Appendix C: Instructions for Stand-Alone Dental Plan Applications

Overview

Pediatric dental is an essential health benefit that must be offered by all issuers in the individual and small group markets. If the pediatric dental benefit is covered by a stand-alone dental plan on the Exchange, then QHPs do not need to cover the pediatric dental EHB. Stand-alone dental plans seeking Exchange certification must meet all the applicable QHP certification standards outlined below.

An issuer that participates solely in the dental market—a Dental Only Issuer—or an issuer that participates in both the medical and dental markets—a Dual Product Issuer—may offer stand-alone dental plans. For purposes of completing the QHP application, a stand-alone dental plan issuer will be considered a Dental Only Issuer if it has its own employer identification number (EIN). A stand-alone dental plan issuer that shares an EIN with another entity will be considered a Dual Product Issuer.

When seeking certification for their stand-alone dental plans, Dual Product Issuers will need to reopen the QHP applications that they previously submitted. Information can be added to those existing QHP applications for stand-alone dental plans; however, none of the QHP information on an existing QHP application should be changed**.**

Throughout this appendix you will find that data fields have been *italicized* and data entries, buttons, and ribbon names have been **bolded**.

Purpose

This appendix will guide you through completing the QHP application for a stand-alone dental plan.

Application Instructions

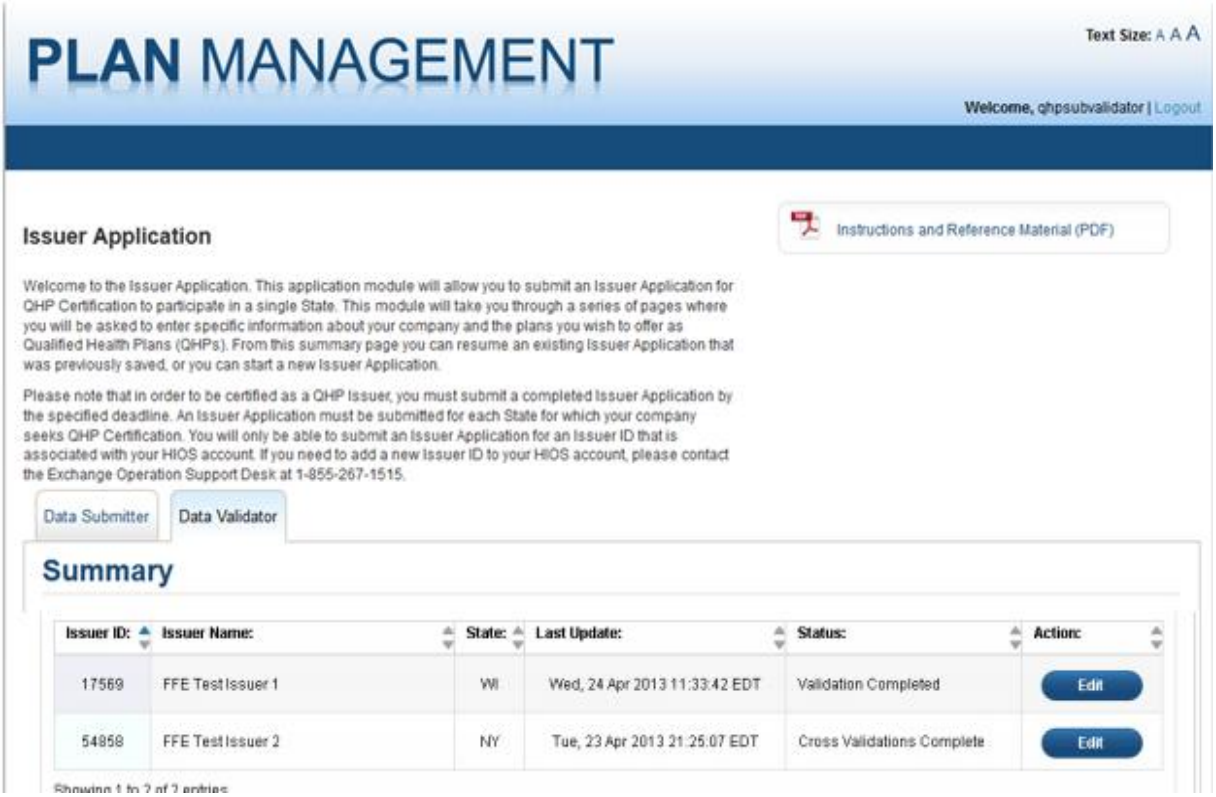
Dental Only Issuers and Dual Product Issuers should use the QHP Application system to complete the relevant application sections and templates. To initiate your application process for a stand-alone dental plan, you may start using the QHP Application system before the official submission window opens; however, an application for a stand-alone dental plan cannot be submitted until May 20, 2013. Applications must be completed by June 5, 2013.

If you are a Dental Only Issuer, please proceed through the QHP Application system as instructed, beginning at the Issuer Module section.

If you are a Dual Product Issuer that has previously submitted a QHP application and would now like to submit additional information for the certification of a stand-alone dental plan, you must return to the Data Validator Review page in each application module you wish to modify by following these steps:

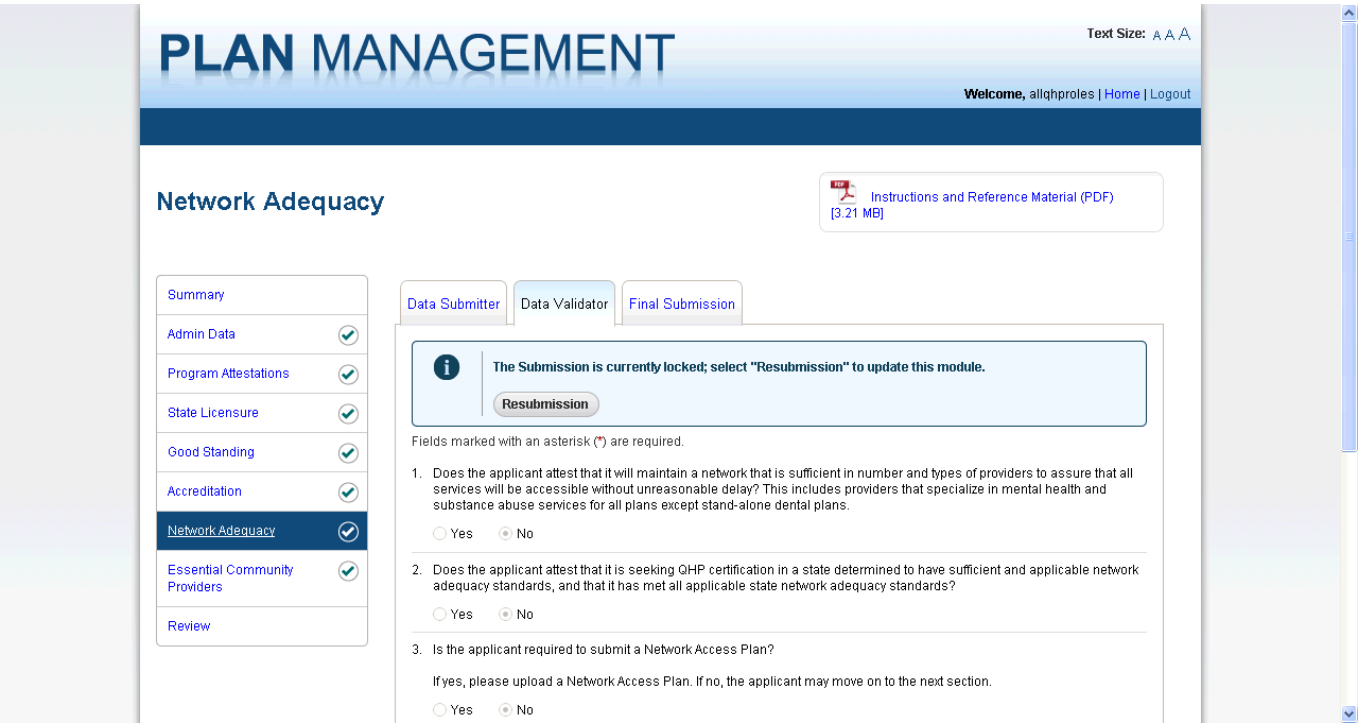
1. In the Issuer Module, select the application you wish to modify by clicking on its corresponding **Edit** button (see Figure C-1).

Figure C-1. Resubmission for Issuer Module



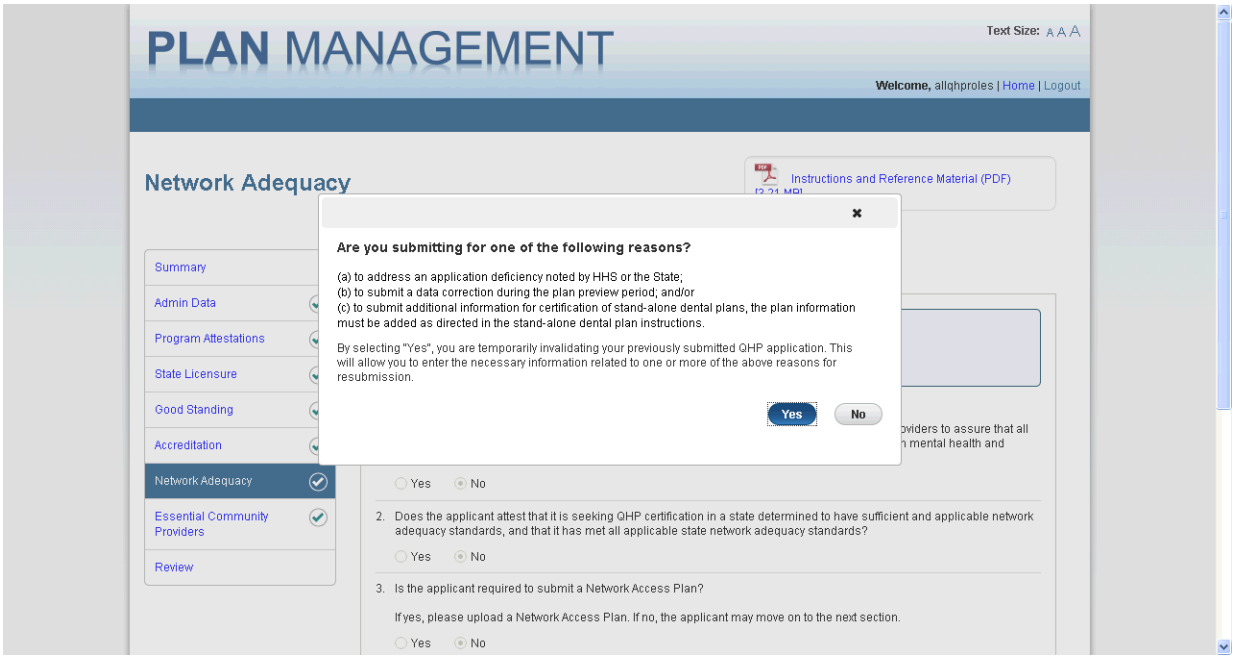
2. Click on the **Resubmission** button (see Figure C-2).

