plans & Benefits Template. QHP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19, and 20 age bands and are allowed to enter a value of $0.00 for adult age bands 21 through 64 and over. SADP child-only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, and 18 age bands and are allowed to enter a value of $0.00 for adult age bands 19 through 64 and over. ◆ QHPs and SADPs that rate by tobacco use should enter a positive non-zero value under *Individual Tobacco Rate* for age bands 21 through 64 and over. For the 0 through 20 age bands, QHPs must enter the same value as the non-tobacco rate under *Individual Tobacco Rate* to avoid applying tobacco rating to underage enrollees. For QHPs, tobacco rating cannot be applied to individuals aged 0–20, for whom the sale and use of tobacco products is prohibited under federal law.
Family Tier	If the issuer's state does not permit rating for age or tobacco use and has established uniform family tiers and corresponding multipliers, or if the issuer is offering SADPs and selected **Family-Tier Rates** in *Rating Method*, enter the individual rate in *Individual Rate*. Selecting **Family-Tier Rates** will also generate the following family tier columns: ◆ *Individual Rate* (required): Enter the rate of an individual primary subscriber. ◆ *Couple* (required): Enter the rate for a couple. A couple is defined as a primary subscriber and his or her spouse. A couple may also be a domestic partnership if Life Partner is allowed by the issuer in the Business Rules Template. ◆ *Primary Subscriber and One Dependent* (required): Enter the rate for a primary subscriber with one dependent. ◆ *Primary Subscriber and Two Dependents* (required): Enter the rate for a primary subscriber with two dependents. ◆ *Primary Subscriber and Three or More Dependents* (required): Enter the rate for a primary subscriber with three or more dependents. ◆ *Couple and One Dependent* (required): Enter the rate for a couple with one dependent. ◆ *Couple and Two Dependents* (required): Enter the rate for a couple with two dependents. ◆ *Couple and Three or More Dependents* (required): Enter the rate for a couple with three or more dependents.

Rates Table Template	Steps
	Note: A dependent is defined as any dependent relationship eligible for plan enrollment as defined in the Business Rules Template. If any member of the enrollment group is determined to be ineligible, no rate will be returned for that plan.

See Figure 2O-1 for an example of a completed Rates Table Template when **Age-Based Rates** is selected.

Figure 2O-1. Rates Table Template (Age-Based Rates)

2027 Rates Table Template v16.0

All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.
If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.
If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.
If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.
To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.

Validate | Finalize | Add Sheet

HIOS Issuer ID*	12345
Rate Effective Date*	1/1/2027
Rate Expiration Date*	12/31/2027
Rating Method*	Age-Based Rates

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
12345VA0001001	Rating Area 1	No Preference	0-14	10.00
12345VA0001001	Rating Area 1	No Preference	15	11.00
12345VA0001001	Rating Area 1	No Preference	16	12.00
12345VA0001001	Rating Area 1	No Preference	17	13.00
12345VA0001001	Rating Area 1	No Preference	18	14.00
12345VA0001001	Rating Area 1	No Preference	19	15.00
12345VA0001001	Rating Area 1	No Preference	20	16.00

See Figure 2O-2 for an example of a completed Rates Table Template when **Family-Tier Rates** is selected.

Figure 2O-2. Rates Table Template (Family-Tier Rates)

2027 Rates Table Template v16.0

All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.
If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.
If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.
If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.
To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.

Validate | Finalize | Add Sheet

HIOS Issuer ID*	12345
Rate Effective Date*	1/1/2027
Rate Expiration Date*	12/31/2027
Rating Method*	Family-Tier Rates

Plan ID*	Rating Area ID*	Individual Rate*	Couple*	Primary Subscriber and One Dependent*	Primary Subscriber and Two Dependents*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Required: Enter the rate of a family based on a single parent with one dependent	Required: Enter the rate of a family based on a single parent with two dependents
12345VA0001001	Rating Area 1	10.00	20.00	30.00	40.0

After entering all data, click **Save** to ensure no data are lost. Once the Rates Table Template is completed, it must be validated, finalized, and uploaded into the MPMS Module.

Template Validation and Submission Step	Step Description
Validate Template	Click **Validate** in the top left of the template. The validation process identifies any data issues that need to be resolved. If no errors are identified, finalize the template.
Validation Report	If the template has any errors, a Validation Report will appear in a pop-up box showing the reason for and cell location of each error. Correct any identified errors and click **Validate** again. Repeat until all errors are resolved. The template will provide a notification when there are no errors with the callout box message “This Template is Valid!”

Template Validation and Submission Step	Step Description
Finalize Template	Click **Finalize** in the template to create the .XML version of the template that will be uploaded to the Plan Validation Workspace in the MPMS Module.
Save Template	**Save** the .XML template. The Centers for Medicare & Medicaid Services recommends saving the validated template as a standard Excel .XLSM file in the same folder as the finalized .XML file for easier reference.
Upload and Link Template	**Upload** the saved .XML file to the Plan Validation Workspace in the MPMS Module and link the validated template to the issuer's application. URR Template data must be linked to the issuer's application prior to submitting the Plan Rates group. Refer to the MPMS User Guide for details on how to complete these steps.

This concludes the Rates Table section of the QHP Application Instructions.

Section 2P: URL Collection

1. Introduction

In the URL section of the Marketplace Plan Management System (MPMS) Module, issuers must submit the following URLs as part of their Qualified Health Plan (QHP) Application: Formulary, Network, Payment, Plan Brochure, and Summary of Benefits and Coverage (SBC).

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

1. Health Insurance Oversight System Issuer ID
2. Formulary URLs
3. Network URLs
4. Payment URLs
5. Plan Brochure URLs
6. SBC URLs.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

Tips for the URL Collection Section
◆ Verify that URLs are functional before submission. ◆ Submit all URLs via the MPMS Module (Formulary, Network, Payment, Plan Brochure, SBC) by September 23, 2026. All URLs must be active and directly route consumers to the appropriate document by the deadline for returning signed QHP Certification Agreements. ◆ Please note that the URL requirements described in this section apply to on-Exchange plans only; URLs for off-Exchange plans are submitted to the Rate & Benefits Information System. ◆ All QHP SBC URL submissions must end with ".PDF" to ensure that the SBC URL leads directly to an SBC form. ◆ Payment URLs are tested in a separate environment/outside of the MPMS Module.

Additional Resources
◆ There are no supporting documents for this section. ◆ There are instructional videos for this section. ◆ There are templates for this section.

4. Detailed Section Instructions

The Generate Populated URL Template page (Figure 2P-1) displays when issuers log into the MPMS Module and navigate to the URL section. Issuers should select one or more URL types (Formulary, Network, Payment, Plan Brochure, and SBC) to pre-populate in the generated URL Template and select the **Generate and Download URL Template** button to download the URL Template file (Figure 2P-2). If issuer's Product Offering is set to SADPs [stand-alone dental plans] Only, the Formulary URL will not appear as an option.

Figure 2P-1. Generate URL Template

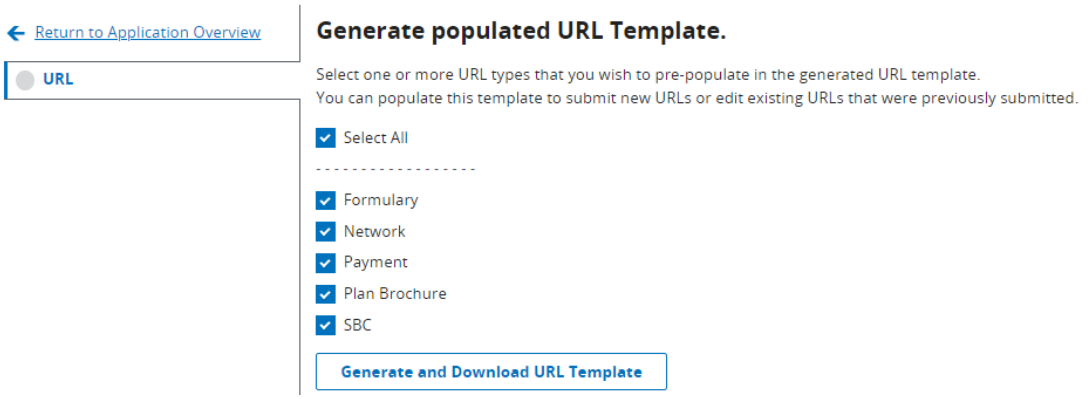


Figure 2P-2. URL Template File

HIOS Issuer ID: 11104
GENERATED
URLs can be edited only with the New URL column (cannot be changed by making edits to the Current URL column). For more details and instructions please reference the user guide that can be downloaded from the UI.

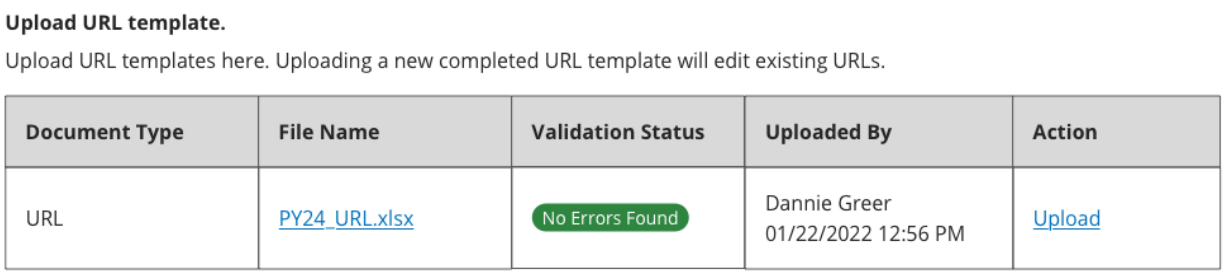
URL Type	URL ID	Market Type	Product Type	Current URL	New URL
Summary of Benefits and Coverage	11104WI0490018-00	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_SIGNATURE_PRESTIGE_25_BRONZE_0_DEDUCTIBLE_NBP015494_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0470016-01	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_50_DV_NBP015534_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0490013-02	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_EHP_NC_NBP015555_CSR_NC.pdf	
Summary of Benefits and Coverage	11104WI0460011-04	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_SILVER_EHP_DV_NBP015510_CSR_73.pdf	
Summary of Benefits and Coverage	11104WI0490013-03	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_EHP_LC_NBP015555_CSR_LC.pdf	
Summary of Benefits and Coverage	11104WI0480013-01	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_EHP_NBP015542_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0480008-00	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_BRONZE_EHP_NBP015473_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0490016-00	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_50_NBP015538_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0470011-06	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_SILVER_EHP_DV_NBP015522_CSR_94.pdf	
Summary of Benefits and Coverage	11104WI0480002-00	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_BRONZE_PLUS_NBP015468_CSR_0.pdf	
Summary of Benefits and Coverage	11104WI0480004-03	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_LC_NBP015545_CSR_LC.pdf	
Summary of Benefits and Coverage	11104WI0490004-02	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_NC_NBP015551_CSR_NC.pdf	
Summary of Benefits and Coverage	11104WI0460013-01	N/A	N/A	https://assets.networkhealth.com/plandocuments/SBC_PRESTIGE_25_GOLD_EHP_DV_NBP015539_CSR_0.pdf	

When completing the URL Template, the free-text fields allow the following special characters in the template. Entering other special characters will result in validation errors when uploading the template to the MPMS Module.

Valid Special Characters for Free-Text Fields in the URL Template						
~ (tilde)	` (grave)	! (exclamation point)	# (hashtag)	@ (at sign)	$ (dollar sign)	% (percentage)
^ (carat)	& (ampersand)	* (asterisk)	( ) (parentheses)	? (question mark)	_ (underscore)	+ (addition sign)
- (hyphen)	= (equal sign)	[ ] (square brackets)	\ (backslash)	{ } (braces)	; (semicolon)	: (colon)
“ ” (quotation marks)	. (period)	/ (forward slash)				

After populating the URL Template, issuers upload it to the MPMS Module by selecting the **Upload** link, as shown in Figure 2P-3. The system validates proper formatting and acceptable values of any URL Template file uploaded. If an uploaded template contains no errors, a message of “No Errors Found” will display in the *Validation Status* field. If errors were identified, issuers must correct the errors and reupload the template to the MPMS Module. If a template passes all validations, the system will store the URL updates.

Figure 2P-3. Upload URL Template File



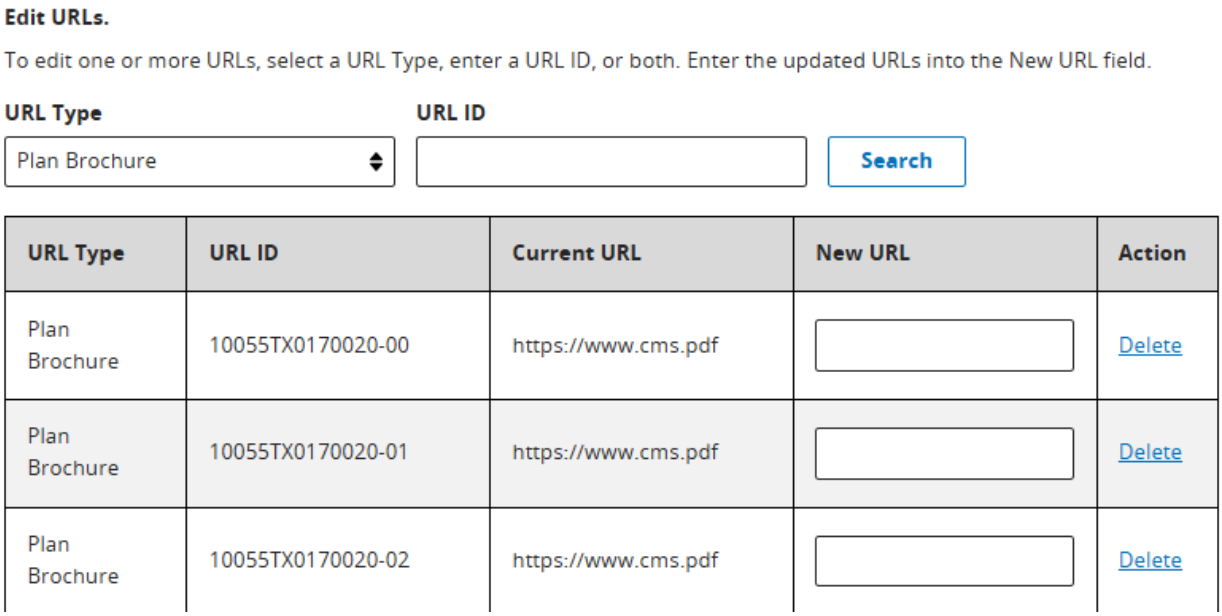
Upload URL template.

