Appendix B.1 QHP Benefit and Service Area Data Requirements

QHP Benefit and Service Area data requirements include the areas of: Health Benefits, Benefit Cost Sharing, Summary of Benefits Coverage (SBC) Scenario Results, Plan, Plan Cost–Sharing, Pharmacy Benefit, Drug, Service Area, and Network ID. The following lays out the specific elements to be collected according to the areas outlined above:

Health Benefit Data Elements

1. Primary Care Visit to Treat an Injury or Illness—Report cost sharing, limitations, and other relevant data for Primary Care Visit to Treat an Injury or Illness.
2. Specialist Visit—Report cost sharing, limitations, and other relevant data for Specialist Visit.
3. Other Practitioner Office Visit (Nurse, Physician Assistant)—Report cost sharing, limitations, and other relevant data for Other Practitioner Office Visit (Nurse, Physician Assistant).
4. Outpatient Facility Fee (e.g., Ambulatory Surgery Center)—Report cost sharing, limitations, and other relevant data for Outpatient Facility Fee (e.g., Ambulatory Surgery Center).
5. Outpatient Surgery Physician/Surgical Services—Report cost sharing, limitations, and other relevant data for Outpatient Surgery Physician/Surgical Services.
6. Hospice Services—Report cost sharing, limitations, and other relevant data for Hospice Services.
7. Non–Emergency Care When Traveling Outside the U.S.—Report cost sharing, limitations, and other relevant data for Non–Emergency Care When Traveling Outside the U.S.
8. Routine Dental Services (Adult)—Report cost sharing, limitations, and other relevant data for Routine Dental Services (Adult).
9. Infertility Treatment—Report cost sharing, limitations, and other relevant data for Infertility Treatment.
10. Long–Term/Custodial Nursing Home Care—Report cost sharing, limitations, and other relevant data for Long–Term/Custodial Nursing Home Care.
11. Private–Duty Nursing—Report cost sharing, limitations, and other relevant data for Private–Duty Nursing.
12. Routine Eye Exam (Adult)—Report cost sharing, limitations, and other relevant data for Routine Eye Exam (Adult).
13. Urgent Care Centers or Facilities—Report cost sharing, limitations, and other relevant data for Urgent Care Centers or Facilities.

14. Home Health Care Services—Report cost sharing, limitations, and other relevant data for Home Health Care Services.
15. Emergency Room Services—Report cost sharing, limitations, and other relevant data for Emergency Room Services.
16. Emergency Transportation/Ambulance—Report cost sharing, limitations, and other relevant data for Emergency Transportation/Ambulance.
17. Inpatient Hospital Services (e.g., Hospital Stay)—Report cost sharing, limitations, and other relevant data for Inpatient Hospital Services (e.g., Hospital Stay).
18. Inpatient Physician and Surgical Services—Report cost sharing, limitations, and other relevant data for Inpatient Physician and Surgical Services.
19. Bariatric Surgery—Report cost sharing, limitations, and other relevant data for Bariatric Surgery.
20. Cosmetic Surgery—Report cost sharing, limitations, and other relevant data for Cosmetic Surgery.
21. Skilled Nursing Facility—Report cost sharing, limitations, and other relevant data for Skilled Nursing Facility.
22. Prenatal and Postnatal Care—Report cost sharing, limitations, and other relevant data for Prenatal and Postnatal Care.
23. Delivery and All Inpatient Services for Maternity Care—Report cost sharing, limitations, and other relevant data for Delivery and All Inpatient Services for Maternity Care.
24. Mental/Behavioral Health Outpatient Services—Report cost sharing, limitations, and other relevant data for Mental/Behavioral Health Outpatient Services.
25. Mental/Behavioral Health Inpatient Services—Report cost sharing, limitations, and other relevant data for Mental/Behavioral Health Inpatient Services.
26. Substance Abuse Disorder Outpatient Services—Report cost sharing, limitations, and other relevant data for Substance Abuse Disorder Outpatient Services.
27. Substance Abuse Disorder Inpatient Services—Report cost sharing, limitations, and other relevant data for Substance Abuse Disorder Inpatient Services.
28. Generic Drugs—Report cost sharing, limitations, and other relevant data for Generic Drugs.
29. Preferred Brand Drugs—Report cost sharing, limitations, and other relevant data for Preferred Brand Drugs.
30. Non–Preferred Brand Drugs—Report cost sharing, limitations, and other relevant data for Non–Preferred Brand Drugs.
31. Specialty Drugs—Report cost sharing, limitations, and other relevant data for Specialty Drugs.
32. Outpatient Rehabilitation Services—Report cost sharing, limitations, and other relevant data for Outpatient Rehabilitation Services.