Figure C-2. Resubmission Button for Issuer Module



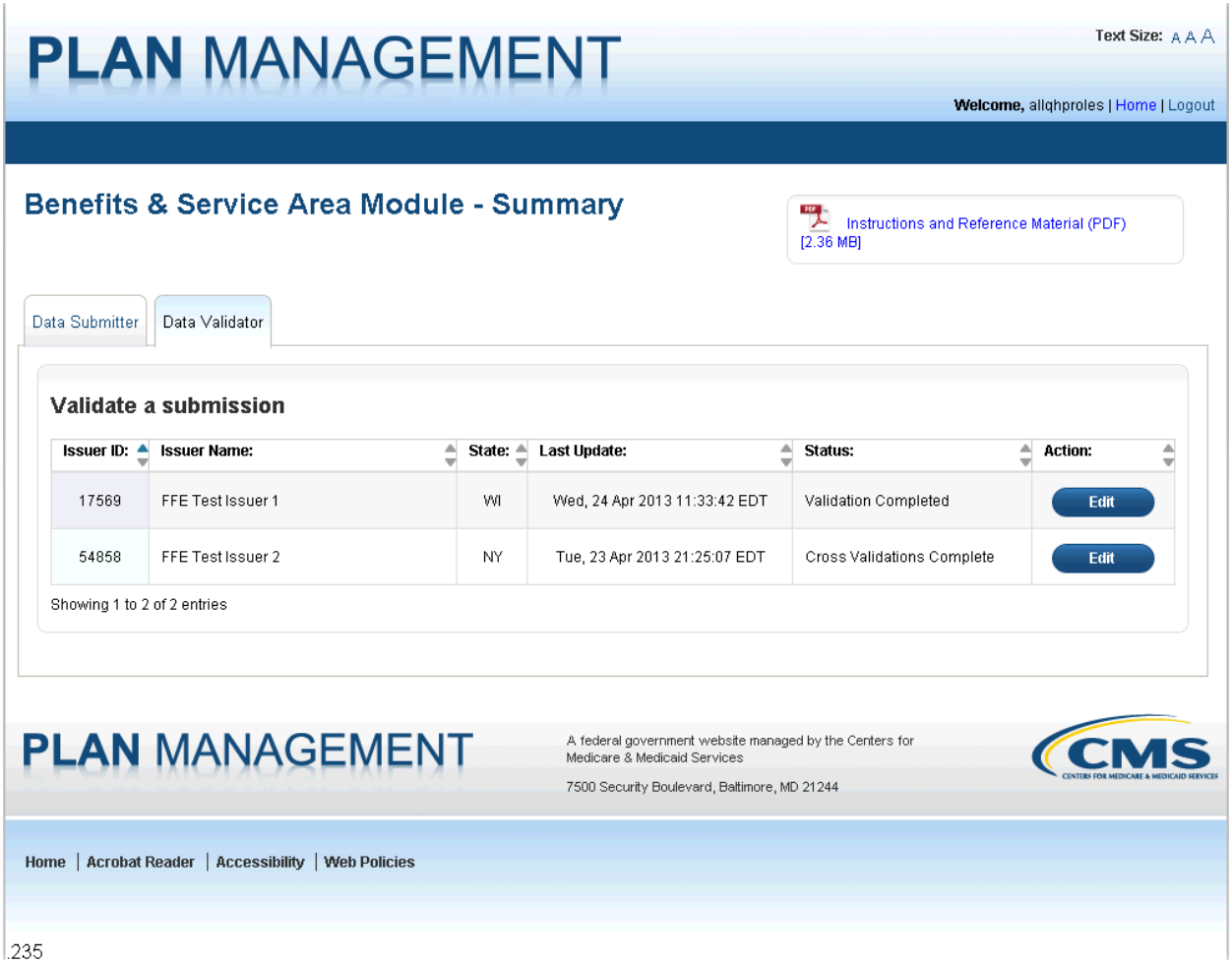
3. After selecting the **Resubmission** button, review the confirmation pop-up screen (see Figure C-3). Select **Yes** to indicate that you are temporarily invalidating your previously submitted QHP application and wish to submit additional information for certification of stand-alone dental plans. Select **No** if you do not want to make any changes to your application; this will close the confirmation pop-up screen and return you to the previous screen.

Figure C-3. Resubmission Confirmation Pop-Up Screen for Issuer Module



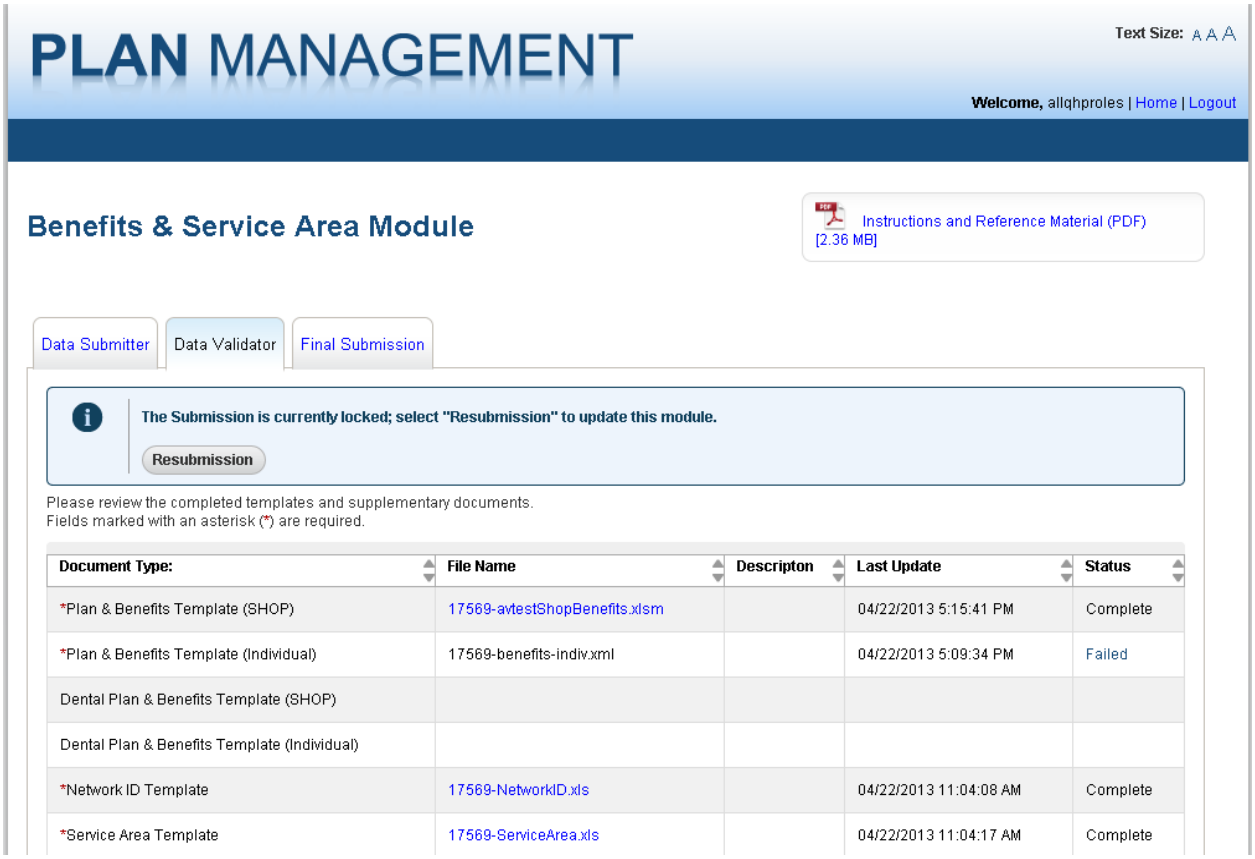
4. In the Benefits & Service Area Module, select the application you wish to modify by clicking on the corresponding **Edit** button (see Figure C-4).