Upload URL templates here. Uploading a new completed URL template will edit existing URLs.

Document Type	File Name	Validation Status	Uploaded By	Action
URL	PY24_URL.xlsx	No Errors Found	Dannie Greer 01/22/2022 12:56 PM	Upload

Issuers can individually edit uploaded URLs by searching for the URL Type and a URL ID in the Edit Single URLs section (Figure 2P-4). To use the search function, enter search parameters by selecting a URL type in the drop-down menu, entering a URL ID, and selecting the **Search** button. Enter full or partial strings of a URL ID to find a specific URL. Leaving the search field blank will return all URLs for the selected type. The MPMS Module performs the same validations for URL updates submitted via the Edit Single URLs section as for those submitted via the URL Template file.

Figure 2P-4. Search & Update URLs Section



Edit URLs.

To edit one or more URLs, select a URL Type, enter a URL ID, or both. Enter the updated URLs into the New URL field.

URL Type Plan Brochure

URL ID

Search

URL Type	URL ID	Current URL	New URL	Action
Plan Brochure	10055TX0170020-00	https://www.cms.pdf		Delete
Plan Brochure	10055TX0170020-01	https://www.cms.pdf		Delete
Plan Brochure	10055TX0170020-02	https://www.cms.pdf		Delete

Issuers can delete URLs in this section. The delete option is disabled for SBC, Network, and Formulary URLs associated with on-Exchange plans, but is enabled for all Enrollment Payment and Plan Brochure URLs because these URL types are optional, and for SBC, Network, and Formulary URLs associated with off-Exchange plans.

Issuers that offer QHPs must submit Network and SBC URLs. If issuers offer SADPs, they must submit Network URLs.

Note: The Upload URL Template section will return errors unless issuers submit all required URLs for each URL ID present in the MPMS Module for that URL type. For example, if issuers submit one Network URL when two Network URL IDs are in the MPMS Module, the system will return an error because a required URL is missing.

URL Collection Process	Step Description
Access the MPMS Module	Log in to the Centers for Medicare & Medicaid Services Enterprise Portal and select the MPMS Module application on the My Portal page.

URL Collection Process	Step Description
Upload URL data into the MPMS Module	In the Generate Populated URL Template section of the URL page, choose the URL types to upload.
	Select **Generate and Download URL Template**.
	Copy all new URL data into the URL Template file under *New URL* and save the template as a .CSV file.
	Upload the completed .CSV version of the URL Template file into the Upload URL Template section of the URL page.
Updating previously submitted URL data	In the Edit Single URLs section of the URL page, enter search criteria, such as the URL type and relevant ID, to locate a previously submitted URL.
	Enter the updated URL under *New URL*.
	Click **Save** to ensure changes are retained.

This concludes the URL Collection section of the QHP Application Instructions.

Appendices

The appendices contain additional or more detailed information on completing and submitting the QHP Application.

Appendix A: Actuarial Value Calculator

Appendix B: Supporting Documentation

Appendix C: Review Tools

Appendix D: Understanding Issuer Types

Appendix E: Network Adequacy Standards

Appendix F: Machine-Readable Submission

Appendix G: Standardized Plan Options Requirements

Appendix A: Actuarial Value Calculator

1. Introduction

The instructions for this section apply to the following issuer types:

- QHP

See Appendix D for additional information.

To satisfy the actuarial value (AV) requirements of 45 *Code of Federal Regulations* (CFR) 156.140 and 156.420, qualified health plan (QHP) issuers must use the AV Calculator developed and made available by the U.S. Department of Health and Human Services (HHS) for the given benefit year unless the plan design is not compatible with the AV Calculator (a unique plan design, 45 CFR 156.135). To assist issuers with this calculation, the Plans & Benefits Template facilitates an automated AV calculation using the AV Calculator and the data entered into the template. When the issuer submits its QHP Application, HHS recalculates this value to validate that the issuer's plan designs meet AV requirements.[1] This section describes how cost sharing information from the Plans & Benefits Template is translated into the inputs for the standalone AV Calculator.

2. Data Requirements

To complete this section, the following are needed:

1. Completed Plans & Benefits Template
2. Standalone AV Calculator.

3. Quick Reference

Key Changes for 2027

- The Final 2027 AV Calculator includes an updated warning message when the cost sharing for Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services is applied to services with both facility and professional components that have default cost sharing.
- The Final 2027 AV Calculator no longer blocks users from receiving an AV result for their input plan design when that plan's maximum out-of-pocket (MOOP) (or sum of the MOOPs, for plans with separate medical and drug MOOPs) exceeds the maximum annual limitation on cost sharing, or MOOP limit.

Tips for Using the AV Calculator

- To aid in resolving difficulty matching AVs from the Plans & Benefits Template to the standalone AV Calculator, follow the instructions on troubleshooting in Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template.
- The AV Calculator has an *Additional Notes* field that outputs error messages that can only be seen in the standalone AV Calculator. These notes are intended to help users understand the AV Calculator's assumptions and to provide some information on the AV calculation being run in the AV Calculator. When an AV calculation is not returned because of an input error, check the *Additional Notes* field for an explanation of the error.[2]
- If any changes are made to the Plans & Benefits Template after running the Check AV Calc procedure, rerun the procedure so that the AVs in the *AV Calculator Output Number* field are updated to reflect the changes.
- If unique plan design features cause the AV Calculator to yield a materially different AV result from that of other approved methods, the plan is not compatible with the AV Calculator. In that case, use one of the alternate accepted methods of AV calculation described in 45 CFR 156.135(b).

Additional Resources

- Download the Final 2027 Standalone AV Calculator.
- There are no supporting documents for this section.
- There are no instructional videos for this section.
- There are templates for this section.

[1] For additional information on the AV Calculator, see the AV Calculator Methodology at https://www.qhpcertification.cms.gov/s/Plans%20and%20Benefits.

[2] These notes include things such as how the special cost-sharing provisions are being engaged in the calculations.

4. Detailed Section Instructions

The Plans & Benefits Template uses the AV Calculator to calculate AVs for all standard, non-catastrophic plans; all silver plan cost-sharing reduction (CSR) variations; and all limited cost sharing plan variations. The AV Calculator cannot be used with catastrophic plans or stand-alone dental plans (SADPs). The **Check AV Calc** procedure skips catastrophic plans entered in the Plans & Benefits Template and does not run for SADP-only Plans & Benefits Templates. If the Cost Share Variances worksheet contains unique plan designs and non-unique plan designs, the **Check AV Calc** procedure attempts to calculate an AV for the unique and the non-unique plan designs. If the standalone AV Calculator returns an error for a unique plan design, resulting in a blank AV Calculator Output Number, the error does not need to be addressed to validate the template if the AV falls within the relevant de minimis range. The Centers for Medicare & Medicaid Services (CMS) recommends issuers run the **Check AV Calc** procedure on Cost Share Variances worksheets that contain unique plan designs so that the issuer's submissions include the AV Calculator Output Number for plans that do not generate an error in the standalone AV Calculator. Table A-1 describes the steps involved when using the **Check AV Calc** procedure in the Plans & Benefits Template.

Table A-1. Plans & Benefits Check AV Calc Steps

Check AV Calc	Steps	
The **Check AV Calc** procedure on the **Plans & Benefits** ribbon allows the user to calculate AVs for all applicable plans.	Step 1	Select the relevant Cost Share Variances worksheet and fill out all the cost-sharing information necessary to run the AV Calculator.
	Step 2	Click **Check AV Calc**. The **Check AV Calc** procedure will prompt the user to select the file location of the standalone AV Calculator. Use a clean copy of the AV Calculator file that does not have any saved output worksheets in it; saved worksheets will cause the AV Calculator to return a warning message for each plan in the Plans & Benefits Template, and the user will need to close all the messages to finish the **Check AV Calc** procedure.
	Step 3	◆ A prompt will appear asking if the user would like to save the screenshots. ◆ Select **Yes** to save screenshots. Using the prompt, select the file name and location to save the output and create a copy of the AV Calculator with worksheets that contain AV screenshots for each plan and plan variation. ◆ Select **No** to skip saving screenshots. The **Check AV Calc** procedure will complete without creating any new files.
	Step 4	A validation message box will appear with the status/error messages from the AV Calculator for each plan or plan variation. The *AV Calculator Output Number* field (column F in the Cost Share Variances worksheet) will be updated with the AV from the AV Calculator. The *AV Calculator Output Number* field will remain blank if an error prevents an AV from being calculated.
	Step 5	If any changes are made to the Plans & Benefits Template after running the **Check AV Calc** procedure, the procedure must be rerun so that the AVs in *AV Calculator Output Number* are updated to reflect the changes.
	Step 6	After the AV Calculator is completed, a procedure auto-populates the AV for each plan or plan variation and copies the resulting AVs into the Plans & Benefits Template.
For Unique Plan Designs: Upload screenshot into the Marketplace Plan Management System (MPMS) Module.[3]	Step 7 (Optional)	If the issuer submits a unique plan design, upload a screenshot of the standalone AV Calculator with the *Plan Name*, *Plan ID*, and *HIOS Issuer ID* fields filled in as a supporting document, and include the plan ID (standard component) and date in the file name. The screenshot is uploaded in the Plans & Benefits section of the application.

[3] Issuers can use the standalone AV Calculator to test plan designs but do not need to submit a completed standalone AV Calculator or other supplemental documentation, such as a screenshot, except in scenarios described in Section 4.1 Unique Plan Design. Instead, issuers should submit a completed Plans & Benefits Template that includes the AVs populated by the **Check AV Calc** procedure.

4.1 Unique Plan Design

If the plan design is unique for purposes of calculating AV under 45 CFR 156.135(b), the application should include the Unique Plan Design—Supporting Documentation and Justification Form to certify 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.[4] For plan designs that are calculated in accordance with 45 CFR 156.135(a) and do not need to use an alternative method under 45 CFR 156.135(b), use of the integrated version of the AV Calculator should be attempted before reverting to using the unique plan design option.

For plans compatible with the AV Calculator, issuers must always use an actuarially justifiable process when inputting plan designs into the AV Calculator.[5] If the AV obtained from the template is not identical to the AV obtained from the standalone AV Calculator, take the following action:

1. Ensure the template has been filled out correctly per the instructions in this appendix.
2. Follow the steps in Section 4.2 Differences between Standalone AV Calculator and Plans & Benefits Template on troubleshooting the AV Calculator.
3. After following the troubleshooting steps, determine whether the results of the standalone AV Calculator can be replicated using the Plans & Benefits Template and its **Check AV Calc** procedure.
    a. If the standalone AV Calculator results cannot be replicated because of the design of the Plans & Benefits Template but the AVs obtained from the standalone AV Calculator and via the Plans & Benefits Template both fall within the relevant de minimis range for the plan's metal level or CSR variation, the plan does not need to be designated as a unique plan design. Instead, set the *Unique Plan Design* field to **No**, leave the *Issuer Actuarial Value* field blank, and run the integrated AV Calculator.
    b. If the AV obtained via the Plans & Benefits Template does not fall within the relevant de minimis range but the AV obtained via the standalone AV Calculator does, designate that particular plan as a unique plan design by setting the *Unique Plan Design* field to **Yes**. For this plan, complete the *Issuer Actuarial Value* field with the value from the standalone AV Calculator. The AV from the standalone AV Calculator must fall within the relevant de minimis range. Upload a screenshot of the standalone AV Calculator with the *Plan Name*, *Plan ID*, and *HIOS Issuer ID* fields filled in as a supporting document and include the plan ID (standard component) and date in the file name. In this situation, designating the plan as a unique plan design does not require submission of an actuarial certification and the plan is not considered unique for review purposes.

Note: There are certain cases in which it may not be possible to match AVs between the Plans & Benefits Template and the AV Calculator, such as in the following examples:

1. One or more benefits apply a coinsurance that is not subject to the deductible in the deductible range, which is not supported by the AV Calculator.[6]
2. One or more benefits that can be split into component parts have a coinsurance equal to the default coinsurance, but the issuer does not wish to split the benefits into their component parts during the coinsurance phase. For instance, the X-rays and Diagnostic Imaging category can be split into Primary Care and Specialist Office Visit components, and the Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services, Imaging (CT/PET Scans, MRIs), Speech Therapy, Occupational and Physical Therapy, Laboratory Outpatient, and Professional Services benefits can be split into Outpatient Facility and Outpatient Professional components.

4.2 Differences between Standalone AV Calculator and Plans & Benefits Template

The screenshot feature allows for a quick comparison between plan designs created using the Plans & Benefits Template and those manually entered into the standalone AV Calculator. When using the **Check AV Calc**

[4] When submitting a plan with a unique plan design, consult state guidance and complete the Unique Plan Design—Supporting Documentation and Justification Form in accordance with the applicable state processes.
[5] For additional guidance, see the May 16, 2014, CMS Frequently Asked Questions on Actuarial Value.
[6] For more information, please refer to the AV Calculator User Guide located in the first tab of the AV Calculator.

procedure in the Plans & Benefits Template, select **Yes** after a prompt appears asking if the user wants to save the AV Calculator screenshots, then select the location where the screenshots should be saved. Once the **Check AV Calc** procedure has finished, the folder can be opened and the automatically generated screenshots can be used to compare with those manually created in the standalone AV Calculator. This side-by-side comparison will help determine if the cost-sharing structure has been entered and applied as intended.