33. Habilitation Services—Report cost sharing, limitations, and other relevant data for Habilitation Services.
34. Chiropractic Care—Report cost sharing, limitations, and other relevant data for Chiropractic Care.
35. Durable Medical Equipment—Report cost sharing, limitations, and other relevant data for Durable Medical Equipment.
36. Hearing Aids—Report cost sharing, limitations, and other relevant data for Hearing Aids.
37. Imaging (CT/PET Scans, MRIs)—Report cost sharing, limitations, and other relevant data for Imaging (CT/PET Scans, MRIs).
38. Preventive Care/Screening/Immunization—Report cost sharing, limitations, and other relevant data for Preventive Care/Screening/Immunization.
39. Routine Foot Care—Report cost sharing, limitations, and other relevant data for Routine Foot Care.
40. Acupuncture—Report cost sharing, limitations, and other relevant data for Acupuncture.
41. Weight Loss Programs—Report cost sharing, limitations, and other relevant data for Weight Loss Programs.
42. Routine Eye Exam for Children—Report cost sharing, limitations, and other relevant data for Routine Eye Exam for Children.
43. Eye Glasses for Children—Report cost sharing, limitations, and other relevant data for Eye Glasses for Children.
44. Dental Check–Up for Children—Report cost sharing, limitations, and other relevant data for Dental Check–Up for Children.
45. Rehabilitative Speech Therapy—Report cost sharing, limitations, and other relevant data for Rehabilitative Speech Therapy.
46. Rehabilitative Occupational and Rehabilitative Physical Therapy—Report cost sharing, limitations, and other relevant data for Rehabilitative Occupational and Rehabilitative Physical Therapy.
47. Well Baby Visits and Care—Report cost sharing, limitations, and other relevant data for Well Baby Visits and Care.
48. Laboratory Outpatient and Professional Services—Report cost sharing, limitations, and other relevant data for Laboratory Outpatient and Professional Services.
49. X–rays and Diagnostic Imaging—Report cost sharing, limitations, and other relevant data for X–rays and Diagnostic Imaging.
50. Basic Dental Care—Child—Report cost sharing, limitations, and other relevant data for Basic Dental Care—Child.