Figure C-4. Resubmission for Benefits & Service Area Module



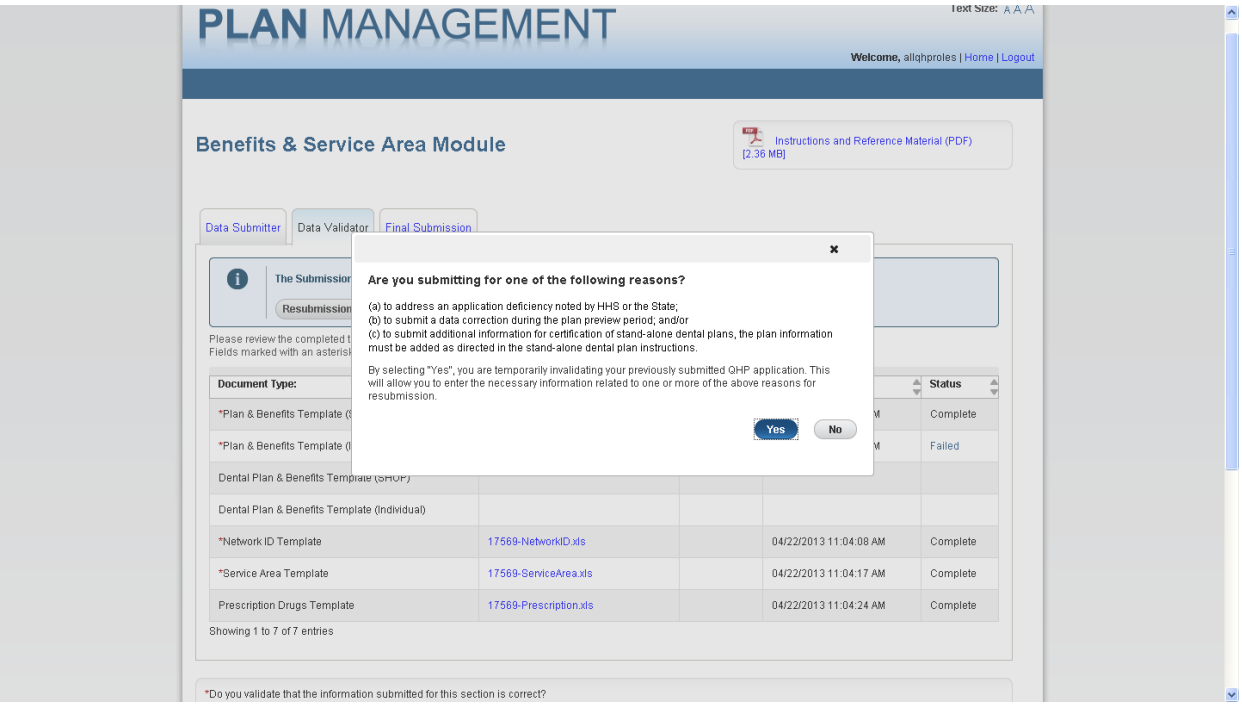
5. Click on the **Resubmission** button on the next screen (see Figure C-5).

Figure C-5. Resubmission Button for Benefits & Service Area Module



6. After selecting the **Resubmission** button, review the confirmation pop-up screen (see Figure C-6). Select **Yes** to indicate that you are temporarily invalidating your previously submitted QHP application and wish to submit additional information for certification of stand-alone dental plans. Select **No** if you do not want to make any changes to your application; this will close the confirmation pop-up screen and return you to the previous screen.

Figure C-6. Resubmission Confirmation Screen for Benefits & Service Area Module



7. Go to the Data Submitter summary screen and click the **Resume** button on the submission to update your application.

8. Please note that any changes you make to your QHP application will not be accepted unless they are related to the following reasons:

   - To address an application deficiency noted by HHS or the State.
   - To submit a data correction during the plan preview period.
   - To submit additional information for certification of stand-alone dental plans.

Figure C-7 lists some key points to keep in mind when completing the application for your stand-alone dental plan.

Figure C-7. Stand-Alone Dental Plan Section Highlights

- Dual Product Issuers should note the following:
  - You must return to the Data Validator Review or Summary page in each application module to begin your application for stand-alone dental plans.
  - You must use the same Administrative, ECP, and Service Area templates previously submitted with your QHP application to add information for stand-alone dental plans. Only one of each of these templates is allowed per issuer.
  - You may only upload one supporting document for each of the state licensure, good standing, program attestations, and network adequacy sections. Please combine all supporting documents in these sections for both QHPs and stand-alone dental plans into a single document.
- Dental Only Issuers and Dual Product Issuers must respond to all program attestation groupings:
  - A Dental Only Issuer or Dual Product Issuer seeking to attest **Yes** to each individual attestation in a grouping should respond by clicking **Yes** for the entire grouping.
    - If you do not participate in the SHOP market, select **Yes** to attest that you offer no SHOP plans.
  - A Dental Only Issuer or Dual Product Issuer seeking to respond **No** to one or more of the individual attestations in a grouping should respond by clicking **No** for the entire grouping. If you select **No** to any grouping, you must submit a Statement of Detailed Attestation Responses. Justifications for specific attestations will be accepted if the issuer answers **No**. If you click **No** and submit a Statement of Detailed Attestation Responses:
    - Save the document using the following naming convention: [Issuer ID] [Title of Document] (for example: "12345_Statement of Detailed Attestation Responses.doc").
    - Upload the document by clicking on the **Other** upload option in the Benefits & Service Area Module of the QHP Application system.
- Dental Only Issuers and Dual Product Issuers are not required to be accredited.
- You must save the Plans & Benefits Add-in file in the same folder as the Plans & Benefits template for the macros to run properly.
- The Network and Service Area templates must have already been completed and saved to your computer before filling out the Plans & Benefits template.
- If you are a registered HIOS user, you may find certain fields in your template have already been populated; these prepopulated fields cannot be changed.
- To complete the Plans & Benefits section of the QHP application, you must complete a Benefits Package for each separate benefits package you wish to offer and a row in an associated Cost Share Variances worksheet for each plan and variation you wish to offer.

Figure C-7. Stand-Alone Dental Plan Section Highlights (continued)

- If you want to create additional benefits packages, click the **Create New Benefits Package** button on the menu bar under the **Plans & Benefits** ribbon. The *HIOS Issuer ID*, *Issuer State*, *Market Coverage*, *Dental Only Plan*, and *TIN* fields will be auto populated.
- The Dental macro in the Plans & Benefits template will restrict data entry to dental specific benefits, will redefine *Level of Coverage* as **High** or **Low** (from metal levels plus catastrophic for QHPs), and will prevent the integration of medical and drug out of pocket maximums and deductibles.
- Dental Only Issuers and Dual Product Issuers wishing to offer plans off the Exchange but have them Exchange certified may do so by selecting **Off Exchange** for *QHP/Non-QHP*.

The following are instructions for Dental Only Issuers and Dual Product Issuers completing a stand-alone dental plan application.

Issuer Module

Administrative Section

Dental Only Issuers and Dual Product Issuers must provide information about the insurance company and any holding company associated with the issuer submitting an application, including contact information. Dental Only Issuers and Dual Product Issuers should complete the Administrative template as instructed in Chapter 1, Instructions for the Administrative Application Section.

If you are Dual Product Issuer, you must complete only one Administrative template for your proposed QHPs and stand-alone dental plans. When resubmitting, you must update the previously submitted Administrative template to include the applicable stand-alone dental plan information. However, no QHP information should be changed**.**

Please note that the *pharmacy benefit manager* and *reinsurance contact* data elements are not applicable to stand-alone dental plans; these are optional data elements in the Administrative template.

Program Attestations Section

Dental Only Issuers and Dual Product Issuers must attest to their compliance with FFE standards as well as their adherence to the programmatic requirements necessary for FFE operational success. Initially in the electronic QHP Application system, Dental Only Issuers and Dual Product Issuers must respond to all attestation groupings as identified by the attestation headings (such as General Issuer Attestations), not to each individual attestation. A Dental Only Issuer or Dual Product Issuer seeking to attest **Yes** to each individual attestation in a grouping should respond by clicking **Yes** for the entire grouping. A Dental Only Issuer or Dual Product Issuer seeking to respond **No** to one or more of the individual attestations in a grouping should respond by clicking **No** for the entire grouping.

If a Dental Only Issuer or Dual Product Issuer responds by clicking **No** to one or more groupings of attestations, the applicant must complete a single Statement of Detailed Attestation Responses

document available at https://zone.cms.gov/ and http://www.Regtap.info, to detail how it is responding to each of the individual attestations in each grouping. CMS will consider a **No** response to certain attestations to be acceptable and will give issuers the opportunity to submit a statement and justification to support the response. Once all attestation responses have been addressed in the Statement of Detailed Attestation Responses, save the document using the title of the document (Statement of Detailed Attestation Responses) and associated issuer ID (to the extent possible). The Dental Only Issuer or Dual Product Issuer must upload the Statement of Detailed Attestation Responses into the **Other** file upload in the Benefits & Service Area Module of the HIOS QHP Application system.

Attestations are worded to be generally applicable to help accommodate stand-alone dental plans and allow the applicant to attest **Yes** but not be held to the specific attestation if it is not feasible for that Dental Only Issuer or Dual Product Issuer. The following attestation is an example of when this may occur:

1. "Applicant attests that it will approve of the use of the following information for display on the FFE Web site for consumer education purposes: information on rates and premiums, information on benefits, the provider network URL(s) provided in this application, the URL(s) for the summary of benefits and coverage provided in this application, the URL(s) for payment provided by this application, information on whether the issuer is a Medicaid managed care organization, and quality information, as applicable, derived from the accreditation survey, including accreditation status and CAHPS data. "

    a. The applicant should attest **Yes** to the attestation, which CMS will interpret to mean that the Dental Only Issuer or Dual Product Issuer will approve information that has been collected for the FFE website (e.g., information on benefits); however, since stand-alone dental plans are not subject to accreditation, the attestation itself does not require accreditation information to be provided by a Dental Only Issuer or Dual Product Issuer.

A separate compliance plan and organizational chart may be uploaded for stand-alone dental plans.

Please refer to Chapter 2, Instructions for the Program Attestations Application Section, for more information about completing this application section.