Table A-2 describes the steps to take to compare the AV generated by the **Check AV Calc** procedure and the AV generated by the standalone AV Calculator.

Table A-2. Comparing Plans & Benefits Template and Standalone AV Calculator Screenshots

Create and Compare Screenshots	
Step 1	Calculate the plan's AV in the standalone AV Calculator and save the screenshot.
Step 2	Calculate the plan's AV in the Plans & Benefits Template and save the screenshot.
Step 3	Compare the two screenshots line-by-line to identify the difference that is causing the AV impact.

For example, if a plan is supposed to have a $30 copay for Primary Care Visits, the cost sharing would be entered into the standalone AV Calculator as shown in Figure A-1. However, if the user entered the benefit cost sharing in the Plans & Benefits Template as shown in Figure A-2, the AV from the standalone AV Calculator and the AV returned from **Check AV Calc** in the Plans & Benefits Template would be significantly different. To resolve the discrepancy between the two AVs, the user could open the screenshot file created by the **Check AV Calc** macro and the standalone AV Calculator. Comparing the standalone AV Calculator screenshot (Figure A-1) and the screenshot generated by the **Check AV Calc** macro in the Plans & Benefits Template (Figure A-3) would show that the *Subject to Deductible?* checkbox is checked in the Plans & Benefits Template screenshot, indicating that the copay is being applied with the deductible only in the Plans & Benefits Template. Resolve this discrepancy by referring to Table A-4, which shows how to correctly enter cost sharing to ensure that it maps from the *Primary Care Visit to Treat an Injury or Illness* field as intended.

Figure A-1. Standalone AV Calculator Screenshot

Click Here for Important Instructions	Tier 1			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00

Figure A-2. Example Plans & Benefits Template Cost Sharing

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*
$30.00		Not Applicable	No Charge after deductible		100.00%

Figure A-3. Screenshot Created by Check AV Calc

Click Here for Important Instructions	Tier 1			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00

5. Field Mapping

This section describes how the **Check AV Calc** procedure automatically maps data from the Plans & Benefits Template into the AV Calculator. If any of the required data fields in the Plans & Benefits Template are blank or contain invalid values, the procedure returns an error. The layout of the following instructions is intended to align with the order that the fields appear in the Plans & Benefits Template.

5.1 Metal Tier

The *Level of Coverage* field in the Plans & Benefits Template is mapped to the *Desired Metal Tier* field in the AV Calculator.

Expanded Bronze Plans: The AV Calculator includes an option for issuers to indicate that they are running an expanded bronze plan as finalized in the *HHS Notice of Benefit and Payment Parameters for 2018*. The expanded bronze plan option in the AV Calculator allows the user to calculate the AV for bronze plans that meet certain requirements, allowing the user to use an expanded bronze plan de minimis range. The option may be used only if the bronze plan either covers and pays for at least one major, non-preventive service 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) as established in 45 CFR 156.140(c). The AV Calculator does not check the plan for compliance with the requirements to use the expanded bronze plan de minimis range. The issuer must ensure its bronze plan meets these requirements if it uses the expanded bronze plan de minimis range in the AV Calculator. For those bronze plans, the allowable AV variation is -2 percentage points and +5 percentage points. See the AV Calculator Methodology and the *HHS Notice of Benefit and Payment Parameters for 2024* for more information. For expanded bronze and silver plan CSR variations, the *Indicate if Plan Meets CSR or Expanded Bronze AV Standard?* checkbox in the AV Calculator is checked. To ensure that the correct continuance table is used for these plans, *Desired Metal Tier* depends on the AV level of the variation. *Desired Metal Tier* for silver plan variances is set to **Silver** for the 73 percent variation, **Gold** for the 87 percent variation, and **Platinum** for the 94 percent variation. *Desired Metal Tier* must be set to **Bronze** for expanded bronze plans.

De Minimis Range: In June 2025, CMS released the *2025 Marketplace Integrity and Affordability Final Rule (CMS-9884-F)* which was set to amend the de minimis variation range for the AV level of coverage in 45 CFR 156.140(c). However, the August 2025 U.S. District Court for the District of Maryland ruling stayed implementation of this provision and returned the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan to −2 percentage points and +2 percentage points.[7] An exception exists for bronze 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 within the meaning of 26 U.S.C. 223(c)(2), in which case the allowable variation in AV for such plan is -2 percentage points and +5 percentage points. An exception also exists for individual market silver QHPs which have an allowable variation of –0 percentage points and +2 percentage points.

5.2 Health Savings Account (HSA)/Health Reimbursement Arrangement (HRA) Options

If **Yes** is entered in *HSA/HRA Employer Contribution* in the Cost Share Variances worksheet of the Plans & Benefits Template, the *HSA/HRA Employer Contribution?* checkbox in the AV Calculator is checked. The dollar amount entered for the *HSA/HRA Employer Contribution Amount* in the Plans & Benefits Template is mapped to the *Annual Contribution Amount* in the AV Calculator.

Figure A-4 shows the HSA/HRA input fields in the Plans & Benefits Template and Figure A-5 shows the corresponding input fields in the AV Calculator.

[7] https://www.govinfo.gov/content/pkg/USCOURTS-mdd-1_25-cv-02114/pdf/USCOURTS-mdd-1_25-cv-02114-0.pdf.

Figure A-4. HSA/HRA Input Fields in Plans & Benefits Template

HSA/HRA Detail		
HSA Eligible *	*HSA/HRA Employer Contribution*	*HSA/HRA Employer Contribution Amount*
Yes	Yes	$500.00

Figure A-5. HSA/HRA Input Fields in AV Calculator

HSA/HRA Options	
HSA/HRA Employer Contribution?	☑
Annual Contribution Amount:	$500.00

5.3 Tiered Network Options

The AV Calculator can accommodate plans using up to two tiers of in-network services. The user may input separate cost-sharing parameters—such as deductibles, default coinsurance rates, MOOP costs, and service-specific copayments and coinsurance—and specify the share of utilization that occurs within each tier. The resulting AV is a blend of the AVs for the two tiers.[8]

If *Multiple In Network Tiers?* is set to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Tiered Network Plan?* checkbox in the AV Calculator is checked. The *1st Tier Utilization* and *2nd Tier Utilization* fields in the Plans & Benefits Template are mapped to the *1st Tier Utilization* and *2nd Tier Utilization* fields in the AV Calculator. The Plans & Benefits Template requires that all silver plan CSR and limited cost sharing plan variations have the same 1st Tier Utilization and 2nd Tier Utilization as the standard plan.

The *Tiered Network Plan?* checkbox in the AV Calculator is not related to the Plan Type selection in the Plans & Benefits Template. Non-point-of-service plans can have multiple in-network tiers in the Plans & Benefits Template, resulting in the *Tiered Network Option* checkbox being checked in the AV Calculator.

Figure A-6 shows the tiered input fields in the Plans & Benefits Template, and Figure A-7 shows the corresponding input fields in the AV Calculator.

Figure A-6. Multiple In-Network Tier Options in Plans & Benefits Template

Multiple In Network Tiers?*	1st Tier Utilization*	2nd Tier Utilization
Yes	80%	20%

Figure A-7. Multi-Tier Options in AV Calculator

Tiered Network Option	
Tiered Network Plan?	☑
1st Tier Utilization:	80%
2nd Tier Utilization:	20%

With the **Not Applicable** option, the user can explicitly indicate which benefits have tiered cost sharing in a plan with multiple in-network tiers. If a benefit has a *Copay—In Network (Tier 2)* and a *Coinsurance—In Network (Tier 2)* equal to **Not Applicable**, the **Check AV Calc** procedure assumes the benefit does not have tiered cost sharing and uses the *Copay—In Network (Tier 1)* and *Coinsurance—In Network (Tier 1)* values when mapping

[8] For more information on this option, please refer to the AV Calculator Methodology and AV Calculator User Guide.

to Tier 2 in the AV Calculator. This exception to the Tier 2 mapping applies to all fields other than MOOP, default coinsurance, and deductibles but will not be noted in the individual sections that follow.

5.4 MOOP and Deductible Values

The AV Calculator uses the individual MOOP and deductible limits to calculate the AV of the plan. Therefore, individual MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AV Calculator. The individual MOOPs and deductibles mapped to the AV Calculator are not the family per-person MOOPs and deductibles.

Because some plans may have only combined in- and out-of-network MOOPs or deductibles (rather than separate in-network and out-of-network MOOPs or deductibles), the following logic determines which MOOPs and deductibles from the Plans & Benefits Template are used as inputs for the AV Calculator.

The following applies if the plan does not have multiple in-network tiers:

1. If *In Network* is a dollar value (**$X**), *In Network* is used for the AV Calculator.
2. If *In Network* is set to **Not Applicable** and *Combined In/Out of Network* is a dollar value (**$X**), *Combined In/Out of Network* is used for the AV Calculator.
3. If the *In Network* and *Combined In/Out of Network* fields are set to **Not Applicable**, the Plans & Benefits Template returns an error when attempting to calculate an AV.

The following applies if the plan has multiple in-network tiers:

1. If the *In Network* and *In Network (Tier 2)* fields are dollar values, the *In Network* and *In Network (Tier 2)* fields are used for the AV Calculator.
2. If the *In Network* and *In Network (Tier 2)* fields are set to **Not Applicable** and the *Combined In/Out of Network* field is a dollar value, the *Combined In/Out of Network* field is used for the AV Calculator. In that case, the combined in-/out-of-network MOOP or deductible is mapped to the Tier 1 and Tier 2 MOOPs or deductibles, respectively, in the AV Calculator.
3. The Plans & Benefits Template returns an error when attempting to calculate an AV in the following scenarios:
    a. *In Network* is a dollar value (**$X**), and *In Network (Tier 2)* is set to **Not Applicable**.
    b. *In Network* is set to **Not Applicable**, and *In Network (Tier 2)* is a dollar value (**$X**).
    c. The *In Network*, *In Network (Tier 2)*, and *Combined In/Out of Network* fields are set to **Not Applicable**.

5.4.1 Maximum Out of Pocket

If *Medical & Drug Maximum Out of Pocket Integrated?* is equal to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate MOOP for Medical and Drug Spending?* checkbox in the AV Calculator is unchecked. The following applies to integrated MOOPs:

1. The *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network—Individual* OR *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 MOOP* in the AV Calculator.
2. If the plan has multiple in-network tiers, the *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—In Network (Tier 2)—Individual* OR *Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 MOOP* field in the AV Calculator.

Figure A-8 shows the integrated medical and drug MOOP fields in the Plans & Benefits Template, and Figure A-9 shows a corresponding example in the AV Calculator.

Figure A-8. MOOP for Medical and Drug EHB Benefits (Total) Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)					
In Network		In Network (Tier 2)		Out of Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*
$4,000 $4000 per person | $8000 per group				$10,000 $10000 per person | $20000 per group	

Figure A-9. Integrated Deductible, Coinsurance, and MOOP in AV Calculator

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)			$1,500.00
Coinsurance (%, Insurer's Cost Share)			70.00%
MOOP ($)			$4,000.00
MOOP if Separate ($)			

If *Medical & Drug Maximum Out of Pocket Integrated?* is set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Separate MOOP for Medical and Drug Spending?* checkbox in the AV Calculator is checked. The following applies to separate MOOPs:

1. The *Maximum Out of Pocket for Medical EHB Benefits—In Network—Individual* OR *Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical MOOP* field in the AV Calculator.
2. The *Maximum Out of Pocket for Drug EHB Benefits—In Network—Individual* OR *Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug MOOP* field in the AV Calculator.
3. If the plan has multiple in-network tiers, the following applies:
   a. The *Maximum Out of Pocket for Medical EHB Benefits—In Network (Tier 2)—Individual* OR *Maximum Out of Pocket for Medical EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical MOOP* in the AV Calculator.
   b. The *Maximum Out of Pocket for Drug EHB Benefits—In Network (Tier 2)—Individual* OR *Maximum Out of Pocket for Drug EHB Benefits—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Drug MOOP* in the AV Calculator.

Figure A-10 shows the separate medical and drug MOOP fields in the Plans & Benefits Template, and Figure A-11 shows a corresponding example in the AV Calculator.

Figure A-10. MOOP for Medical EHB Benefits and MOOP for Drug EHB Benefits Fields in Plans & Benefits Template

Maximum Out of Pocket for Medical EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*
$3,000 $3000 per person | $6000 per group				$8,000 $8000 per person | $16000 per group	

Maximum Out of Pocket for Drug EHB Benefits					
In Network		In Network (Tier 2)		Out of Network	
Individual	*Family*	*Individual*	*Family*	*Individual*	*Family*
$1,000 $1000 per person | $2000 per group				$5,000 $5000 per person | $10000 per group	

Figure A-11. Separate Deductible and MOOP in AV Calculator

	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,500.00	$500.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	80.00%	
MOOP ($)			
MOOP if Separate ($)	$3,000.00	$1,000.00	

Prior to PY2027, the AV Calculator checked whether the annual limitation on cost sharing, also known as the MOOP (or sum of the MOOPs, for plans with separate medical and drug MOOPs), exceeded the maximum annual limitation on cost sharing, or MOOP limit. When the user entered a plan design with a MOOP exceeding the MOOP limit, the AV Calculator would show an error message instead of providing an AV result. The Final 2027 AV Calculator no longer blocks users from receiving an AV result for their input plan design when that plan's MOOP exceeds the MOOP limit. For PY2027, the maximum annual limitation on cost sharing is $12,000 for self-only coverage as specified in the Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2027 Benefit Year. Refer to this guidance for final self-only coverage and other than self-only coverage amounts for the maximum annual limitation on cost sharing and the reduced maximum annual limitation on cost sharing for cost-sharing plan variations. Issuers must still ensure their plans meet ACA standards by validating their plan data in the MPMS Module.