51. Orthodontia—Child—Report cost sharing, limitations, and other relevant data for Orthodontia—Child.
52. Major Dental Care—Child—Report cost sharing, limitations, and other relevant data for Major Dental Care—Child.
53. Basic Dental Care—Adult—Report cost sharing, limitations, and other relevant data for Basic Dental Care—Adult.
54. Orthodontia—Adult—Report cost sharing, limitations, and other relevant data for Orthodontia—Adult.
55. Major Dental Care—Adult—Report cost sharing, limitations, and other relevant data for Major Dental Care—Adult.
56. Abortion for Which Public Funding Is Prohibited—Report cost sharing, limitations, and other relevant data for Abortion for Which Public Funding Is Prohibited.
57. Transplant—Report cost sharing, limitations, and other relevant data for Transplant.
58. Accidental Dental—Report cost sharing, limitations, and other relevant data for Accidental Dental.
59. Dialysis—Report cost sharing, limitations, and other relevant data for Dialysis.
60. Allergy Treatment—Report cost sharing, limitations, and other relevant data for Allergy Treatment.
61. Chemotherapy—Report cost sharing, limitations, and other relevant data for Chemotherapy.
62. Radiation—Report cost sharing, limitations, and other relevant data for Radiation.
63. Diabetes Education—Report cost sharing, limitations, and other relevant data for Diabetes Education.
64. Prosthetic Devices—Report cost sharing, limitations, and other relevant data for Prosthetic Devices.
65. Infusion Therapy—Report cost sharing, limitations, and other relevant data for Infusion Therapy.
66. Treatment for Temporomandibular Joint Disorders—Report cost sharing, limitations, and other relevant data for Treatment for Temporomandibular Joint Disorders.
67. Nutritional Counseling—Report cost sharing, limitations, and other relevant data for Nutritional Counseling.
68. Reconstructive Surgery—Report cost sharing, limitations, and other relevant data for Reconstructive Surgery.
69. Identify State Mandates Beyond Those Listed Above—Indicate whether there are any state mandates beyond those benefits listed above.

70. Issuer–Added Benefits Above EHB—Indicate Issuer–Added Benefits for applicable state above EHB benchmark.

Benefit Cost Sharing Data Elements

This list of data elements describes quantitative limits and benefit–level cost–sharing (cost–sharing data are applicable to specific benefits, though not all cost–sharing factors are applicable to all benefits).

1. Covered?—Is this benefit covered, not covered?
2. Out of Pocket Maximum Across In–Network Tiers—If yes to Multiple In–Network Provider Tiers, identify whether you have different out–of–pocket maximums across the multiple tiers.
3. Deductible Across In–Network Tiers—If yes to Multiple In–Network Provider Tiers, identify whether you have different deductibles across the multiple tiers.
4. Coinsurance (In–Network), if different—If an in–network coinsurance is charged that is different from the default, enter the percentage here. If you have multiple in–network tiers, enter coinsurance for both Tier 1 and Tier 2 if different from the default.
5. Coinsurance (Out–of–Network)—If an out–of–network coinsurance is charged, enter the percentage here. If no coinsurance is charged, leave blank.
6. Copayment (In–Network), if separate—If an in–network copayment is charged that is separate, enter the amount here. If you have multiple in–network tiers, enter the copayment for both Tier 1 and Tier 2.
7. Copayment (In–Network) charge per day or stay?—Options are day or stay, only applicable to skilled nursing and inpatient care.
8. Copayment (Out–of–Network)—If an out–of–network copayment is charged, enter the amount here. If no copayment is charged, leave blank.
9. Start Day if Charge is Day—If the charge chosen is day, enter the start date.
10. End Day if Charge is Day—If the charge chosen is day, enter the end date.
11. Begin Primary Care Cost-Sharing After a Set Number of Visits? Only applicable to primary care visit. Select this option if you begin primary care cost sharing after a certain number of (fully covered) visits have occurred. If this option does not apply, leave field as the default value, which is “N/A”. If this option does apply, enter number of visits.
12. Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? — Only applicable to primary care visit. Select this option if you subject primary care visits to the deductible or coinsurance rates only after a certain number of primary care visits with copay have occurred. If this option does not apply, leave field as the default value, which is “N/A”. If this option does apply, enter number of visits.