State Licensure Section

Dental Only Issuers and Dual Product Issuers must indicate their licensure status and provide documentation that they satisfy licensure requirements for the applicable QHP markets, service areas, and plans. If a Dental Only Issuer or Dual Product Issuer is not yet licensed and is therefore unable to provide licensure documentation during the initial application submission, that issuer must submit evidence of licensure during the QHP application resubmission window.

A separate dental license may be uploaded for stand-alone dental plans.

Please refer to Chapter 3, Instructions for the State Licensure Application Section, for more information about completing this application section.

Good Standing Section

Dental Only Issuers and Dual Product Issuers must demonstrate compliance with all applicable state solvency requirements and if applicable, identify any corrective action related to financial review. If a Dental Only Issuer or Dual Product Issuer is not compliant with the state solvency requirements or is under corrective action related to financial review, it must provide supporting documentation and supply a justification.

Separate good standing documents may be uploaded for stand-alone dental plans.

Please refer to Chapter 4, Instructions for the Good Standing Application Section, for more information about completing this application section.

Accreditation Section

Dental Only Issuers and Dual Product Issuers are not required to be accredited for their stand-alone dental plans. Dental Only Issuers should select **No** to the question *"Are any of the health plans you are currently offering in the commercial and/or Medicaid market in this State accredited by NCQA and/or URAC?"*, review the Accreditation Terms and Conditions and check the attestation box to submit the Accreditation section and continue to the next section of the QHP application. Dual Product Issuers should not change their previously submitted accreditation responses for QHPs and are not required to complete this section for their stand-alone dental plans.

Please refer to Chapter 5, Instructions for the Accreditation Application Section, for more information.

Network Adequacy Section

Dental Only Issuers and Dual Product Issuers should submit a Network Access Plan and cover sheet for their stand-alone dental plans (tier 3). Dual Product Issuers that fall into tier 1 or tier 2 for their QHPs should upload their Network Access Plan and cover sheet for their stand-alone dental plans into the **Other** file upload in the Benefits & Service Area Module of the HIOS QHP Application system. Dual Product Issuers that fall into tier 3 for QHPs can upload a separate Network Access Plan and cover sheet for their stand-alone dental plans.

The cover sheet is available at http://cciio.cms.gov/programs/exchanges/qhp.html.

Please complete the following elements on the Network Access Plan cover sheet:

- Standards for network composition (references to mental health and substance abuse providers do not apply to stand-alone dental plans)
- Ongoing monitoring process
- Plan for addressing needs of special populations
- Member communication methods

- Continuity of care plan (in the event of provider contract termination or corporate insolvency).

Any remaining elements on the cover sheet do not apply to stand-alone dental plans.

Please refer to Chapter 6, Instructions for the Network Adequacy Application section, for more information.

Essential Community Provider Section

Dental Only Issuers and Dual Product Issuers are required to have a sufficient number and geographic distribution of essential community providers (ECPs), where available. Dental Only Issuers and Dual Product Issuers should refer to the non exhaustive HHS-provided list of ECPs (generally FQHCs) that provide dental services, which is located at http://cciio.cms.gov/programs/exchanges/qhp.html, to identify the ECPs in each of their networks or should write-in other providers that meet the definition of an ECP.

Dual Product Issuers should complete the ECP template with medical and dental providers for each network—it is not necessary to distinguish between them. The percentage thresholds will apply at the network level, not the provider level. When resubmitting, you must update the previously submitted ECP template to include applicable stand-alone dental plan information. However, no QHP information should be changed; Dual Product Issuers should have already responded to the ECP question indicating whether a supplemental response form is required**.** If the issuer does not meet the percentage thresholds for a dental-only network, the issuer can submit a supplemental ECP response form into the **Other** file upload in the Benefits & Service Area Module of the HIOS QHP Application system. A blank supplemental response form is available at http://cciio.cms.gov/programs/exchanges/qhp.html.

Dental Only Issuers should respond to the ECP question indicating whether a supplemental response form is required and include dental providers in the ECP template for their networks. The percentage thresholds will apply at the network level and only to the dental providers in this case. As with other networks, if the issuer does not meet the percentage thresholds for a dental-only network, the issuer can submit a supplemental ECP response form describing why the issuer is unable to meet the threshold. A blank supplemental response form is available at http://cciio.cms.gov/programs/exchanges/qhp.html. The supplemental response form should indicate that the network is dental-only for a Dental Only Issuer.

Please refer to Chapter 7, Instructions for the ECP Application Section, for more information.

Benefits & Service Area Module

Service Area

Dental Only Issuers and Dual Product Issuers are required to identify proposed service areas by state and county in the Service Area template. In almost all situations, HHS will only approve service areas covering full counties. In the rare case when the issuer is requesting to cover a service area containing a partial county, the issuer must provide the included ZIP codes, a justification for why the entire county will not be served, and a detailed description that illustrates why the request is not discriminatory. If you plan to serve a partial county, you are

required to submit a detailed justification with your QHP application. In the template justification box, enter the justification document file name, using the following naming convention: [Issuer ID] [Service Area ID] [County Name] (for example: "12345_MDS001_Montgomery.doc"). Upload the justification document using the **Other** upload option in the Benefits & Service Area Module of the QHP Application system. Issuers can also indicate statewide coverage in the template.

If you are Dual Product Issuer, you must complete only one Service Area template for your proposed QHPs and stand-alone dental plans. When resubmitting, you must update the previously submitted Service Area template to include applicable stand-alone dental plan information. However, no QHP information should be changed**.**

Please refer to Chapter 9, Instructions for the Service Area Application Section, for more information.

Plans & Benefits

In this section of the application, issuers are asked to supply information for each dental plan, including plan identifiers, attributes, dates, geographic coverage, URLs, benefit information, and cost sharing information. Dental Only Issuers and Dual Product Issuers should complete the Plans & Benefits template. This template will be customized for stand-alone dental plans by activating the Dental macro. To activate the Dental macro select **Yes** for *Dental Only Plan*.

The Plans & Benefits template contains two worksheets (tabs). The first worksheet is the "Benefits Package," which includes high-level information regarding the plans as well as a list of benefits with any quantitative limits or exclusions. All plans defined in a Benefits Package will share the same set of benefits and limits but will differ in cost sharing.

The second worksheet is the "Cost Share Variances" (CSR). The CSR tab allows you to provide Deductibles and Maximum Out of Pocket information for In/Out/Combined Networks, for both Individual and Family, as well as In/Out/Combined Network Copays and Coinsurances. This information must be for each plan.

Before using this template, you must enable macros in Microsoft Excel. Enable template macros by using the **Options** button on the Security Warning toolbar and then by selecting "Enable this content." If macros are not enabled prior to entering data, the template will not recognize your data and you will have to reenter the template information.

Plans & Benefits Data Requirements

To complete this section you will need the following:

1. Health Insurance Oversight System (HIOS) generated Issuer ID
2. Tax Identification Number (TIN)
3. HIOS generated Product ID
4. HIOS generated Plan ID

5. Plan Marketing Name

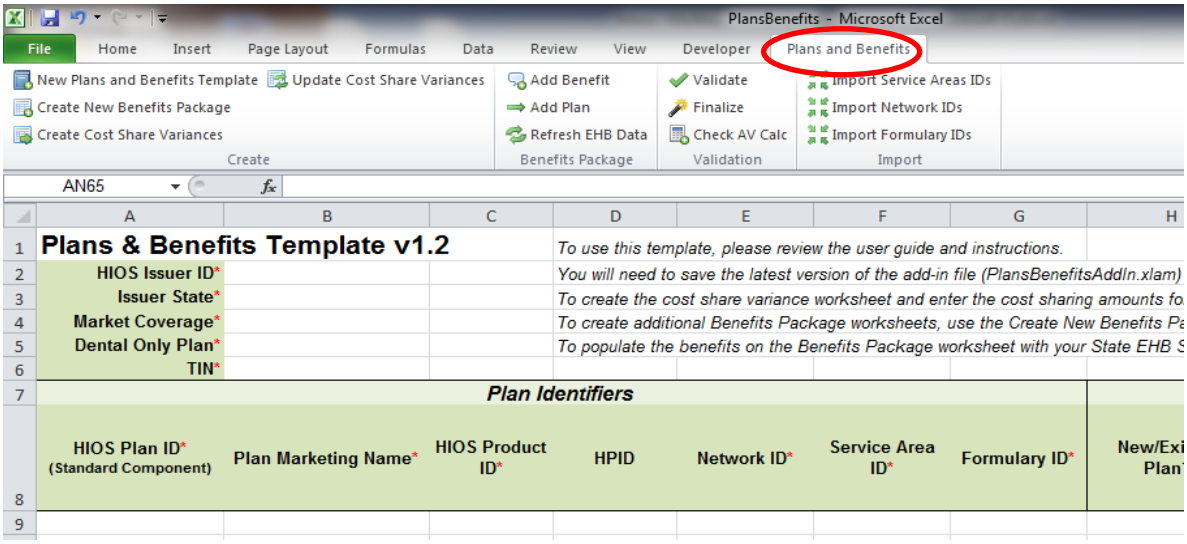
6. Plan Type

7. Benefits packages and cost sharing information.

Plans & Benefits Template Instructions

Complete the downloaded Plans & Benefits template (see Figure C-8) from HIOS using the following instructions, to provide information on each health plan you wish to submit. The instructions follow the same order as the elements in the template. Enter information using the drop-down menus when available.

Figure C-8. Plans and Benefits Ribbon and Plans & Benefits Template



NOTE: You must save the Plans & Benefits Add-in file in the same folder as the Plans & Benefits template in order for the macros to run properly. To ensure proper functionality, please download the latest add-in file and delete any older versions.

Important: The Network and Service Area templates must have already been completed before filling out the Plans & Benefits template. (Instructions for the Service Area section are above.)