The AV Calculator does not allow a plan to have separate MOOPs if it has an integrated medical and drug deductible. If *Medical & Drug Maximum Out of Pocket Integrated?* is set to **No** and *Medical & Drug Deductibles Integrated?* is set to **Yes** in the Plans & Benefits Template, the Plans & Benefits Template returns an error when attempting to calculate the AV.

5.4.2 Deductibles

If a plan has a deductible greater than $0, one service must be subject to the deductible or the AV Calculator will return an error.

If *Medical & Drug Deductibles Integrated?* is set to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AV Calculator is checked.[9] The following applies to integrated deductibles:

1. The *Combined Medical & Drug EHB Deductible—In Network—Individual* OR *Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Combined Deductible* in the AV Calculator.
2. If the plan has multiple in-network tiers, the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Individual* OR *Combined Medical & Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Combined Deductible* in the AV Calculator.

Figure A-12 shows the integrated deductible fields in the Plans & Benefits Template. Figure A-9 displays a corresponding example in the AV Calculator.

[9] For information on the combined versus separate deductible in the AV Calculator, please refer to the AV Calculator User Guide on the first tab of the AV Calculator.

Figure A-12. Combined Medical and Drug EHB Deductible Fields in Plans & Benefits Template

Combined Medical and Drug EHB Deductible							
In Network			In Network (Tier 2)			Out of Network	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*
$1,500	$1500 per person | $3000 per group	30%	$2,000	$2000 per person | $4000 per group	40%	$5,000	$5000 per person | $10000 per group
$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group
$1,500	$1500 per person | $3000 per group	30%	$2,000	$2000 per person | $4000 per group	40%	$5,000	$5000 per person | $10000 per group

If *Medical & Drug Deductibles Integrated?* is set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Use Integrated Medical and Drug Deductible?* checkbox in the AV Calculator is unchecked. The following applies to separate medical and drug deductibles:

1. The *Medical EHB Deductible—In Network—Individual* OR *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Medical Deductible* in the AV Calculator.
2. The *Drug EHB Deductible—In Network—Individual* OR *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 1 Drug Deductible* in the AV Calculator.
3. If the plan has multiple in-network tiers, the following applies:
   a. The *Medical EHB Deductible—In Network (Tier 2)—Individual* OR *Medical EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Medical Deductible* in the AV Calculator.
   b. The *Drug EHB Deductible—In Network (Tier 2)—Individual* OR *Drug EHB Deductible—Combined In/Out Network—Individual* value in the Plans & Benefits Template is mapped to the *Tier 2 Drug Deductible* in the AV Calculator.

Figure A-13 and Figure A-14 show the separate medical and drug deductible fields, respectively, in the Plans & Benefits Template, and Figure A-15 shows a corresponding example of separate medical and drug deductibles in the AV Calculator.

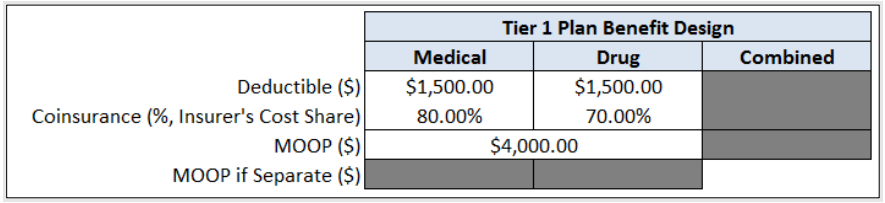
Figure A-13. Medical EHB Deductible Fields in Plans & Benefits Template

Medical EHB Deductible							
In Network			In Network (Tier 2)			Out of Network	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*
$1,500	$1500 per person | $3000 per group	20%	$2,000	$2000 per person | $4000 per group	30%	$3,000	$3000 per person | $6000 per group
$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group
$1,500	$1500 per person | $3000 per group	20%	$2,000	$2000 per person | $4000 per group	30%	$3,000	$3000 per person | $6000 per group

Figure A-14. Drug EHB Deductible Fields in Plans & Benefits Template

Drug EHB Deductible							
In Network			In Network (Tier 2)			Out of Network	
Individual	*Family*	*Default Coinsurance*	*Individual*	*Family*	*Default Coinsurance*	*Individual*	*Family*
$1,500	$1500 per person | $3000 per group	30%	$2,000	$2000 per person | $4000 per group	40%	$5,000	$5000 per person | $10000 per group
$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group	0%	$0	$0 per person | $0 per group
$1,500	$1500 per person | $3000 per group	30%	$2,000	$2000 per person | $4000 per group	40%	$5,000	$5000 per person | $10000 per group

Figure A-15. Separate Medical and Drug Deductibles and Integrated MOOP in AV Calculator



	Tier 1 Plan Benefit Design		
	Medical	Drug	Combined
Deductible ($)	$1,500.00	$1,500.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	70.00%	
MOOP ($)	$4,000.00		
MOOP if Separate ($)			

5.5 Default Coinsurance

While the coinsurance values in the Plans & Benefits Template represent the percentage of costs the enrollee pays for a given service, the coinsurance values in the AV Calculator represent the percentage of costs the issuer pays. Thus, the coinsurance values entered into the AV Calculator must be set to **1−X percent**, where X percent is the coinsurance value entered in the Plans & Benefits Template. For example, if enrollees pay 10 percent of specialist visit costs, the coinsurance in the Plans & Benefits Template would be equal to 10 percent. The coinsurance in the AV Calculator would be equal to 90 percent to represent the 90 percent of costs the issuer will incur. Table A-3 shows the mapping between the Plans & Benefits Template and the AV Calculator and provides examples of coinsurance values in both.

Table A-3. Coinsurance Mapping between the Plans & Benefits Template and the AV Calculator

Plans & Benefits (Enrollee's Cost Share)	AV Calculator (Issuer's Cost Share)
X%	(1−X)%
10%	90%
40%	60%

If the plan has an integrated medical and drug deductible, it also must have an integrated default coinsurance in the AV Calculator. *If Medical & Drug Deductibles Integrated?* is set to **Yes** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Combined Medical & Drug EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Combined Coinsurance* in the AV Calculator (found in the Tier 1 Plan Benefit Design table).
2. If the plan has multiple in-network tiers, one minus the *Combined Medical & Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Combined Coinsurance* in the AV Calculator (found in the Tier 2 Plan Benefit Design table).

Figure A-12 shows the integrated medical and drug default coinsurance fields in the Plans & Benefits Template, and Figure A-9 shows an example in the AV Calculator.

If the plan has separate medical and drug deductibles, it also must have separate default coinsurance values in the AV Calculator. If *Medical & Drug Deductibles Integrated?* is set to **No** in the Cost Share Variances worksheet of the Plans & Benefits Template, the following applies:

1. One minus the *Medical EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Medical Coinsurance* in the AV Calculator (found in the Tier 1 Plan Benefit Design table).
2. One minus the *Drug EHB Deductible—In Network—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 1 Drug Coinsurance* in the AV Calculator.
3. If the plan has multiple in-network tiers, the following applies:
    a. One minus the *Medical EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Medical Coinsurance* in the AV Calculator (found in the Tier 2 Plan Benefit Design table).

b. One minus the *Drug EHB Deductible—In Network (Tier 2)—Default Coinsurance* percent value in the Plans & Benefits Template is mapped to the default *Tier 2 Drug Coinsurance* in the AV Calculator.

5.6 Subject to Deductible?

The copay and coinsurance qualifiers in the Plans & Benefits Template determine whether the *Subject to Deductible?* checkbox in the AV Calculator is checked (see Figure A-16 and Figure A-17). For each benefit, if either the *Copay—In Network (Tier 1)* OR the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template contains the text "with deductible" or "after deductible," the *Tier 1 Subject to Deductible?* checkbox for the corresponding benefit in the AV Calculator is checked. If a benefit has multiple in-network tiers (the plan has multiple tiers and both *Copay—In Network (Tier 2)* and *Coinsurance—In Network (Tier 2)* are not equal to **Not Applicable**), the same logic applies to Tier 2.

Figure A-16. Fields in Plans & Benefits Template Mapping to Subject to Deductible? Fields in AV Calculator

Primary Care Visit to Treat an Injury or Illness						Specialist Visit					
Copay			Coinsurance			Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*
$20.00	$25.00	$40.00	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	10.00% Coinsurance after deductible	20.00% Coinsurance after deductible	40.00% Coinsurance after deductible

Figure A-17. Benefit Categories in AV Calculator

Click Here for Important Instructions	Tier 1			
Type of Benefit	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance, if different**	**Copay, if separate**
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSU)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00
Specialist Visit	☑	☑	90%	
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		
Speech Therapy	☑	☑		
Occupational and Physical Therapy	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		
Skilled Nursing Facility	☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑		
Drugs	☑ All	☑ All		
Generics	☑	☑		
Preferred Brand Drugs	☑	☑		
Non-Preferred Brand Drugs	☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑		

Table A-4 shows all possible mappings of copay and coinsurance values from the Plans & Benefits Template to the AV Calculator—including the *Subject to Deductible?* logic—for all benefits other than Mental/Behavioral Health and Substance Use Disorder benefits. For Mental Health and Substance Abuse benefits, see Table A-6. Section 5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services describes the copay and coinsurance mappings in more detail.

Table A-4. Benefit Category Cost-Sharing Mapping between Plans & Benefits Template and AV Calculator

Plans & Benefits Template		AV Calculator				
Copay	**Coinsurance**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance**	**Copay**	**Copay applies only after deductible?**
$X Copay after deductible $X Copay per Day after deductible $X Copay per Stay after deductible No Charge after deductible	X% X% Coinsurance after deductible	Checked	Checked	(1–X)%	Blank	Unchecked
No Charge Not Applicable	X% Coinsurance after deductible					
$X $X Copay per Day $X Copay per Stay	X% Coinsurance after deductible	Checked	Checked	(1–X)%	$X	Unchecked
$X Copay with deductible $X Copay per Day with deductible $X Copay per Stay with deductible	X% X% Coinsurance after deductible					
No Charge Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge Not Applicable					
No Charge after deductible	No Charge after deductible					
$X Copay after deductible $X Copay per Day after deductible $X Copay per Stay after deductible	No Charge Not Applicable No Charge after deductible	Checked	Unchecked	Blank	$X	Checked
$X $X Copay per Day $X Copay per Stay	No Charge after deductible	Checked	Unchecked	Blank	$X	Unchecked
$X Copay with deductible $X Copay per Day with deductible $X Copay per Stay with deductible	No Charge Not Applicable No Charge after deductible					

Plans & Benefits Template		AV Calculator				
Copay	**Coinsurance**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance**	**Copay**	**Copay applies only after deductible?**
No Charge Not Applicable	X%	Unchecked	Checked	(1–X)%	Blank	Unchecked
$X $X Copay per Day $X Copay per Stay	X%	Unchecked	Checked	(1–X)%	$X	Unchecked
No Charge Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
$X $X Copay per Day $X Copay per Stay	No Charge Not Applicable	Unchecked	Unchecked	Blank	$X	Unchecked

5.7 Subject to Coinsurance?

For each benefit, if *Coinsurance—In Network (Tier 1*) is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for the corresponding benefit in the AV Calculator is checked. For a plan with multiple in-network tiers, if *Coinsurance—In Network (Tier 2)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 2 Subject to Coinsurance?* checkbox for the corresponding benefit in the AV Calculator is checked.

5.8 Different Coinsurance Values

A coinsurance value for a benefit category is mapped to the AV Calculator only if the coinsurance for the given benefit differs from the relevant default coinsurance. For each benefit, if the *Tier 1 Subject to Coinsurance?* checkbox in the AV Calculator is checked as described above, **1–X%**, where **X%** is the coinsurance value from the *Coinsurance—In Network (Tier 1)* field in the Plans & Benefits Template, is mapped to the *Tier 1 Coinsurance, if different* field for the corresponding benefit in the AV Calculator. For a benefit with multiple in-network tiers, if the *Tier 2 Subject to Coinsurance?* checkbox in the AV Calculator is checked, **1–X%**, where **X%** is the coinsurance value from the *Coinsurance—In Network (Tier 2)* field, is mapped to the *Tier 2 Coinsurance, if different* field for the corresponding benefit in the AV Calculator.

The AV Calculator functionality does not support plan designs in which the benefit has a coinsurance without being subject to the deductible or a copay element. Please refer to the AV Calculator User Guide for more information on the operation of copay and coinsurance cost sharing in the deductible and coinsurance ranges.[10]

The AV Calculator treats **No Charge** (or **Not Applicable**) and **0%** coinsurance differently when a benefit's copay is greater than $0. If the benefit has coinsurance equal to **No Charge** (or **Not Applicable**) and a copay greater than $0, the relevant *Subject to Coinsurance?* checkbox in the AV Calculator is unchecked, and the AV Calculator assumes that the enrollee pays a copay until reaching the MOOP. If the benefit has a coinsurance equal to **0%** and a copay greater than $0, the relevant *Subject to Coinsurance?* checkbox in the AV Calculator is checked and **100%** is entered into the relevant *Coinsurance, if different* field in the AV Calculator. In the latter case, the AV Calculator assumes that the enrollee pays a copay until meeting the deductible and then pays nothing.

5.9 Copay Values

For each benefit, if *Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **$X**, **$X Copay with deductible**, **$X Copay per Day**, **$X Copay per Stay**, **$X Copay per Stay with deductible**, or **$X Copay per**

[10] The AV Calculator User Guide can be found on the first tab of the AV Calculator. The appendix at the end of the User Guide contains charts that provide detail and examples regarding the application of cost sharing within the deductible and coinsurance range.

