

## Instructions for the Benchmark Plan Benefit Data Submission

Instructions for issuer submission for potential default benchmarks; please fill out the following data elements for your plan:

Benefits Template: Complete each row.

- a. *Benefit* (user does not change this field): List of Benefits from RBIS. Option to select “Other” and add rows as necessary for “Other” if there are additional services not listed.
- b. *Covered* (required field), choose from the following options:
  - i. **Covered**—if this benefit is covered in the plan. A benefit is considered covered if the insurer covers the cost of benefit listed in a policy either through first-dollar coverage or in combination with a cost-sharing mechanism (for example, copays, coinsurance, deductibles).
  - ii. **Not Covered**—if this benefit is not covered by the plan. A benefit is considered not covered if it requires the subscriber to pay the full cost of the services with no effect on deductible and maximum out-of-pocket (MOOP) limits.
- c. *Benefit Description* (required field if user enters **Covered** in the *Covered* field), free text field to describe the benefit.
- d. *Quantitative Limit on Service?* (required field if user enters **Covered** in the *Covered* field, and default value is **No**): Choose from the following:
  - i. **No**—there are no quantitative limits on this benefit.
  - ii. **Yes**—there are quantitative limits on this benefit.
- e. *Limit Quantity* (required if *Quantitative Limit on Service?* is **Yes**): Enter a numerical value here to indicate the quantitative limits you place on this benefit. (For example, if you have a limit of two Dental Check-Up for Children per year, enter “2” here.)
- f. *Limit Units* (required if *Quantitative Limit on Service?* is **Yes**): Enter the units that are being restricted per interval here to indicate the quantitative limits you place on this benefit. (For example, if you have a limit of two Dental Check-Up for Children per year, enter **Visits per year** here.) Choose from a pre-populated drop-down box or select Other (free text field).
- g. *Other Limit Units Description* (required if **Other** is selected for *Limit Units*), free text entry if desired limit unit was not available as a choice from *Limit Units*.
- h. *Minimum Stay* (optional):
  - i. If there is a minimum stay, list the minimum stay in hours for this benefit.
  - ii. If there is no minimum stay, leave this field blank.
- i. *Exclusions* (optional), free text field.

- i. If particular services or diagnoses are subject to exclusions (i.e. covered under some circumstances but not others), list those specific exclusions.
    - ii. If no services or diagnoses are excluded, leave this field blank.
  - j. *Explanation* (optional field, default is blank), free text field.
    - i. User can enter any notes into this field as desired
  - k. *Are there additional Limitations or Exclusions?* (required field if user enters **Covered** in the *Covered* field), choose from the following:
    - i. **No**—if there are no additional limitations or exclusions.
    - ii. **Yes**—if yes, a row will be added to the template (details tab, see item 2 below). If there are benefits that are not included in the list of benefits or there is a need to further define the benefit, answering **Yes** to “*Other*” benefit will add row as well.
2. Details: The same fields are required for entry and the same fields are optional for entry on this table as described for the Benefits Template above. This table gets auto filled with the name of the benefit that the user responded **Yes** to *Are there additional Limitations or Exclusions for this benefit?*
    - a. The user can enter as many rows to this table as desired; each row represents a distinct benefit as a subset of the original benefit specified.
    - b. For each distinct benefit, the user will enter information regarding the limitation, exclusions and state mandates that apply to all services within this benefit.
  3. Issuer and Plan Identification Data: Please provide information necessary to identify the issuer, product and plan. This includes reporting for issuer name; HIOS Issuer ID; product name, HIOS product ID, company legal name, State, plan name, plan type, and number of enrollees in the plan. Additionally, please upload documents that will be used to support the benchmark plan (e.g., SBC and SPD). To the extent possible, we will leverage information collected under the Health Insurance Web Portal PRA package to auto-populate this data.
  4. Prescription Drug Template: Please provide information on the covered drugs in your plan, i.e., reporting of the national drug code.

Instructions for State submission for State-selected benchmarks; please fill out the following data elements for your plan:

1. Please provide all of the information listed above.
2. Please indicate the type of benchmark selected and identify which ACA categories are covered by the benchmark.
3. Please indicate if you are supplementing your benchmark plan with benefits from another plan option for one or more of the Essential Health Benefits categories.
4. Alternate Approach- if a State chooses to select as its benchmark one of the three largest small group market benchmark options, the State may choose to provide HHS with the

name, benchmark selection type ID, and other necessary identifying information. If the State chooses this option, HHS will ensure coverage in all ten statutorily required categories. Please submit the information to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov).

## **Instructions for Issuers that Intend to Offer Stand-alone Dental Coverage in the Exchange**

(Voluntary) If you intend to offer stand-alone dental coverage in the Exchange, please fill out the following data elements and submit the information to [Dental@cms.hhs.gov](mailto:Dental@cms.hhs.gov):

### Stand-alone Dental Template:

1. *Issuer Name:* Please indicate the full name of the State-level legal entity authorized to do business in the service areas applied for in the State.
2. *List of States:* Please list the State or States in which the issuer intends to offer coverage in an Exchange as a stand-alone dental plan.
3. *State:* Please identify from the list of States, the State in which the anticipated stand-alone dental plan would be offered.
4. *Individual Market Intended Participation:* Please indicate Y/N whether you intend to offer Stand-alone dental coverage in an individual market.
5. *Small Group Market Intended Participation:* Please indicate Y/N whether you intend to offer Stand-alone dental coverage in a small group market.
6. *Individual Market Service Area:* Please provide information on the service area covered by the plan.
7. *Small Group Service Area:* Please provide information on the service area covered by the plan.

## **Instructions for States to Submit State Mandated Benefits**

(Voluntary) We encourage States to voluntarily submit information on State-mandated benefits. Please fill out the following data elements and submit the information to [EssentialHealthBenefits@cms.hhs.gov](mailto:EssentialHealthBenefits@cms.hhs.gov):

1. *State Mandate Required?* (optional). Choose from the following:
  - i. **Yes**—if the benefit is mandated by the State.
  - ii. **No**—if the benefit is not mandated by the State.
2. *Name of Mandated Benefit* (optional), free text field.
  - i. Enter the name of the state-mandated benefit.
3. *Description of Benefit Mandates* (optional), free text field:
  - i. Enter a brief description of the state mandated benefit.

4. *Market Applicability* (optional). Identify the market to which the mandate applies.
5. *Enacted prior to 12/31/2011?* (optional). Choose from the following:
  - i. **Yes**—if the date mandate was enacted prior to 12/31/2011.
  - ii. **No**—if the date mandate was not enacted prior to 12/31/2011.
6. *Citation Number* (optional), free text field:
  - i. Provide the legal reference.
- b. *Citation URL* (optional), free text field:
  - i. Enter the URL (web address) for the citation.