For Dental Only Issuers, please refer to Chapter 8, Instructions for Network Identification Application Section, for more information on the Network template. For Dual Product Issuers, add any dental-only networks to your existing Network template and upload it again.

By activating the Dental macro, many fields in the Plans & Benefits template will be unavailable for data entry. The following instructions only address fields that should be completed as part of a stand-alone dental plan submission.

General Information

1. *HIOS Issuer ID* (required): Enter the five-digit HIOS-generated issuer identification number.

2. *Issuer State* (required): Select the state in which you are licensed to offer this plan using the drop-down menu.

3. *Market Coverage* (required): Select the market coverage. Choose from the following:

    a. **Individual**—if the plan is offered on the individual market.

    b. **Small Group**—if the plan is offered on the small group market.

4. *Dental Plan Only* (required): **Yes** must be selected for SADPs.

5. *TIN* (required): Enter the issuer's nine-digit TIN.

Plan Identifiers

Complete the following for each plan you want to create for this benefits package. A benefits package is a group of plans that cover the same set of benefits. Each plan can have different cost sharing, which is defined in the Cost Share Variances tab. If you run out of empty rows for new plans, click the **Add Plan** button on the menu bar under the **Plans and Benefits** ribbon and a new row will appear for an additional plan.

1. *HIOS Plan ID (Standard Component)* (required): Enter the 14-character HIOS-generated plan identification number.

2. *Plan Marketing Name* (required): Enter the plan marketing name. The plan name should be at the plan level.

3. *HIOS Product ID* (required): Enter the 10-character HIOS-generated product identification number.

4. *HPID* (optional): Enter the 10-digit National Health Plan Identifier.

5. *Network ID* (required): Click the **Import Network IDs** button on the menu bar under the **Plans and Benefits** ribbon and select the appropriate Excel file to import a list of values from the Network template, and select one from the drop-down menu. (You must have completed the Network template before importing the Network IDs.)

6. *Service Area ID* (required): Click the **Import Service Area IDs** button on the menu bar under the **Plans and Benefits** ribbon and select the appropriate Excel file to import a list of values from the Service Area template, and select one from the drop-down menu. (You must have completed the Service Area template before importing the Service Area IDs.)

Plan Attributes

1. *New/Existing Plan?* (required): Indicate whether this is a new or existing plan. Choose from the following options:

    a. **New**—if this is a new plan. A new plan is a set of benefits and cost sharing linked to a form filing that has been newly approved or is under review by a state and is being reported to the federal government for the first time.

b. **Existing**—if this plan currently has enrollment.

2. *Plan Type* (required): Select the plan type. Choose from the following options:

   a. **Indemnity**

   b. **PPO** (preferred provider organization)

   c. **HMO** (health maintenance organization)

   d. **POS** (point of service)

   e. **EPO** (exclusive provider organization).

3. *Level of Coverage* (required): Select the level of coverage of the plan based on its actuarial value (AV). A de minimis variation of +/-2 percentage points is allowed. This actuarial value should be calculated based on the portion of the pediatric dental benefits that are EHB:

   a. **High**—AV of 85 percent

   b. **Low**—AV of 70 percent.

4. *QHP/Non-QHP* (required): Indicate whether the plan is offered on the Exchange, off the Exchange, or both. Choose from the following options:

   a. **On Exchange**—if the plan will be offered on the Exchange.

   b. **Off Exchange**—if the plan will be offered off the Exchange.[1]

   c. **Both**—if the plan will be offered both on and off the Exchange.

5. *Plan Level Exclusions* (optional): Enter any plan exclusions.

6. *Child-Only Offering* (required): Choose from the following options:

   a. **Allows Adult and Child-Only**—if the plan allows Child-Only enrollment.

   b. **Allows Adult-Only**—N/A for stand-alone dental; do not select this option.

   c. **Allows Child-Only**—this if the plan is Child-Only.

Stand-Alone Dental Only

1. *EHB Apportionment for Pediatric Dental*. Enter the dollar amount of the expected premium allocated for the pediatric dental EHB. This amount will be used in calculations

[1] Select **Off Exchange** if you are seeking Exchange certification but will only be offering coverage outside of the Exchange. If you select this option, you are indicating that your plan will not be sold on the Exchange.

for advance payments of the premium tax credit. This amount may not be changed after certification, even if the rate is estimated.

2. *Guaranteed vs. Estimated Rate*. This indicates if the rate for this stand-alone dental plan is a guaranteed rate or an estimated rate. The rates that a consumer sees are calculated by CMS using the rate tables and the Business Rules template. By indicating that the rate is a "guaranteed rate," the issuer is committing to charging the premium shown to the consumer on the website, which has been calculated by taking into account consumers' geographic location, age, and other permissible rating factors provided for in the rate tables and Rating Business Rules template. Estimated rates will require enrollees to contact the issuer to calculate a final rate. Signifying a guaranteed rate means that the issuer agrees to charge only the rate reported.

   Select if this plan offers guaranteed or estimated rates:

   a. **Guaranteed Rate**—if the plan offers a guaranteed rate.

   b. **Estimated Rate**—if the plan offers an estimated rate.

Plan Dates

1. *Plan Effective Date* (required): Enter the effective date of the plan, using the mm/dd/yyyy format. It must be January 1—that is, 01/01/xxxx—for individual markets and SHOP markets.

2. *Plan Expiration Date* (optional): Enter the date that a plan becomes expired and no longer accepts new enrollments, using the mm/dd/yyyy format. It must be December 31—that is, 12/31/xxxx— for individual markets.

Geographic Coverage

1. *Out of Country Coverage* (required): Indicate whether care obtained outside the country is covered under the plan. Choose from the following options:

   a. **Yes**—Select this if the plan covers care obtained out of the country.

   b. **No**—Select this if the plan does not cover care obtained out of the country.

2. *Out of Country Coverage Description* (required if you answered **Yes** to *Out of Country Coverage*): Enter a short description of whether care obtained outside the country is covered under the plan.

3. *Out of Service Area Coverage* (required): Indicate whether care obtained outside the service area is covered under the plan. Choose from the following options:

   a. **Yes**—Select this if the plan covers care obtained outside the plan service area.

   b. **No**—Select this if the plan does <u>not</u> cover care obtained outside the plan service area.

4. *Out of Service Area Coverage Description* (required if you answered **Yes** to *Out of Service Area Coverage*): Enter a short description of whether care obtained outside the service area is covered under the plan.

5. *National Network* (required): Indicate whether a national network is available. Choose from the following options:

    a. **Yes**—Select this if a national network is available.

    b. **No**—Select this if a national network is <u>not</u> available.

URLs

1. *URL for Summary of Benefits & Coverage* (optional): Enter the website location for the Summary of Benefits and Coverage.

2. *URL for Enrollment Payment* (optional): Enter the website location for enrollment payment information.

3. *Plan Brochure* (optional): Enter the website location for the plan brochure.

Benefit Information

After the information above has been entered, click the **Refresh EHB Data** button on the menu bar under the **Plans and Benefits** ribbon. Scroll down the worksheet to the Benefit Information section (see Figure C-9). The following fields auto populate:

- *EHB*
- *State Mandate*
- *Is this Benefit Covered?*
- *Quantitative Limit on Service*
- *Limit Quantity*
- *Limit Unit*
- *Explanation*.

Figure C-9. Benefit Information and General Sections

Benefit Information			General Information							
Benefits	EHB	State Mandate	Is this Benefit Covered?	Quantitative Limit on Service	Limit Quantity	Limit Unit	Minimum Stay	Exclusions	Explanation (text field)	EHB Variance Reason
Routine Dental Services (Adult)			Covered	Yes	1	Visit(s) per 6 Months				Above EHB
Dental Check-Up for Children	Yes		Covered	Yes	1	Visit(s) per 6 Months				
Basic Dental Care – Child	Yes		Covered							
Orthodontia – Child	Yes		Covered							
Major Dental Care – Child	Yes		Covered							
Basic Dental Care – Adult			Covered							Above EHB
Orthodontia – Adult			Not Covered							
Major Dental Care – Adult			Covered							Above EHB

Only the following benefits will be available for Dental Only Issuers and Dual Product Issuers to enter coverage information:

- Routine Dental Services (Adult)
- Dental Check-Up for Children
- Basic Dental Care—Child
- Major Dental Care—Child
- Orthodontia—Child
- Basic Dental Care—Adult
- Orthodontia—Adult
- Major Dental Care—Adult.

If you need to enter information on a benefit that is not part of this list, see the section on how to add a benefit, which follows shortly in this appendix.

If you click the **Refresh EHB Data** button after filling out the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections, the default values will return and all inputs, including any added benefits, will be deleted.

1. *EHB* (required): This field will be prepopulated for all benefits listed in the template according to the state EHB benchmark. Users cannot edit this field.

2. *State Mandates* (required): This field will be auto populated if a particular state and market has a state mandate for that benefit for at least one type of plan. For example, in the small group market, there may be a state mandate that applies only to a PPO with more than five enrollees. To determine whether this benefit needs to be covered, you should refer to the list of state mandates (http://www.cciio.cms.gov/resources/data/ehb.html) for your state. Users cannot edit this field.