Day with deductible, then the *Tier 1 Copay, if separate* field in the AV Calculator is set equal to **X**. If *Copay—In Network (Tier 1)* is equal to **$X Copay after deductible**, **$X Copay per Stay after deductible**, or **$X Copay per Day after deductible** and the corresponding *Coinsurance—In Network (Tier 1)* field is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable**, then the *Tier 1 Copay, if separate* field in the AV Calculator is set equal to **X**. If *Copay—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable**, then the *Tier 1 Copay, if separate* field in the AV Calculator is left blank.

When both coinsurance and copay values are present for a given benefit, the AV Calculator can consider a copay in the deductible range and a coinsurance rate in the coinsurance range. However, the standalone AV Calculator does not support applying both a copay and a coinsurance in the coinsurance range. If a benefit's copay is only after the deductible and before the MOOP and the benefit also has a coinsurance, the AV Calculator considers only the coinsurance value in the coinsurance range. Therefore, if *Copay—In Network (Tier 1)* is equal to **$X Copay after deductible**, **$X Copay per Stay after deductible**, or **$X Copay per Day after deductible** and *Coinsurance—In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Copay, if separate* field in the AV Calculator is left blank. For benefits with multiple in-network tiers, the logic described above for Tier 1 also applies to Tier 2.

As discussed in the AV Calculator Methodology and AV Calculator User Guide, five service types (Mental/ Behavioral Health and Substance Use Disorder Outpatient Services, Imaging, Speech Therapy, Occupational Therapy and Physical Therapy, and Laboratory Outpatient and Professional Services) include services also classified as Outpatient-Facility and Outpatient-Professional. If special cost-sharing provisions are indicated for Outpatient-Facility or Outpatient-Professional claims and no special cost sharing is indicated for the service type, services including both an Outpatient-Facility component and an Outpatient-Professional component will be split into their component parts and the relevant cost sharing applied. The Final 2027 AV Calculator includes an updated warning message when the cost sharing for Outpatient Facility Fee and Outpatient Surgery Physician/Surgical Services is applied to services with both facility and professional components that have default cost sharing. "Default cost sharing" refers to a benefit being subject to deductible and subject to coinsurance, with both the specific coinsurance and copay fields left blank—this is the cost sharing displayed upon opening an unmodified AV Calculator workbook. If issuers don't intend to enter this plan design, the "Outpatient - Facility and Outpatient - Professional Visits" section and FAQ Q21 in the AV Calculator User Guide provide additional guidance on how to enter a plan design without the cost sharing being overridden.

The AV Calculator also allows the user to indicate the cost sharing for Primary Care and Specialist Office Visits and X-rays. The standalone AV Calculator will indicate if the special cost sharing was engaged in the AV calculation in the *Additional Notes* field. For additional information on the operations of these features, review the AV Calculator Methodology and AV Calculator User Guide.

5.10 Copay Applies Only After Deductible

For each benefit, if *Copay—In Network (Tier 1)* is equal to **$X after deductible**, **$X Copay per Stay after deductible**, or **$X Copay per Day after deductible** and *Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the *Tier 1 Copay applies only after the deductible?* checkbox for the corresponding benefit in the AV Calculator is checked. If a benefit has multiple in-network tiers, the same logic applies to Tier 2. Although the standalone AV Calculator returns an error if the *Copay applies only after the deductible?* checkbox is checked and the benefit is also subject to a coinsurance, a copay after the deductible is never mapped from the Plans & Benefits Template if the benefit also has a coinsurance.

5.11 Benefit Categories[11]

Table A-5 shows the alignment of benefit categories in the Plans & Benefits Template and the AV Calculator, and Figure A-17 displays the benefit categories, along with their cost-sharing fields, in the AV Calculator.

No inputs into the AV Calculator are specific to the Pediatric Dental or Vision benefits. Pediatric Dental and Vision are generally low-cost benefits that do not have a material impact on AV. Additional information on how Pediatric Dental and Vision benefits are taken into account in the AV Calculator is available in the AV Calculator Methodology.

Table A-5. Benefit Category Alignment between Plans & Benefits Template and AV Calculator

Plans & Benefits Template Category Name	AV Calculator Category Name
Emergency Room Services	Emergency Room Services
Inpatient Hospital Services (e.g., hospital stay)	All Inpatient Hospital Services (including MHSU)
Primary Care Visit to Treat an Injury or Illness	Primary Care Visit to Treat an Injury or Illness (excluding Preventive and X-rays)
Specialist Visit	Specialist Visit
Mental/Behavioral Health Outpatient Services	Mental/Behavioral Health and Substance Use Disorder Outpatient Services
Substance Abuse Disorder Outpatient Services	
Imaging (CT/PET Scans, MRIs)	Imaging (CT/PET Scans, MRIs)
Rehabilitative Speech Therapy	Speech Therapy
Rehabilitative Occupational and Rehabilitative Physical Therapy	Occupational and Physical Therapy
Preventive Care/Screening/Immunization[12]	Preventive Care/Screening/Immunization
Laboratory Outpatient and Professional Services	Laboratory Outpatient and Professional Services
X-rays and Diagnostic Imaging	X-rays and Diagnostic Imaging
Skilled Nursing Facility	Skilled Nursing Facility
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	Outpatient Surgery Physician/Surgical Services
Generic Drugs	Generics
Preferred Brand Drugs	Preferred Brand Drugs
Non-Preferred Brand Drugs	Non-Preferred Brand Drugs
Specialty Drugs	Specialty Drugs (high-cost)

5.11.1 Inpatient Hospital Services

If *Inpatient Hospital Services Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **$X Copay per Day**, **$X Copay per Day with deductible**, or **$X Copay per Day after deductible**, then the *Apply Inpatient Copay per Day?* checkbox in the AV Calculator is checked. If the Inpatient Hospital Services copay is charged

[11] The 2026 AV Calculator updates the factor applied to trend claims from 2021 to 2025. Spending was trended forward from 2021 to 2022 at an annual rate of 3.2 percent for medical and 4.55 percent for drug spending. For 2022 to 2023, projection factors of 5.8 percent for medical costs and 8.7 percent for drug costs were selected and, for 2023 to 2024, CMS added projection factors of 5.4 percent for medical costs and 8.2 percent for drug costs. For trending from 2024 to 2025, CMS added 1 year projection factors of 6.4 percent for medical and 9.9 percent for drug spending. For information about the considerations of the new claims data, please refer to the AV Calculator Methodology.

[12] Section 2713 of the Public Health Service Act, codified in 45 CFR 147.130, requires issuers to offer certain preventive care services without cost sharing, so the standalone AV Calculator automatically takes into account no cost sharing for these services in the AV calculation and does not allow issuers to enter cost sharing for the Preventive Care/Screening/Immunization benefit category. Thus, regardless of the cost sharing in the Preventive Care/Screening/Immunization benefit category in the Plans & Benefits Template, no mapping occurs between the Plans & Benefits Template and the standalone AV Calculator for this benefit category.

per day for Tier 1, the AV Calculator automatically assumes that the Inpatient Hospital Services copay is also charged per day for Tier 2, if applicable.

If *Maximum Number of Days for Charging an Inpatient Copay?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, then the *Set a Maximum Number of Days for Charging an In Patient (IP) Copay?* checkbox in the AV Calculator is checked and the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template is mapped to *# Days (1–10)* in the AV Calculator. If the *Maximum Number of Days for Charging an Inpatient Copay?* field is blank in the Plans & Benefits Template, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox in the AV Calculator is unchecked and *# Days (1–10)* in the AV Calculator is left blank.

The *Maximum Number of Days for Charging an Inpatient Copay?* field is set at the plan variation level, allowing the values to differ between variations. However, the *Set a Maximum Number of Days for Charging an IP Copay?* checkbox and the *# Days (1–10)* field cannot vary between Tier 1 and Tier 2. Figure A-18 shows the *Maximum Number of Days for Charging an Inpatient Copay?* field in the Plans & Benefits Template, and Figure A-19 shows the corresponding checkbox and field in the AV Calculator.

If the issuer intends to use the *Maximum Number of Days for Charging an Inpatient Copay?* feature when filling out the standalone AV Calculator, ensure that the *Apply Inpatient Copay per Day?* checkbox in the AV Calculator (Figure A-20) is checked. Otherwise, the AV Calculator will return an error when trying to calculate the AV. On the Plans & Benefits Template side, follow the instruction in the first paragraph of this section and select a cost-sharing option that includes the text "per day" to ensure the *Apply Inpatient Copay per Day?* checkbox is checked in the AV Calculator mapping.

Figure A-18. AV Calculator Additional Benefit Design Fields in Plans & Benefits Template

AV Calculator Additional Benefit Design			
Maximum Coinsurance for Specialty Drugs	*Maximum Number of Days for Charging an Inpatient Copay?*	*Begin Primary Care Cost-Sharing After a Set Number of Visits?*	*Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?*
$200	5	3	

Figure A-19. Maximum Number of Days for IP Copay Checkbox and Field in AV Calculator

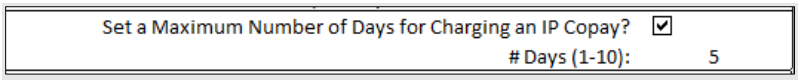
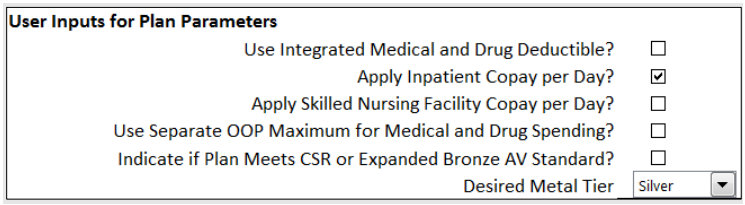


Figure A-20. Apply IP Copay Checkbox in AV Calculator



5.11.2 Skilled Nursing Facility

If the *Skilled Nursing Facility Copay—In Network (Tier 1)* in the Plans & Benefits Template is equal to **$X Copay per Day, $X Copay per Day with deductible**, or **$X Copay per Day after deductible**, then the *Apply Skilled Nursing Facility Copay per Day?* checkbox in the AV Calculator is checked. If the skilled nursing facility copay is charged per day for Tier 1, the AV Calculator automatically assumes that the skilled nursing facility copay is also charged per day for Tier 2, if applicable.

If the issuer intends to charge a skilled nursing facility copay per day, the issuer should ensure the *Apply Skilled Nursing Facility Copay per Day?* checkbox is selected while filling out the standalone AV Calculator to ensure the accuracy of AV calculations.

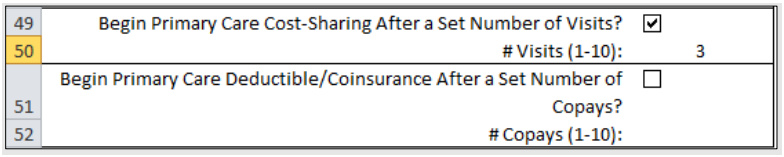
5.11.3 Primary Care

If *Begin Primary Care Cost-Sharing After a Set Number of Visits?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, then the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AV Calculator is checked and the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field in the Plans & Benefits Template is mapped to *# Visits (1–10)* in the AV Calculator. If the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* field is blank in the Plans & Benefits Template, then the *Begin Primary Care Cost-Sharing After a Set Number of Visits?* checkbox in the AV Calculator is unchecked and *# Visits (1–10)* in the AV Calculator is left blank. As discussed in the AV Calculator User Guide, the use of this option does not imply a benefit designed for primary care visits after the initial fully covered visits have occurred. The issuer must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under *Primary Care Visit to Treat an Injury or Illness*.

If *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* is equal to a whole number between 1 and 10 in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AV Calculator is checked and the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field in the Plans & Benefits Template is mapped to *# Copays (1–10)* in the AV Calculator. If the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* field is blank in the Plans & Benefits Template, then the *Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?* checkbox in the AV Calculator is unchecked and *# Copays (1–10)* in the AV Calculator is left blank. Per the AV Calculator User Guide, the use of this option does not imply a benefit design for primary care visits after the initial copays have occurred. The issuer must still indicate whether primary care visits are subject to the deductible and any other cost-sharing provisions during the coinsurance range and reflect that cost sharing (such as deductible and coinsurance) in the Plans & Benefits Template under *Primary Care Visit to Treat an Injury or Illness*.

The *Begin Primary Care Cost-Sharing After a Set Number of Visits?* and *Begin Primary Care Deductible/ Coinsurance After a Set Number of Copays?* fields (Figure A-21) are set at the plan variation level, allowing the values to differ between variations. However, these primary care fields and checkboxes (Figure A-21) cannot vary between Tier 1 and Tier 2. In addition to inputting any copay amount, these options must be used in conjunction with the *Subject to Deductible?* option for primary care services. Unchecking *Subject to Deductible?* with these options selected will trigger an error message.

Figure A-21. Primary Care Options in AV Calculator



5.11.4 Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services

The AV Calculator Mental/Behavioral Health and Substance Use Disorder Outpatient Services copay and coinsurance inputs are weighted averages of the *Mental/Behavioral Health Outpatient Services* and the *Substance Abuse Disorder Outpatient Services* cost-sharing fields in the Plans & Benefits Template. However, the **Check AV Calc** procedure uses only the copay and coinsurance values for the Mental/Behavioral Health Outpatient Services benefit in the Plans & Benefits Template when mapping to the *Mental/Behavioral Health and Substance Use Disorder Outpatient Services Subject to Deductible?*, *Subject to Coinsurance?*, and *Copay applies only after the deductible?* checkboxes in the AV Calculator. The copay and coinsurance values for the Substance Abuse Disorder Outpatient Services benefit in the Plans & Benefits Template do not affect the mapping to these AV Calculator checkboxes.

If either *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* or *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* in the Plans & Benefits Template contain the text “with deductible” or “after deductible,” the *Mental/Behavioral Health and Substance Use Disorder Outpatient Services Tier 1 Subject to Deductible?* checkbox in the AV Calculator is checked.

If *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **X% Coinsurance after deductible** or **X%** in the Plans & Benefits Template, the *Tier 1 Subject to Coinsurance?* checkbox for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AV Calculator is checked. Then, [0.8 × (*Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)*)] + [0.2 × (*Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)*)] is mapped to the *Tier 1 Coinsurance, if different* field for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AV Calculator.

In the following two scenarios, [0.8 × (*Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)*)] + [0.2 × (*Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)*)] is mapped to the *Tier 1 Copay, if separate* field for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AV Calculator:

1. *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **$X** or **$X with deductible** in the Plans & Benefits Template.
2. *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **$X after deductible** and the *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template.

If *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* is equal to **$X after deductible** and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* is equal to **No Charge**, **No Charge after deductible**, or **Not Applicable** in the Plans & Benefits Template, then the *Tier 1 Copay applies only after the deductible?* checkbox for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AV Calculator is checked.

The logic described above (and captured generically in Table A-5) also applies to the Tier 2 coinsurance and copay fields for Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services unless both the Tier 2 copay and Tier 2 coinsurance are equal to **Not Applicable**. If *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 2)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the *Mental/Behavioral Health Outpatient Services—Copay—In Network (Tier 1)* and *Mental/Behavioral Health Outpatient Services—Coinsurance—In Network (Tier 1)* values when mapping to the Tier 2 checkboxes and fields for Mental/Behavioral Health and Substance Use Disorder Outpatient Services in the AV Calculator. If *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 2)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 2)* are both equal to **Not Applicable**, then the **Check AV Calc** procedure will use the *Substance Abuse Disorder Outpatient Services—Copay—In Network (Tier 1)* and *Substance Abuse Disorder Outpatient Services—Coinsurance—In Network (Tier 1)* values for Substance Abuse Disorder Outpatient Services when mapping to the Mental/Behavioral Health and Substance Use Disorder Outpatient Services Tier 2 fields in the AV Calculator.

Table A-6 shows the detailed mappings described in this section.

Table A-6. Mental/Behavioral Health and Substance Abuse Disorder Outpatient Cost-Sharing Mapping between Plans & Benefits Template and AV Calculator

<table>
<tr><th colspan="2">Plans & Benefits Template—Mental/Behavioral Health Outpatient Services</th><th colspan="5">AV Calculator—Mental/Behavioral Health and Substance Use Disorder Outpatient Services</th></tr>
<tr><th>Copay</th><th>Coinsurance</th><th>Subject to Deductible?</th><th>Subject to Coinsurance?</th><th>Coinsurance</th><th>Copay</th><th>Copay applies only after deductible?</th></tr>
<tr><td>$X Copay after deductible
No Charge after deductible</td><td>X%
X% Coinsurance after deductible</td><td rowspan="2">Checked</td><td rowspan="2">Checked</td><td rowspan="2">1 – (80% Mental + 20% Substance)</td><td rowspan="2">Blank</td><td rowspan="2">Unchecked</td></tr>
<tr><td>No Charge
Not Applicable</td><td>X% Coinsurance after deductible</td></tr>
</table>

Plans & Benefits Template—Mental/Behavioral Health Outpatient Services		AV Calculator—Mental/Behavioral Health and Substance Use Disorder Outpatient Services				
Copay	**Coinsurance**	**Subject to Deductible?**	**Subject to Coinsurance?**	**Coinsurance**	**Copay**	**Copay applies only after deductible?**
$X	X% Coinsurance after deductible	Checked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
$X Copay with deductible	X% X% Coinsurance after deductible					
No Charge Not Applicable	No Charge after deductible	Checked	Unchecked	Blank	Blank	Unchecked
No Charge after deductible	No Charge Not Applicable No Charge after deductible					
$X Copay after deductible	No Charge Not Applicable No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Checked
$X	No Charge after deductible	Checked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked
$X Copay with deductible	No Charge Not Applicable No Charge after deductible					
No Charge Not Applicable	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	Blank	Unchecked
$X	X%	Unchecked	Checked	1 – (80% Mental + 20% Substance)	80% Mental + 20% Substance	Unchecked
No Charge Not Applicable	No Charge Not Applicable	Unchecked	Unchecked	Blank	Blank	Unchecked
$X	No Charge Not Applicable	Unchecked	Unchecked	Blank	80% Mental + 20% Substance	Unchecked

5.11.5 Drugs

The Plans & Benefits Template and the AV Calculator require cost sharing for four types of drugs: Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, and Specialty Drugs.

The AV Calculator does not allow a drug benefit to have both a copay and a coinsurance not equal to the relevant default coinsurance. If a copay and a coinsurance (that differs from the relevant default coinsurance) are entered for a drug benefit in the Plans & Benefits Template, the AV Calculator returns an error. If a drug benefit has only a copay, enter **No Charge**, **No Charge after the deductible**, or **Not Applicable** rather than **0%** or **0% Coinsurance after deductible** in the *Coinsurance—In Network (Tier 1)* or *Coinsurance—In Network (Tier 2)* fields in the Plans & Benefits Template to avoid an error from the AV Calculator. Likewise, if a drug benefit has only a coinsurance, enter **No Charge**, **No Charge after the deductible**, or **Not Applicable** rather than **$0** or **$0 Copay after deductible** in the *Copay—In Network (Tier 1)* or *Copay—In Network (Tier 2)* fields in the Plans & Benefits Template.

5.11.5.1 Specialty Drugs

If the *Maximum Coinsurance for Specialty Drugs* field includes a positive number in the Cost Share Variances worksheet of the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AV Calculator is checked, and the *Maximum Coinsurance for Specialty Drugs* field in the Plans

& Benefits Template is mapped to the *Specialty Rx Coinsurance Maximum* field in the AV Calculator. If the *Maximum Coinsurance for Specialty Drugs* field is blank in the Plans & Benefits Template, the *Set a Maximum on Specialty Rx Coinsurance Payments?* checkbox in the AV Calculator is unchecked and the *Specialty Rx Coinsurance Maximum* field in the AV Calculator is left blank.

The *Maximum Coinsurance for Specialty Drugs* field (Figure A-22) is set at the plan variation level, allowing the values to differ between variations. However, the *Specialty Drugs Maximum Coinsurance* checkbox and *Amount* field (Figure A-22) cannot vary between Tier 1 and Tier 2.

Figure A-22. Specialty Drugs Maximum Payment Fields in AV Calculator



6. Zero Cost Sharing and Limited Cost Sharing Plan Variations

Zero cost sharing plan variations, which are required to have zero cost sharing for all EHB categories, are automatically assigned an AV of 100 percent because they cover 100 percent of the average enrollee's costs. Limited cost sharing plan variations, which are required to have the same cost sharing and MOOPs as the standard plan for all EHB categories, must have the same AV as the standard plan. Although limited cost sharing plan variations must provide zero cost sharing to certain individuals for EHB items or services furnished directly by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization or via referral under contract health services (45 CFR 156.420[b][2]), these CSRs are not represented in the Plans & Benefits Template and are not included in the AV calculation.

Appendix B: Supporting Documentation

The issuer may be asked to submit supporting documentation and justifications as part of the Qualified Health Plan (QHP) Application process, but this is not a requirement for all application sections.

Table B-1 lists the supporting documentation and justifications for each application section and provides a description of the file, the submission criteria, the section to which the supporting documentation or justification applies, and the suggested file-naming convention when naming the supporting documentation or justification.

Table B-1. Supporting Documentation and Submission Criteria

Title	Description	Submission Criteria	Submission Location	Suggested File Name
State Partnership Exchange Issuer Program Attestation Response Form	Provides program attestations if the issuer is in a state performing plan management functions and the issuer is unable to respond to attestations via the Marketplace Plan Management System (MPMS) Module.	Required only if the issuer is in a state performing plan management functions (see Section 2C: Program Attestations).	System for Electronic Rates & Forms Filing (SERFF)	[Issuer ID]_SPEissuer Attestations
Accreditation Certificate	Demonstrates that the issuer is accredited.	The issuer may choose to submit this certificate if accredited.	Accreditation	[Issuer ID]_[Name of Accrediting entity]
Quality Improvement Strategy (QIS)	Describes a payment structure that provides increased reimbursement or other market-based incentives to improve plan enrollee health outcomes. Access the QIS Guidance and QIS forms on the QIS webpage of the Centers for Medicare & Medicaid Services (CMS) website.	Required if the issuer has issued QHPs on an Exchange for 2 or more consecutive years that offer family or adult-only medical coverage and meet the QIS minimum enrollment threshold in the Individual Market or Small Business Health Options Program Market. Review the QIS threshold in the QIS Technical Guidance and User Guide for the 2027 Plan Year. Issuer submission requirements are in the QIS Issuer List for the 2027 Plan Year.	Issuer Quality	If submitting an Implementation Plan: [5-digit HIOS Issuer ID]_ [Issuer Name]_QIS_[IP] If submitting a Progress Report: [5-digit HIOS Issuer ID]_ [Issuer Name]_QIS_[PR] If submitting a Modification Summary: [5-digit HIOS Issuer ID]_ [Issuer Name]_QIS_[MS]
Network Adequacy Justification Form	Explains why the issuer is not meeting the network adequacy requirements and describes ongoing provider recruitment activities. Issuers that receive a correction notice for not meeting one or more of the network adequacy standards should complete the required fields within the partially pre-populated	CMS will notify the issuer of any failure to meet one or more of the network adequacy standards by issuing a correction notice and partially pre-populated Network Adequacy Justification Form for the issuer to complete and submit via the MPMS Module.	Network Adequacy	(Issuer ID)-NA-(Round Abbreviation) Example for issuer ID 12345 in the Initial Round: 12345-NA-IR. For Second Round, use SR in place of IR and for Final Round, use FR.

Title	Description	Submission Criteria	Submission Location	Suggested File Name
	Network Adequacy Justification Form generated by the CMS posted in the Network Adequacy section of the MPMS Module and submit the completed justification via the MPMS Module.			
Service Area Partial County Supplemental Response	Describes why the issuer cannot serve an entire county.	Required if the issuer requests to serve only part of a county in a service area.	Service Area	[Issuer ID]_[State Abbreviation]_service_area_partial_county
Combined Prescription Drug Supporting Documentation and Justification	Explains why a correction was required in Non-Discrimination Clinical Appropriateness, Non-Discrimination Formulary Outlier, or Category/Class Benchmark Count and how each is not discriminatory.	Required if CMS issues a correction in Non-Discrimination Clinical Appropriateness, Non-Discrimination Formulary Outlier, or Category/Class Benchmark Count.	Prescription Drug	Category/Class Benchmark Count: [Issuer ID]_[State Abbreviation]_combineddrug_[catclass] Note: SERFF-submitting issuers should submit as Category/Class Benchmark Count Supporting Documentation and Justification document. Clinical Appropriateness: [Issuer ID]_[State Abbreviation]_[combineddrug]_[clinicalapp] Note: SERFF-submitting issuers should submit as Non-Discrimination Clinical Appropriateness Supporting Documentation and Justification document. Formulary Outlier: [Issuer ID]_[State Abbreviation]_[combineddrug]_[formularyout] Note: SERFF-submitting issuers should submit as Non-Discrimination Formulary Outlier Supporting Documentation and Justification document.

Title	Description	Submission Criteria	Submission Location	Suggested File Name
Non-Discrimination Treatment Protocol Calculator Supporting Documentation and Justification	Explains why a medical benefit or drug list's outlying out-of-pocket cost is not discriminatory.	Required if CMS determines the out-of-pocket cost is an outlier.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ treatmentprotocol
Non-Discrimination Cost Sharing Supporting Documentation and Justification	Explains why outlying cost sharing values should be allowed and are not discriminatory.	Required if CMS determines cost sharing values are outliers at the national and state levels, and the issuer does not correct them. States determine the SERFF submission requirements.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ discrimination_ cost_sharing
Non-Discrimination Adverse Tiering Supporting Documentation and Justification	Explains why the prescription benefit covers all recommended drugs on the highest drug tier(s).	Required if CMS issues a correction in the review based on drug tier coverage.	Prescription Drug	[Issuer ID]_[State Abbreviation]_ adversetiering Note: SERFF submitting issuers should submit as Non-Discrimination Adverse Tiering Supporting Documentation and Justification document.
Unique Plan Design—Supporting Documentation and Justification	Describes why a plan qualifies as unique, specifically why it is incompatible with the standard Actuarial Value (AV) Calculator and the methods used to calculate the AV.	Required if the issuer responds **Yes** to *Unique Plan Design?*	Plans & Benefits	[Issuer ID]_[State Abbreviation]_ unique_plan_design
EHB-Substituted Benefit Actuarial Equivalent Supporting Documentation and Justification	Describes essential health benefit (EHB) compliance for issuers that opt to substitute benefits for EHBs.	The issuer may submit this form or an alternative form to demonstrate EHB compliance. Issuers that submit via SERFF are not required to submit this form.	Plans & Benefits	[Issuer ID]_[State Abbreviation]_EHB_ actuarial_equivalent
Network Adequacy General Acute Care Hospital (GACH) List Feedback Form	Provides a standardized list of active general acute care hospitals from which issuers may select to be included on their Network Adequacy Template toward satisfaction of the time and distance standards and allows	The issuer may submit this form if they want to provide feedback on the GACH List.	Network Adequacy	GACH List Feedback Form.pdf

Title	Description	Submission Criteria	Submission Location	Suggested File Name
	feedback on the GACH List to ensure issuers correctly include only those hospitals CMS has deemed meet the criteria for the acute inpatient hospital facility specialty type.			