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

a. Look through the drop-down menu to see whether the benefit already exists, and select it if it does. If the benefit is not listed in the drop-down menu, click the **Custom** button and type in the name of the benefit. The benefit name you type in may not be identical to any of the benefit names in the drop-down menu.

b. A row for this benefit will then appear below the last row in the Benefit Information section.

c. If you mistakenly add a benefit, that benefit name cannot be deleted, but you can do one of the following as a work around:

   i. You may select **Not Covered** under the *Is this Benefit Covered?* field (described below).

   ii. You may click the **Refresh EHB Data** button on the menu bar under the **Plans and Benefits** ribbon. This will delete the added benefit, but you will also lose any other data you have entered in the Benefit Information, General Information, or Deductible and Out of Pocket Exceptions sections.

d. If the benefit added is not an EHB found in the state's benchmark, and the benefit is not being used to substitute an EHB found in the state's benchmark, select **Above EHB** as the *EHB Variance Reason*.

e. If the benefit added is not an EHB found in the state's benchmark, and the benefit is being used to substitute an EHB found in the state's benchmark, select **Additional EHB Benefit** as the *EHB Variance Reason*.

f. If the benefit added is a state mandate enacted after December 2011, select **Above EHB** as the *EHB Variance Reason*.

g. A benefits package should not have duplicate benefit names.

General Information

1. *Is this Benefit Covered?* (required). This field will be auto populated for benefits identified in the template as **Covered** for an EHB or a State Mandate. If this data element is changed to **Not Covered** for an EHB, then you must substitute another benefit or combination of benefits in its place and must include the EHB-Substituted Benefit (Actuarial Equivalent) Supporting Documentation and Justification document to support the actuarial equivalence of the substitution. (Reference the list of *EHB Variance Reason* data fields in number 7 below, and see Chapter 13, Justification, for more details.) If a benefit is **Not Covered**, the rest of the fields for this benefit may be left blank. Choose from the following options:

   a. **Covered**—if this benefit is covered by the plan. A benefit is considered covered if the issuer covers the cost of the benefit listed in a policy either through first-dollar

coverage or in combination with a cost-sharing mechanism (for example, copays, coinsurance, or deductibles).

b. **Not Covered**—if this benefit is not covered by the plan. A benefit is considered not covered if the subscriber is required to pay the full cost of the services with no effect on deductible and MOOP limits.

c. If a benefit is changed to **Not Covered** for a State Mandate that is not applicable to the benefits package, choose the appropriate *EHB Variance Reason* from the list in number 7 below.

d. If a benefit is changed to **Not Covered** due to a law or regulation, such as Adult Dental, choose the appropriate *EHB Variance Reason* from the list in number 7 below.

2. *Quantitative Limit on Service* (required if **Covered** has been entered in the *Is this Benefit Covered?* field): This field is auto populated for benefits identified in the template as EHBs. If this data element is changed, you must provide an EHB Variance Reason and associated supporting documents. For any benefits not identified as EHBs, choose from the following:

   a. **Yes**—Select this option if this benefit has quantitative limits.

   b. **No**—Select this option if this benefit does not have quantitative limits.

3. *Limit Quantity* (required if **Yes** has been entered in the *Quantitative Limit on Service?* field): This field is auto populated for benefits in the template identified as EHBs. If this data element is changed, you must provide an EHB Variance Reason and associated supporting documents. For any benefits not identified as EHBs, enter a numerical value showing the quantitative limits placed on this benefit. (For example, if you have a limit of two Dental Check-Ups for Children per year, enter 2 here.)

4. *Limit Unit* (required if **Yes** has been entered in the *Quantitative Limit on Service?* field): This field is auto populated for benefits in the template identified as EHBs. If this data element is changed, you must select the *EHB Variance Reason* **Substantially Equal**. For any benefits not identified as EHBs, use the drop-down menus to enter the units being restricted per interval to show the quantitative limits you place on this benefit. (For example, if you have a limit of two Dental Check-Ups for Children per year, enter **Visits per year** here.) Choose from the following drop-down menu options:

   a. **Hours per week**

   b. **Hours per month**

   c. **Hours per year**

   d. **Days per week**

e. **Days per month**

f. **Days per year**

g. **Months per year**

h. **Visits per week**

i. **Visits per month**

j. **Visits per year**

k. **Lifetime visits**

l. **Treatments per week**

m. **Treatments per month**

n. **Lifetime treatments**

o. **Lifetime admissions**

p. **Procedures per week**

q. **Procedures per month**

r. **Procedures per year**

s. **Lifetime procedures**

t. **Dollars per year**

u. **Dollars per visit**

v. **Days per admission**

w. **Procedures per episode**.

5. *Exclusions* (optional): Enter in this field any benefit level exclusions:

   a. If particular services or diagnoses are subject to exclusions (that is covered under some circumstances but not others), list those specific exclusions.

   b. If no services or diagnoses are excluded, leave this field blank.

6. *Explanation* (optional): Enter any explanations in this field.

7. *EHB Variance Reason* (required if you changed any of the following fields: *Is this Benefit Covered?*, *Limit Units*, *Limit Quantity*, and *Minimum Stay*, or if the benchmark

has an unallowable limit or exclusion under the Affordable Care Act. See the "Guide to Reviewing Essential Health Benefits Benchmark Plans" document on the CCIIO website for more information): Select from the following *EHB Variance Reasons* if this benefit differs from your state's benchmark:

a. **Above EHB**—if this benefit is not an EHB found in the state's benchmark.

b. **Substituted**—if this benefit or combination of benefits is in the state's benchmark and you are substituting a different benefit, you should select **Substituted** as the *EHB Variance Reason* for the original benefit. For an added benefit that is used for substitution, please see the Additional EHB Benefit section.

c. **Substantially Equal**—if this benefit limit is changed and the benefits package is still actuarially equivalent to the state's benchmark.

    i. If the *Limit Quantity* for a benefit is now different from, but still substantially equal to, the benefit in the respective state EHB-benchmark.

    ii. If the *Limit Unit* for a benefit is now different from, but still substantially equal to, the benefit in the respective state EHB-benchmark.

d. **Other Law/Regulation**—if another law or regulation overrides the benefit or quantitative limit in the state's benchmark.

    i. For example, if the benchmark includes adult dental services or adult vision services.

    ii. If a benefit is not in the state benchmark but is a state mandate and the state mandate is not applicable to the benefits package, the *EHB Variance Reason* selected should be **Other Law/Regulation**, and the benefit should be changed to **Not Covered**.

e. **Additional EHB Benefit**—if there is a benefit in the EHB benchmark that is not included in the auto populated list by state, or if the benefit is being substituted for an EHB.

    i. For example, the drug benefits may not be listed as **Covered** in the auto populated table when in fact they are. In this case, you would change the benefit to **Covered** and choose this as the *EHB Variance Reason*.

    ii. If a benefit not in the state's benchmark is being used as a substitute for an EHB benefit that is in the state's benchmark, the *EHB Variance Reason* selected for this new benefit should be **Additional EHB Benefit**, and an attestation should be submitted indicating that the benefit or set of benefits is actuarially equivalent to the reference benefit in the state's EHB-benchmark plan.

f. **Dental Only Plan Available**—Not applicable for stand-alone dental plans. Do not use.

Deductible and Out of Pocket Exceptions

This template section is for indicating whether each benefit is subject to the deductible or excluded from the MOOP. All plans in a benefits package must have the same deductible MOOP structure.

- If the plans only have a combined (no in network) MOOP (or deductible), either all of the plans in a benefits package need to set their in network MOOP (or deductible) to a dollar value, or all the plans need to have their in network MOOP (or deductible) set to **Not Applicable** and have their combined in network/out of network MOOP (or deductible) set to a dollar value.

- Either all of the plans in a benefits package need to have multiple in network tiers, or they all need to use only one tier.

- All of the plans in a benefits package need to exclude the same benefits from the MOOP.

- All of the plans in a benefits package need to subject the same benefits to the deductible.

To create plans with a different deductible or MOOP structure, you must create a new benefits package and subsequently a new Cost Share Variances worksheet.

- If the plans only have a combined (no in network) MOOP, set *Excluded from In Network MOOP* equal to *Excluded from Out of Network MOOP*.

- If the plans only have a combined (no in network) Deductible, set *Subject to Deductible [Tier 1]* equal to *Subject to Deductible [Tier 2]*.

- If the plans do not have multiple in network tiers, set *Subject to Deductible [Tier 2]* equal to *Subject to Deductible [Tier 1]*.

- If *Is this Benefit Covered?* for a benefit is **Not Covered**, leave the *Subject to Deductible [Tier 1]*, *Subject to Deductible [Tier 2]*, *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, set *Excluded from Out of Network MOOP* equal to **Yes**.

In this section you must complete the following fields:

1. *Subject to Deductible [Tier 1]* (required). Indicate whether the benefit is subject to a deductible in network tier 1. Choose from the following:

    a. **Yes**—Select this option if the enrollee is required to pay a deductible for this benefit.

b. **No**—Select this option if the enrollee is not required to pay a deductible for this benefit.

2. *Subject to Deductible [Tier 2]* (required). Indicate whether the benefit is subject to a deductible in network tier 2. Choose from the following:

   a. **Yes**—Select this option if the enrollee is required to pay a deductible for this benefit.

   b. **No**—Select this option if the enrollee is not required to pay a deductible for this benefit.

3. *Excluded from In Network MOOP* (required). Indicate whether the benefit is excluded from the in-network MOOP. Only those benefits not part of the state EHB benchmark can be excluded from the in network MOOP. Choose from the following:

   a. **Yes**—Select this option if this benefit is excluded from the in network MOOP.

   b. **No**—Select this option if this benefit is not excluded from the in network MOOP.

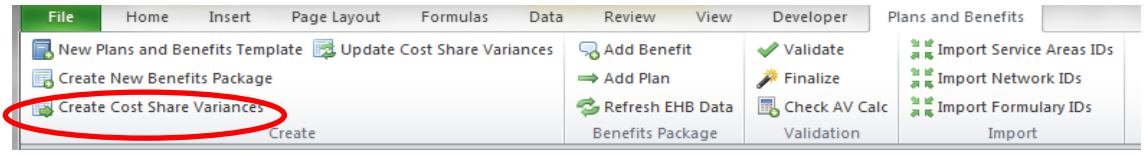
4. *Excluded from Out of Network MOOP* (required). Indicate whether this benefit is excluded from the out-of-network MOOP. Choose from the following:

   a. **Yes**—Select this option if this benefit is excluded from the out-of-network MOOP.

   b. **No**—Select this option if this benefit is not excluded from the out-of-network MOOP.