Saving Supporting Documents

Save supporting documentation and justifications using the file-naming conventions in the last column of Table B-1. The following special characters are not allowed in the names of files uploaded to the MPMS Module:

Invalid Characters in File Names for Upload to the MPMS Module						
< > (angle bracket)	: (colon)	; (semicolon)	/ (slash)	\ (backslash)	| (vertical bar)	? (question mark)
‘ ’ (apostrophe/ single quote)	“ ” (quotation mark)	= (equal sign)	% (percent sign)	* (asterisk)		

Appendix C: Review Tools

Although these review tools are available for identifying and resolving data errors, issuers must use the Plan Validation Workspace within the Marketplace Plan Management System Module after populating templates. This step is necessary since templates cannot be linked to an application and submitted for Centers for Medicare & Medicaid Services review unless they successfully pass all validations performed during the upload process in the Plan Validation Workspace. Issuers that submit via the System for Electronic Rates & Forms Filing (SERFF) also have access to the Plan Validation Workspace and should use it to validate data before submitting materials to SERFF. Table C-1 provides a high-level description of each tool's functionality.

Table C-1. High-Level Description of Each Tool's Functionality

Tool	Purpose
Data Integrity Tool[a]	Identifies critical data errors within and across templates. Provides immediate feedback about data to reduce issuer resubmissions. Alerts issuers and state reviewers to irregularities in the template submissions. Imports qualified health plan (QHP) and stand-alone dental plan (SADP) data from most application templates. Conducts validations beyond the standard Health Insurance Oversight System and SERFF checks. Looks across templates for consistency in key fields. Produces error reports that describe the error and its location in a template.
Plan ID Crosswalk Tool[a]	Checks that the Plan ID Crosswalk Template has been completed accurately by ensuring that all counties in all Federally-facilitated Exchange plans that were offered in 2026 are included in the crosswalk, the plans are crosswalked to valid 2027 plans, the crosswalk reasons selected are consistent with plan offerings, and the crosswalk is compliant with the regulation in 45 *Code of Federal Regulations* (CFR) 155.335(j).
Data Consolidation Tool[a] (formerly Master Review Tool)	Aggregates data from the Plans & Benefits, Service Area, Network Adequacy, and Prescription Drug Templates and serves as a data input file to the other standalone tools.
Essential Community Providers (ECP) Tool for Medical QHPs	Calculates the total number of medical ECPs an issuer has in each plan's network and compares this to the number of available medical ECPs in that service area. This tool checks whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235. The tool also checks for satisfaction of the ECP category per county and Indian health provider contract offering requirements. Note: Should only be used by issuers operating in states using the State-based Exchange model.
Essential Community Providers Tool[a] for SADPs	Calculates the total number of dental ECPs an issuer has in each plan's network and compares this to the number of available dental ECPs in that service area. This tool checks whether the percentage of the plan's networked ECPs is equal to or greater than the ECP threshold (as defined by federal or state regulators) to demonstrate satisfaction of the ECP inclusion standard set forth in 45 CFR 156.235. The tool also checks for satisfaction of the Indian health provider contract offering requirement. Note: Should only be used by issuers operating in states using the State-based Exchange model.
Non-Discrimination Tool	Performs an outlier analysis for *QHP Discriminatory Benefit Design* as discussed in the 2027 Letter to Issuers. This tool looks at all plans in the state, goes through a group of predetermined benefits, and determines whether any plan has a significantly higher copay or coinsurance for those benefits, which could potentially mean that the coverage is discriminatory.
Cost Sharing Tool[a]	Runs four different checks (when they are applicable to the plan) for cost-sharing standards: the Maximum Out-of-Pocket Cost Review, Cost-Sharing Reduction Plan Variation Review, Expanded Bronze Plan Review, and Catastrophic Plan Review.

Tool	Purpose
Category & Class Drug Count Tool	Compares the count of unique, chemically distinct drugs in each United States Pharmacopeia (USP) Medicare Model Guidelines v9.0 category and class for each drug list against a state's benchmark.
Formulary Review Suite: Non-Discrimination Formulary Outlier Review	Identifies and flags as outliers those plans that have unusually large numbers of drugs subject to prior authorization or step therapy requirements in 27 USP classes.
Formulary Review Suite: Non-Discrimination Clinical Appropriateness Review	Analyzes the availability of covered drugs associated with certain conditions as recommended in clinical guidelines to ensure that issuers are offering sufficient types and numbers of drugs.
Non-Discrimination Adverse Tiering Tool	Analyzes the drug tier coverage of RxNorm Concept Unique Identifiers used to treat high-cost and chronic medical conditions.

[a] Indicates tools that apply to SADP issuers.

Appendix D: Understanding Issuer Types

An issuer's Qualified Health Plan (QHP) Application submission will differ based on whether the issuer offers medical QHPs, stand-alone dental plans (SADPs), or both plan types. Each section of this document features a callout box that identifies the type of issuers the information applies to, as shown in Figure D-1.

Figure D-1. Callout Box

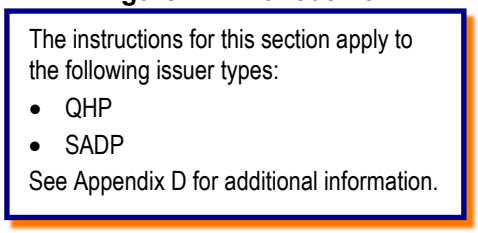


Table D-1 defines how the Centers for Medicare & Medicaid Services categorizes issuer types for this document.

Table D-1. Terms and Descriptions

Term	Description
QHP	Qualified health plan. As defined in Section 1301(a) of the Affordable Care Act (ACA), a QHP is an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits, follows established limits on cost sharing, and meets other requirements outlined within the application process.
SADP	Stand-alone dental plan. As defined in Section 1302(b)(1)(J) and Section 1311(b)(2)(B)(ii) of the ACA, an SADP is an insurance plan that only provides limited scope dental benefits. SADPs provide dental benefits that are offered in a separate plan and are generally considered to be "excepted benefits" with varying applicable statutory and regulatory standards that differ from QHPs. SADPs are exempted from the insurance market reform provisions of the Public Health Service Act and the ACA, including but not limited to medical loss ratio standards; rating standards related to age, family size, rating area, and tobacco use; and guaranteed availability and guaranteed renewability standards.

Appendix E: Network Adequacy Standards

To count toward meeting the time and distance standards, individual and facility providers listed in Table E-1, Table E-2, and Table E-3 must be appropriately licensed, accredited, or certified to practice in their state, as applicable, and must have in-person services available.

Table E-1. Time and Distance Standards for Individual Provider Specialty Types for Medical Qualified Health Plans (QHPs) for Exchange Plan Year (PY) 2027 QHP Certification

Individual Provider Specialty Types	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dental	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Emergency Medicine	20	10	45	30	80	60	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
General Surgery	20	10	30	20	50	35	75	60	95	85
Gynecology, OB/GYN	10	5	15	10	30	20	40	30	70	60
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Oncology–Medical, Surgical	20	10	45	30	60	45	75	60	110	100
Oncology–Radiation	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85

Individual Provider Specialty Types	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		Counties with Extreme Access Considerations (CEAC)	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Outpatient Clinical Behavioral Health (licensed, accredited, or certified professionals)	10	5	15	10	30	20	40	30	70	60
Physical Medicine and Rehabilitation	30	15	45	30	80	60	90	75	125	110
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Primary Care–Adult	10	5	15	10	30	20	40	30	70	60
Primary Care–Pediatric	10	5	15	10	30	20	40	30	70	60
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130

[a] Time standard is measured in minutes. Distance standard is measured in miles.

Table E-2. Time and Distance Standards for Facility Specialty Types for Medical QHPs for Exchange PY2027 QHP Certification

Facility Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Acute Inpatient Hospitals (must have Emergency services available 24/7)	20	10	45	30	80	60	75	60	110	100
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140

Facility Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Critical Care Services–Intensive Care Units (ICUs)	20	10	45	30	160	120	145	120	155	140
Diagnostic Radiology (free-standing; hospital outpatient; ambulatory health facilities with Diagnostic Radiology)	20	10	45	30	80	60	75	60	110	100
Inpatient or Residential Behavioral Health Facility Services	30	15	70	45	100	75	90	75	155	140
Mammography	20	10	45	30	80	60	75	60	110	100
Outpatient Infusion/ Chemotherapy	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Surgical Services (outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Urgent Care	20	10	45	30	80	60	75	60	110	100

[a] Time standard is measured in minutes. Distance standard is measured in miles.

Table E-3. Time and Distance Standards for Stand-Alone Dental Plans for Exchange PY2027 QHP Certification

Individual Provider Specialty Type	Maximum Time and Distance Standards[a]									
	Large Metro County		Metro County		Micro County		Rural County		CEAC	
	Time	Distance	Time	Distance	Time	Distance	Time	Distance	Time	Distance
Dental	30	15	45	30	80	60	90	75	125	110

[a] Time standard is measured in minutes. Distance standard is measured in miles.

Appendix F: Machine-Readable Submission

1. Introduction

In the *Issuer Details* section of the Marketplace Plan Management System (MPMS) Module, issuers must submit and/or edit their index URL and technical point of contact (POC) email for their machine-readable (MR) data.

The instructions for this section apply to the following issuer types:

- QHP
- SADP

See Appendix D for additional information.

2. Data Requirements

To complete this section, issuers need the following:

1. State
2. Health Insurance Oversight System Issuer ID
3. MR Index URL
4. Technical POC Email Address.

3. Quick Reference

Key Changes for 2027
◆ No changes for the 2027 QHP Application.

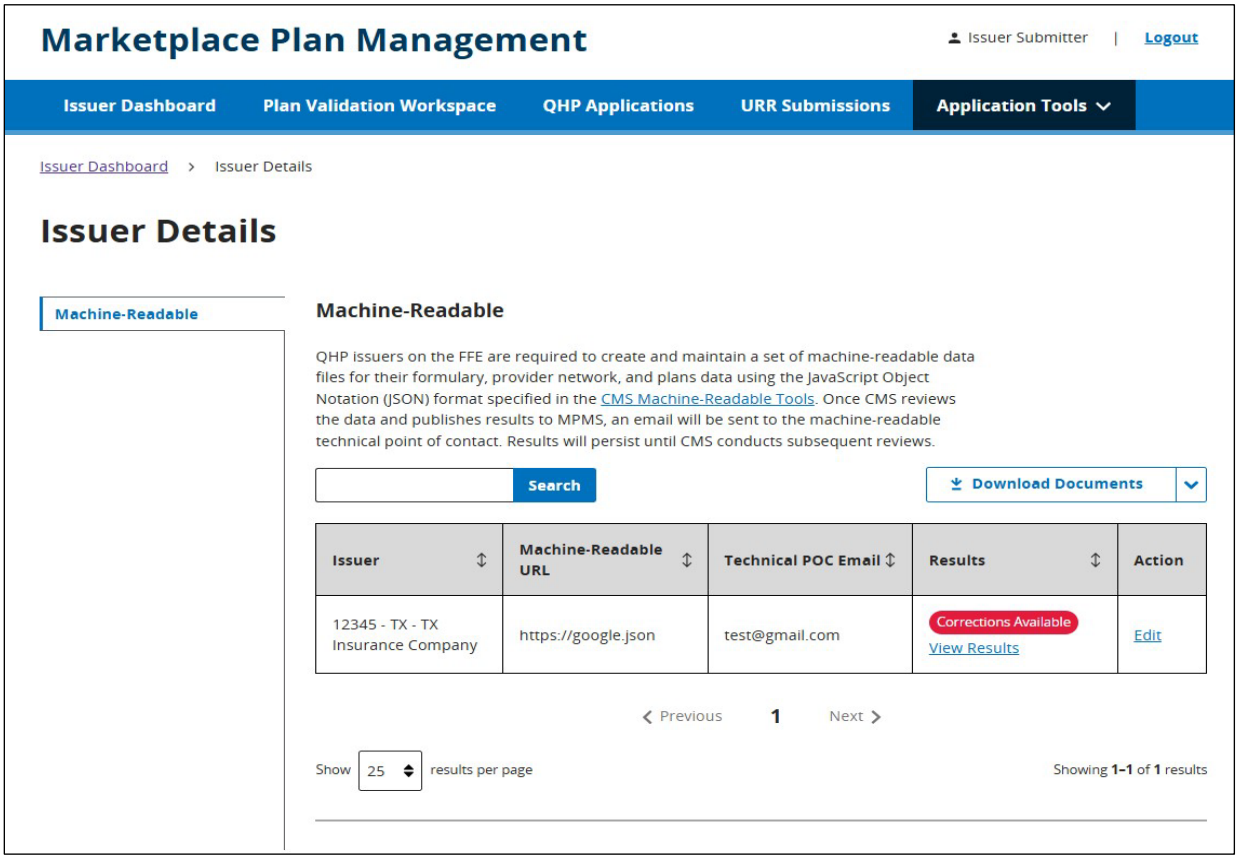
Tips for the Machine-Readable Submission Section
◆ Issuers must verify the functionality of MR index URLs before submitting them. ◆ Issuers must submit all MR index URLs via the MPMS Module by the deadline of September 23, 2026, confirming that all MR index URLs are active and directly route to the issuer's MR JSON data.

Additional Resources
◆ The Coverage Portal contains additional information, frequently asked questions (FAQs), and tools to support the MR submission process.

4. Detailed Section Instructions

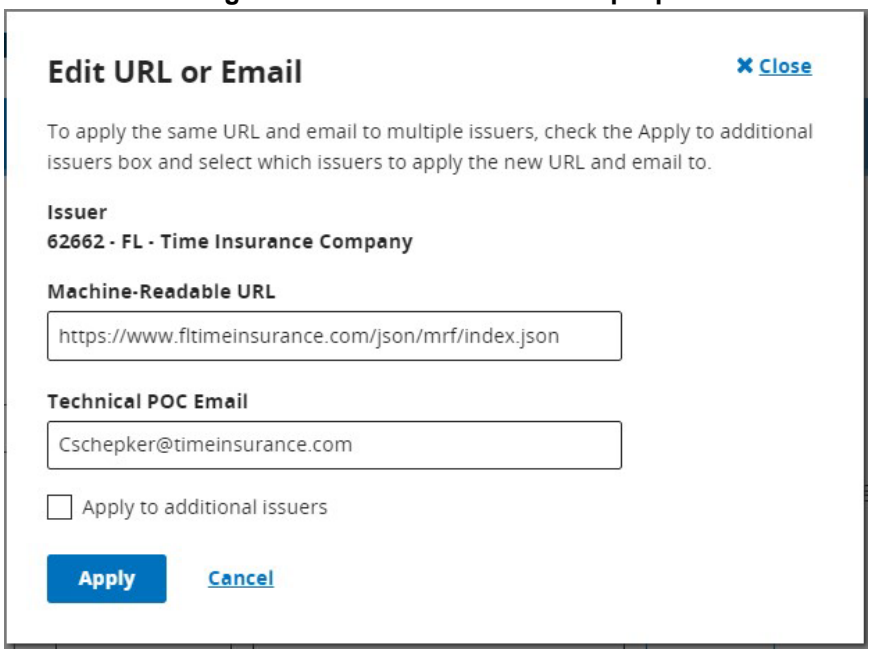
On the *Issuer Details* tab in the MPMS Module, users can view and edit URLs and associated details for issuers the account holder can access. Users can narrow down the list of issuers to review via the search bar (Figure F-1).

Figure F-1. Issuer Details Page in MPMS



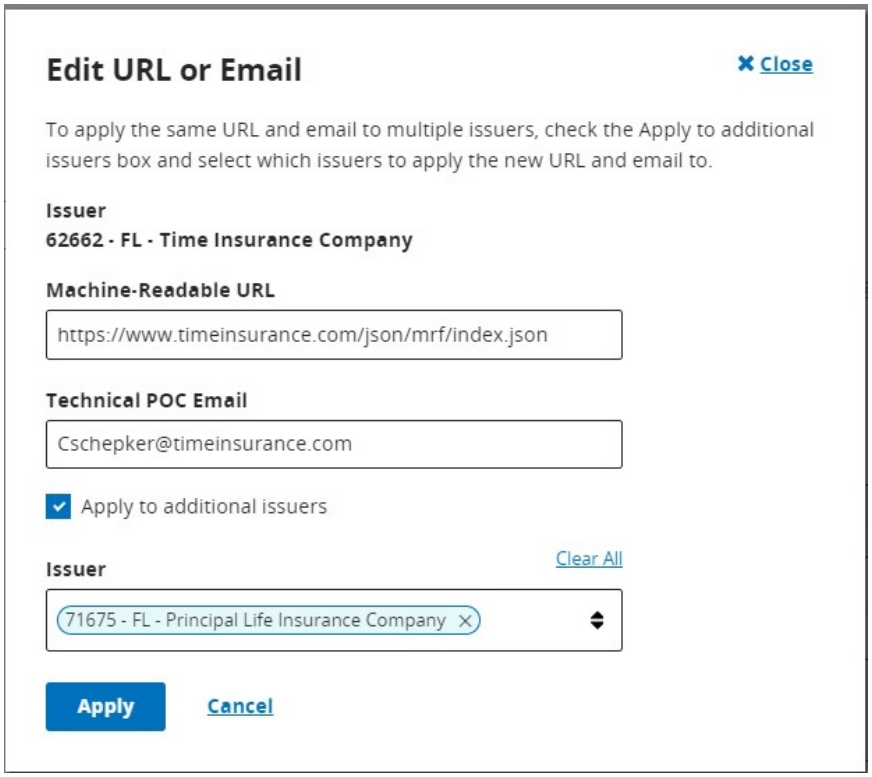
Select **Edit** in the Action column of the table to open the *Edit URL or Email* pop-up window to submit or edit the MR index URL and technical POC email (Figure F-2). After updating the MR index URL or technical POC email, click the **Apply** button to save the changes. Select **Cancel** to avoid making any changes or **Close** to reject any changes.

Figure F-2. Edit URL or Email Pop-Up



To apply the same MR index URL and technical POC email to multiple issuers, click the **Apply to additional issuers** check box and select additional issuers to apply the MR index URL and technical POC email to (Figure F-3).

Figure F-3. Edit URL or Email Pop-up—Additional Issuers



Selecting **Apply** begins the validation process. A pop-up window will appear to indicate that the validation process has started (Figure F-4).

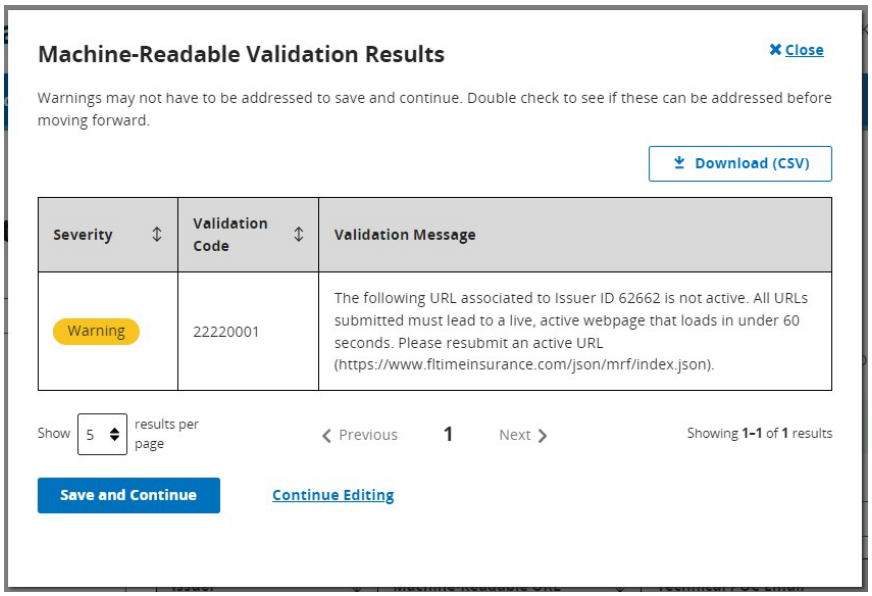
Figure F-4. Validation in Progress Pop-Up



Users will receive an error if they do not use “https://” at the start of the MR index URL and “.json” at the end of the MR index URL. In-line errors will disable the **Apply** button.

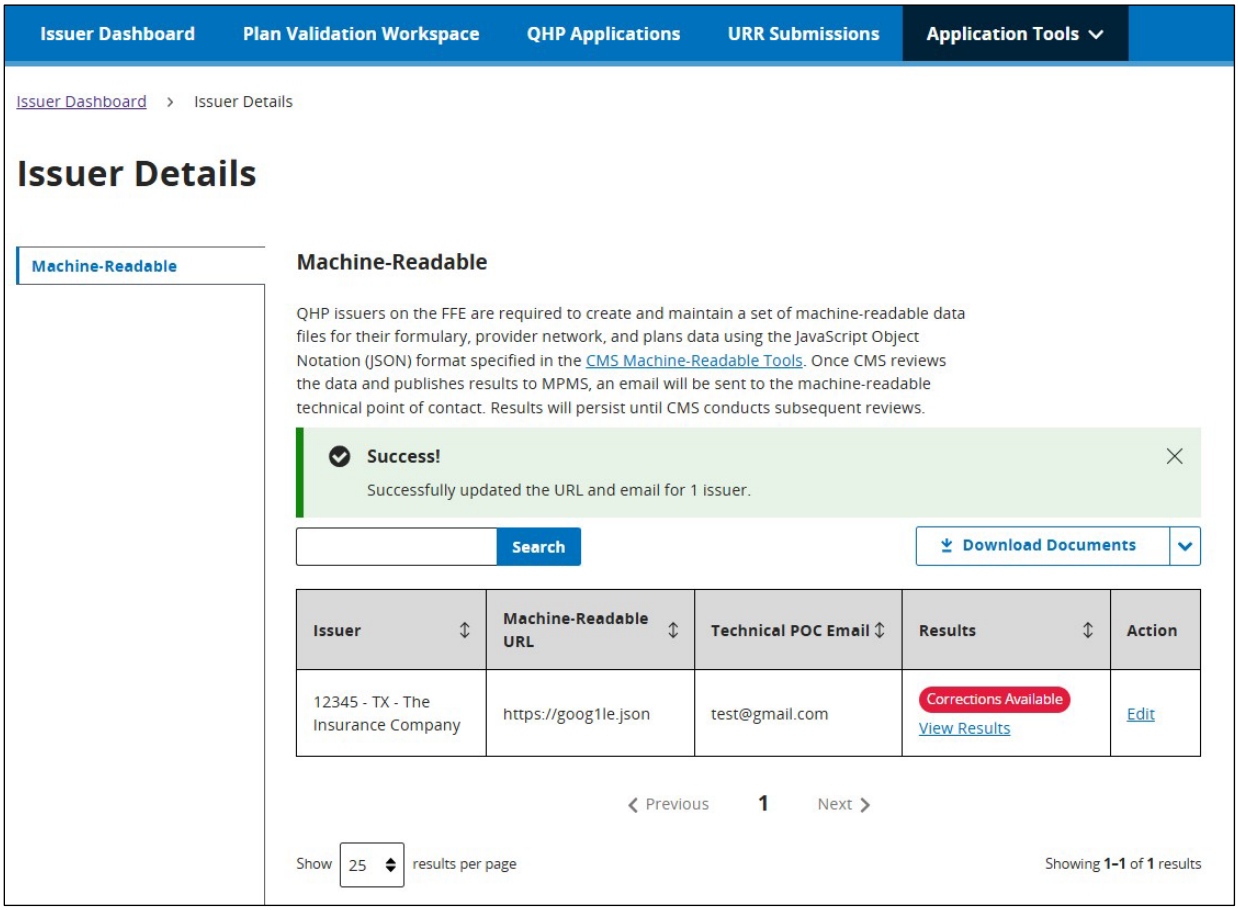
A pop-up message will display any validation warnings or errors. Selecting the **Continue Editing** button redirects the user back to the *Edit URL or Email* pop-up to edit any data with errors (Figure F-5).

Figure F-5. Validation Results Pop-Up



If there are no validation results to review, the *Issuer Details* page will open and display a success banner, confirming that the MR index URL and technical POC email have been updated (Figure F-6).

Figure F-6. Success Banner on Issuer Details Page



MR Submission Process	Step Description
Access the MPMS Module	Log in to the Centers for Medicare & Medicaid Services (CMS) Enterprise Portal and select the MPMS Module application on the My Portal page.
Go to Issuer Details	In the MPMS Module, go to **Application Tools** at the top of the page and click the **Issuer Details** tab.
Edit or Submit MR Index URL and Technical POC Email	Select **Edit** in the Action column for the issuer for whom information is being added or edited.
	A pop-up window will appear to edit or submit the MR index URL or technical POC email details.
	To apply the same MR index URL and email to multiple issuers, click the **Apply to additional issuers** check box and select issuers to apply the MR index URL and technical POC email to.
	Select the **Apply** button to save changes.

This concludes the Machine-Readable Submission section of the QHP Application Instructions.

Appendix G: Standardized Plan Options Requirements

Table G-1. 2027 Standardized Plan Options Set One
(For All FFE and SBE-FP Issuers, Excluding Issuers in Delaware, Louisiana, and Oregon)

Plan Element	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	63.10%	70.00%	73.07%	87.02%	94.01%	78.05%	88.00%
Deductible	$7,500	$6,400	$2,900	$800	$0	$2,500	$0
Annual Limitation on Cost Sharing	$12,000	$10,300	$9,000	$3,600	$3,500	$8,600	$5,900
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$250*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	$400*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$30*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$40*
Mental Health & Substance Use Disorder Outpatient Office Visit	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$250*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Habilitation Services	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$60*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$60*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$250*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$250*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$250*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$10*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$15*	$30*	$20*
Non-preferred Brand Drugs	$100	$80	$80	$60	$50*	$60*	$60*
Specialty Drugs	$500	$350	$350	$250	$150*	$250*	$250*

*Benefit category not subject to the deductible.

Table G-2. 2027 Standardized Plan Options Set Two (For Exchange Issuers in Delaware and Louisiana)

Plan Element	Expanded Bronze	Standard Silver	Silver 73 CSR	Silver 87 CSR	Silver 94 CSR	Gold	Platinum
Actuarial Value	63.10%	70.00%	73.00%	87.05%	94.02%	78.03%	88.01%
Deductible	$7,500	$6,400	$3,000	$700	$0	$2,500	$0
Annual Limitation on Cost Sharing	$12,000	$10,300	$9,000	$3,800	$3,700	$8,700	$6,400
Emergency Room Services	50%	40%	40%	30%	25%*	25%	$250*
Inpatient Hospital Services (Including Mental Health & Substance Use Disorder)	50%	40%	40%	30%	25%*	25%	$400*
Primary Care Visit	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Urgent Care	$75*	$60*	$60*	$30*	$5*	$45*	$30*
Specialist Visit	$100*	$80*	$80*	$40*	$10*	$60*	$40*
Mental Health & Substance Use Disorder Outpatient Office Visit	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Imaging (CT/PET Scans, MRIs)	50%	40%	40%	30%	25%*	25%	$250*
Speech Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Occupational, Physical Therapy	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Habilitation Services	$50*	$40*	$40*	$20*	$0*	$30*	$20*
Laboratory Services	50%	40%	40%	30%	25%*	25%	$60*
X-rays/Diagnostic Imaging	50%	40%	40%	30%	25%*	25%	$60*
Skilled Nursing Facility	50%	40%	40%	30%	25%*	25%	$250*
Outpatient Facility Fee (Ambulatory Surgery Center)	50%	40%	40%	30%	25%*	25%	$250*
Outpatient Surgery Physician & Services	50%	40%	40%	30%	25%*	25%	$250*
Generic Drugs	$25*	$20*	$20*	$10*	$0*	$15*	$5*
Preferred Brand Drugs	$50	$40*	$40*	$20*	$5*	$30*	$10*
Non-preferred Brand Drugs	$100	$80	$80	$60	$10*	$60*	$50*
Specialty Drugs	$150	$125	$125	$100	$20*	$100*	$75*

*Benefit category not subject to the deductible.