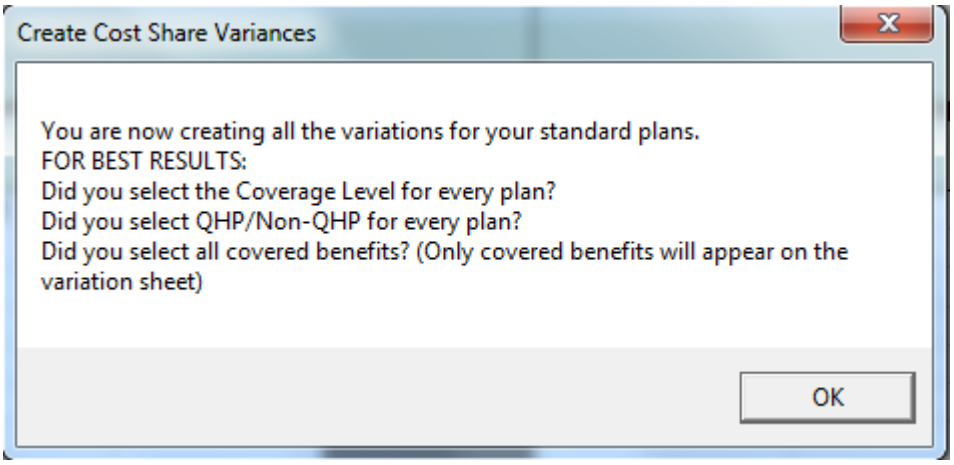
After the benefit-related information has been completed, click the **Create Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon (see Figure C-10). The Cost Share Variances tab is designed to collect more detailed cost sharing benefit design information for all plans submitted by the issuer.

Figure C-10. Create Cost Share Variances Button



Click **OK** after reading the warning (see Figure C-11) and make any of the necessary changes listed in the pop-up box.

Figure C-11. Warning Pop-Up Box



The following questions will pop up regarding deductible subgroups. Deductible subgroups should be used to identify benefits or groupings of benefits with their own deductibles. These deductible subgroups are not separate deductibles outside of any maximums allowed, and they still contribute to the overall MOOP and deductible limits. You are not required to have any deductible subgroups.

1. Do you have any deductible subgroups?

   a. **Yes**—Select this option if the plan contains deductible subgroups.

   b. **No**—Select this option if the plan does not contain deductible subgroups.

2. How many deductible subgroups do you have? Enter the correct number, and click **OK**.

3. What is the name of this deductible subgroup? Enter the name of each subgroup, and click **OK** after each. You must use a different name for each subgroup.

A new worksheet, Cost Share Variances, will be created for each Benefits Package worksheet (see Figure C-12). Corresponding sheets will be labeled with the same number. For example, enter information on Cost Share Variances 2 for benefits on Benefits Package 2. The worksheet contains several auto populated cells; verify that the information in each is accurate.

Figure C-12. Cost Share Variances Worksheet

			Cost Sharing Reduction Information				
HIOS Plan ID* **(Standard Component + Variant)**	**Plan Marketing Name***	**Level of Coverage*** **(Metal Level)**	**CSR Variation Type***	**Issuer Actuarial Value**	**Multiple In Network Tiers?***	**1st Tier Utilization***	**2nd Tier Utilization**
12345VA0019999-00	Sample Dental Plan	High	Standard High Off Exchange Plan				
12345VA0019999-01		High	Standard High On Exchange Plan				

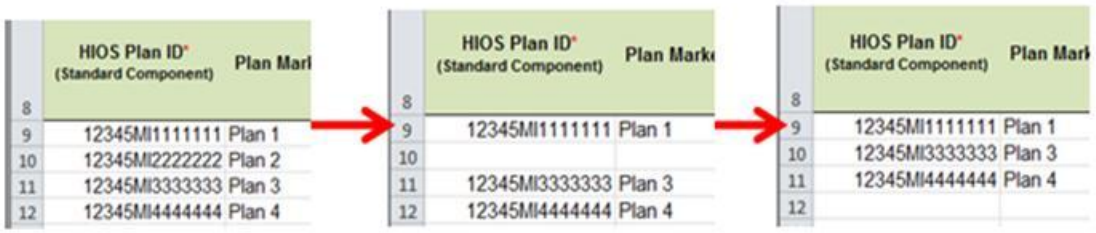
Once the Cost Share Variances tab has been created, you can update it as follows:

- If you add a new plan on the Benefits Package tab, click the **Update Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon. It will add the new plan to the Cost Share Variances worksheet.

- If you need to delete a plan on the Benefits Package tab, you will need to delete all data for that plan's row. If there are any plans below that row, you will need to cut these rows and paste them into the empty row, as illustrated in the example depicted in Figure C-13. This is an important step because if there is an empty row between plans on the worksheet, when **Update Cost Share Variances Plan** is clicked all the plans below this blank row, as well as those plans' corresponding data, will be deleted from the Cost Share Variances tab.

  Example: If you wish to delete Plan 2 (see Figure C-13), follow the following steps and then click the **Update Cost Share Variances Plan** and Plan 2 will be removed from the Cost Share Variances tab.

Figure C-13. Deleting a Plan



- If you change any benefits package data about a specific plan that already exists, the data does not update when you click the **Update Cost Share Variances** button. If you need to update the information for an existing plan, you first need to delete that plan on the Benefits Package worksheet, as explained above, and then click the **Update Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon. All previously entered information for this plan on the Cost Share Variances tab will be deleted. Reenter the plan and its associated data on the Benefits Package tab, and then click the **Update Cost Share Variances** button.

- If you change whether a benefit is **Covered** on the Benefits Package tab it will not update when the **Update Cost Share Variances** button is clicked. Instead, you must delete the entire Cost Share Variances worksheet and then click the **Create Cost Share Variances** button on the menu bar under the **Plans and Benefits** ribbon, and start again.

Cost Sharing Reduction Information

Please note: The Cost Share Variances tab is designed to collect more detailed cost sharing benefit design information for all plans submitted by the user. However, cost sharing reductions are not applicable to Dental Only Issuers or Dual Product Issuers.

1. *HIOS Plan ID [Standard Component + Variant]* (required): The HIOS-generated number that auto populates for each stand-alone dental plan.

2. *Plan Marketing Name* (required): The name of the plan auto populates for plans.

3. *Level of Coverage*: The coverage level for the plan auto populates.

4. *Issuer Actuarial Value* (required): Enter the issuer-calculated actuarial value.

    a. Issuers are required to submit supporting documentation certifying that their actuarial value was developed by a certified member of the American Academy of Actuaries using generally accepted principles and methodologies. See Chapter 13m, "Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification," for a suggested format.

5. *Multiple In Network Tiers?* (required): Indicate whether there are multiple in-network provider tiers. The value must be the same for all variations of a plan. Choose from the following:

    a. **Yes**—Select this option if there are multiple in network provider tiers. Enter your Tier 1 information into *In Network—Family* and *In Network—Individual*.

    b. **No**—Select this option if there are <u>not</u> multiple in network provider tiers. You should not enter information into *In Network (Tier 2)—Family* and *In Network (Tier 2)—Individual*.

6. *1st Tier Utilization* (required): If the answer to *Multiple In Network Tiers?* is **Yes**, enter the 1st Tier Utilization as a percentage here. If the answer to *Multiple In Network Tiers?* is **No**, the field will auto populate to 100%.

MOOP and Deductible Requirements and Guidance

The following contains requirements and guidance for the MOOP and deductible values when completing the MOOP and Deductible template sections described below:

1. When entering the MOOP and Deductible values, ensure the following limits are met:

    a. The MOOP values must be equal to or below the required limits of $700 for individuals and $1,400 for families.

    b. The deductible values must equal to or below the required limits of $2,000 for individuals and $4,000 for families in the small group market. The deductible value may not be higher than the MOOP value.

    c. Please note that for stand-alone dental plans, an individual would be considered one child and a family would be considered two or more children.

    Please note that for stand-alone dental plans an individual would be considered one child and a family would be considered two or more children.

2. When multiple children are taking part in the child-only plans, this is captured in the family fields.

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

    a. If the plan does not have multiple in-network tiers, the following applies:

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

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

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

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

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

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

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

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

    c. To represent a plan with no in-network deductible, enter **$0** in the relevant *In Network* or *In Network Tier 2* fields (Dental EHB). Entering **Not Applicable** in the *In Network* deductible fields implies that in-network service costs accumulate toward the combined In/Out of Network deductible.

Maximum Out of Pocket for Dental EHB Benefits

This template section is for inputting MOOP values for dental EHB benefits. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* MOOP for EHB benefits in the following areas on the template:

1. *In Network—Individual*. Enter the In Network Individual Maximum Out of Pocket for EHBs dollar amount.

2. *In Network—Family*. Enter the In Network Family Maximum Out of Pocket for EHBs dollar amount.

3. *Out of Network—Individual*. Enter the Out of Network Individual Maximum Out of Pocket for EHBs dollar amount.

4. *Out of Network—Family*. Enter the Out of Network Family Maximum Out of Pocket for EHBs dollar amount.

5. *Combined In/Out of Network—Individual*. Enter the Combined In/Out of Network Individual Maximum Out of Pocket for EHBs dollar amount.

6. *Combined In/Out of Network—Family*. Enter the Combined In/Out of Network Family Maximum Out of Pocket for EHBs dollar amount.

Dental EHB Deductible

This template section is for inputting deductible values for dental EHB benefits. Using the drop-down menus, enter the appropriate values for the *Individual* and *Family* dental deductible data elements in the following areas on the template:

1. *In Network—Individual*. Enter the In Network Individual Dental Deductible dollar amount.

2. *In Network—Family*. Enter the In Network Family Dental Deductible dollar amount.

3. *In Network—Default Coinsurance*. Enter the numerical value for the in network coinsurance.

4. *In Network (Tier 2)—Default Coinsurance*. Enter the numerical value for the in-network coinsurance.

5. *Out of Network—Individual*. Enter the Out of Network Individual Dental Deductible dollar amount.

6. *Out of Network—Family*. Enter the Out of Network Family Dental Deductible dollar amount.

7. *Combined In/Out of Network—Individual*. Enter the Combined In/Out of Network Individual Dental Deductible dollar amount.

8. *Combined In/Out of Network—Family*. Enter the Combined In/Out of Network Family Dental Deductible dollar amount.

Other Deductible

Users will be required to complete this template section if they have deductible subgroups; the user can add an unlimited number and name them. Enter the appropriate values for the *Individual* and *Family* data elements in the following areas on the template. (These values are not separate

deductibles outside of any maximums allowed, and they still contribute to the MOOP and deductible limits.)

1. *In Network—Individual*. Enter the In Network Individual Other Deductible dollar amount.

2. *In Network—Family*. Enter the In Network Family Other Deductible dollar amount.

3. *Out of Network—Individual*. Enter the Out of Network Individual Other Deductible dollar amount.

4. *Out of Network—Family*. Enter the Out of Network Family Other Deductible dollar amount.

5. *Combined In/Out of Network—Individual*. Enter the Combined In/Out of Network Individual Other Deductible dollar amount.

6. *Combined In/Out of Network—Family*. Enter the Combined In/Out of Network Family Other Deductible dollar amount.

Covered Benefits

This template section contains fields for copay and coinsurance values for all covered benefits. The covered benefits appear on the Cost Share Variances tab. Fill in information for each of the benefits, using the following guidance:

- If you have multiple in-network tiers, for any benefit category that does not have tiers, enter the same value for *Tier 2* as you enter for *Tier 1*.

- If you have plans that do not have out-of-network benefits for a given category, enter **$0** for the *out of network copay* fields and **100%** for the *out of network coinsurance* fields.

- The fields for each benefit are laid out as shown in Figure C-14.

Figure C-14. Benefit Information

Dental Check-Up for Children					
Copay			Coinsurance		
In Network (Tier 1)	*In Network (Tier 2)*	*Out of Network*	*In Network (Tier 1)*	*In Network (Tier 2)*	*Out of Network*

Fill in the following information for each covered benefit on the Benefits Package worksheet:

1. *Copay—In Network (Tier 1)*. If an in-network copayment is charged, enter the dollar amount here. If no copayment is charged, enter **No Charge.** Choose from the following:

    a. **No Charge**

    b. **No Charge after deductible**

    c. **$X Copay**

    d. **$X Copay after deductible**

    e. **$X Copay before deductible**.

2. *Copay—Out of Network*. If an out-of-network copayment is charged, enter the amount here. If no copayment is charged, enter **No Charge.** Choose from the following:

    a. **No Charge**

    b. **No Charge after deductible**

    c. **$X Copay**

    d. **$X Copay after deductible**

    e. **$X Copay before deductible**.

3. *Coinsurance—In Network (Tier 1)*. If an in-network coinsurance is charged, enter the percentage here. If no coinsurance is charged, enter **No Charge**, unless your 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:

    a. **No Charge**

    b. **No Charge after deductible**

    c. **X% Coinsurance after deductible**

    d. **X%**.

4. *Coinsurance—Out of Network*. If an out-of-network coinsurance is charged, enter the percentage here. If no coinsurance is charged, enter **No Charge**, unless your plan has an out-of-network copayment that the enrollee pays only until the deductible is met. In this case, enter **0%**. Choose from the following:

    a. **No Charge**

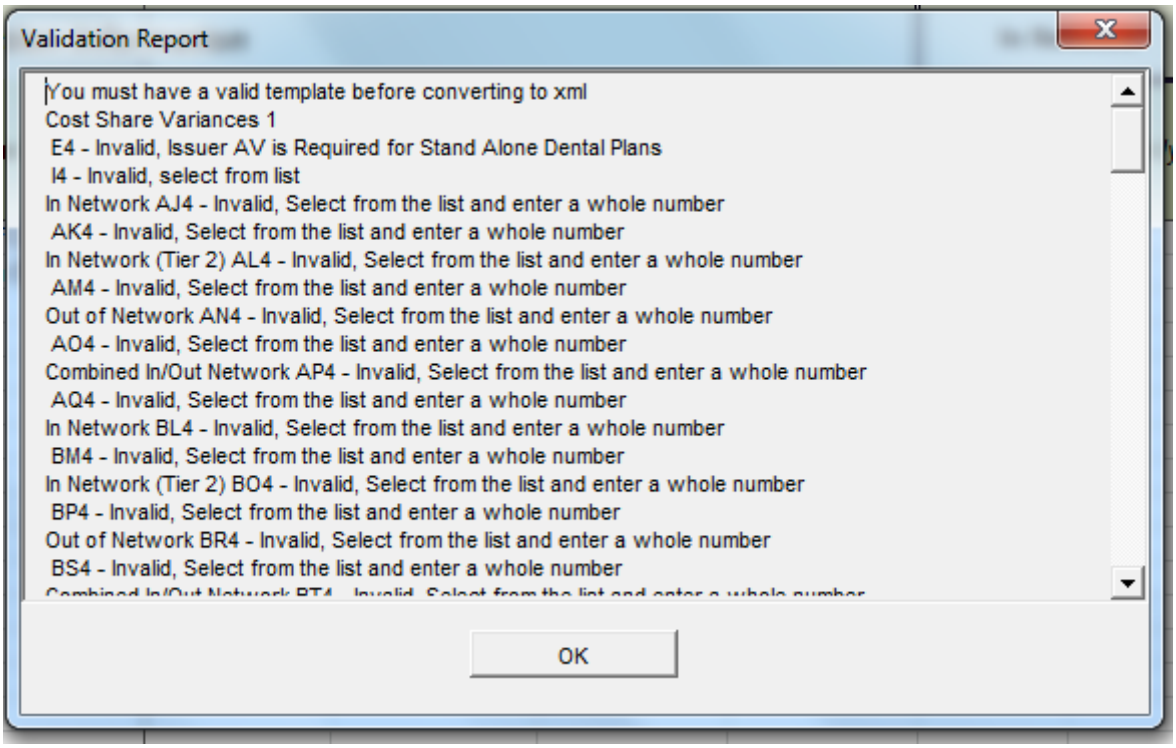
    b. **No Charge after deductible**

c. **X% Coinsurance after deductible**

d. **X%**.

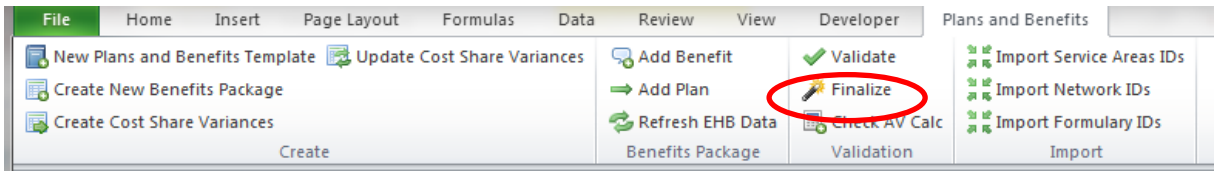
5. Once the entire template, including all Benefits Package and Cost Sharing Variances tabs, has been completed, click the **Validate** button on the menu bar under the **Plans and Benefits** ribbon. Review the errors (see Figure C-15), and click **OK**. Make the necessary changes.

Figure C-15. Error Report



6. Click the **Finalize** button on the menu bar under the **Plans and Benefits** ribbon (see Figure C-16) after the **Validation** button returns no errors and save the validated template.

Figure C-16. Finalize Button



7. Follow the HIOS instructions to upload your completed template and supporting documents into HIOS, if applicable.

Dental Only Issuers and Dual Product Issuers must also submit a "Description of EHB Allocation." This supporting document must be submitted to the Exchange annually. The document must include a detailed description of the methods and specific bases used to perform the EHB apportionment for pediatric dental, in order to meet the requirement at 45 CFR 156.470(e). This document must also include an attestation that the determination of the apportionment was performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies. See Chapter 13n, "Stand-Alone Dental Plans – Description of EHB Allocation," for a suggested format.

Rate Review Template Instructions

Dental Only Issuers and Dual Product Issuers of stand-alone dental plans do not need to submit the Unified Rate Review template. Dual Product Issuers should not be making changes to the Unified Rate Review template.

Rating Template Instructions

Issuers of stand-alone dental plans should follow the instructions on RegTap (posted 4/2/13) and Zone for the Rating template and the Rating Business Rules template. As outlined in the Letter to Issuers, for the purposes of completing the application for certification of stand-alone dental plans in the FFE, stand-alone dental plans must complete the rates table and associated business rules table according to the rating rules. Stand-alone dental plans, as excepted benefits, have additional flexibility to adjust premiums based on other rating factors. The modified dental plan and benefits template will have a data field where the dental issuer will indicate whether it is committing to the rates in the template and is thereby voluntarily complying with the rating rules, or whether the issuer reserves the right to make further premium adjustments. The plan display will indicate to consumers whether the premium displayed for stand-alone dental plans is a guaranteed rate or an estimated rate. Please see pages 31-32 of the Letter to Issuers located at http://cciio.cms.gov/resources/regulations/Files/2014_letter_to_issuers_04052013.pdf for additional information.