13. Maximum Number of Days for Charging an Inpatient Copay? -- Select this option to limit the number of days on which a patient can be charged a copay for an inpatient stay, if the insurance plan design charges inpatient stays by day. Enter the maximum number of days allowed.
14. Maximum Coinsurance for Specialty Drugs—Only applicable to specialty drugs. If you have a maximum coinsurance for specialty high–cost drugs, enter the maximum dollar value. If no maximum coinsurance, leave field as the default value, which is "N/A".
15. Quantitative Limit on Service (Y/N)?—If there are quantitative limits on this benefit, enter Y.
16. Limit Quantity—If there are limits on this benefit, enter the numerical limit (e.g., day or visit limits for essential health benefits, dollar limits on services other than essential health benefits).
17. Limit Unit—Is the limit the number of visits (e.g., 30 physical therapy visits in one year), number of days, etc.?
18. Minimum Stay—If there is a minimum stay, list the minimum stay in hours for this benefit.
19. Explanation (text field)—Free text field to list any notes.
20. Exclusions—If particular services or diagnoses are excluded, please list those exclusions.
21. Excluded from In–Network MOOP—Y/N
22. Excluded from Out–of–Network MOOP—Y/N
23. Excluded from In– and Out–of–Network MOOP—Y/N
24. Benefit Subject to Deductible?—Y/N related to both medical and drug benefits. If you have multiple in–network tiers, enter Y/N for both Tier 1 and Tier 2.
25. Benefit Subject to Coinsurance?—Y/N related to both medical and drug benefits. If you have multiple in–network tiers, enter Y/N for both Tier 1 and Tier 2.
26. EHB Variance Reason—Select a reason that benefit varies from EHB, such as above EHB, substituted, substantially equal.

Summary of Benefits and Coverage (SBC) Scenario Results Data Elements

This list of data elements illustrates deductibles, copayments, and coinsurance associated with sample scenarios.

1. Having a Baby: Deductible—SBC example, having a baby. What is the deductible?
2. Having a Baby: Copayment—SBC example, having a baby. What is the copayment due from the insured?
3. Having a Baby: Coinsurance—SBC example, having a baby. What is the coinsurance due from the insured?

4. Having a Baby: Limits—SBC example, having a baby. What is the total cost to the customer for limits and exclusions?
5. Managing Diabetes: Deductible—SBC example, managing diabetes. What is the deductible?
6. Managing Diabetes: Copayment—SBC example, managing diabetes. What is the copayment due from the insured?
7. Managing Diabetes: Coinsurance—SBC example, managing diabetes. What is the coinsurance due from the insured?
8. Managing Diabetes: Limits—SBC example, managing diabetes. What is the total cost to the customer for limits and exclusions?

Plan Data Elements

This list of data elements provides plan–level identification information that does not vary by the individual health benefit and was not captured in the issuer application.

1. Plan ID—HIOS–generated number assigned to a specific proposed QHP.
2. Plan Marketing Name—Name of each plan.
3. HIOS Product ID—The HIOS Product ID associated with each proposed exchange plan.
4. Exchange Market—Market coverage, individual or small group.
5. Do you intend to offer this plan on the exchange, off the exchange, or both?—Indicate from a dropdown if you intend to offer this plan on the exchange, off the exchange, or both.
6. Level of Coverage—Coverage level for a specific proposed plan (Platinum, Gold, Silver, Bronze, Catastrophic for medical plans, or High or Low for stand-alone dental plans).
7. Is this a unique plan for actuarial value purposes (Y/N)?—Indicate if health plan design is not compatible with the Actuarial Value Calculator.
8. Issuer calculated actuarial value ?—Enter issuer calculated actuarial value. Only applicable to those health plans that indicate they are a unique plan for actuarial value purposes.
9. HSA–Eligible?—Plan meets all of the requirements to be a Health Savings Account (HSA). Qualified high–deductible health plan HSAs are one avenue many consumers use to manage overall health care expenses.
10. HSA/HRA Employer Contribution—Indicate whether the employer contributes to HSA/HRA
11. HSA/HRA Employer Contribution Amount—Indicate employer contribution amount to HSA/HRA if applicable.
12. Child–Only Offering—Indicator of whether a specific plan will also be offered at a child–only rate or have a corresponding child–only plan; one option must be

selected consistent with requirements at 45 CFR 156.200. Not applicable if the plan's coverage level is catastrophic.

13. Child–Only Plan ID—HIOS–generated number assigned to a child–only offering that corresponds to this plan.
14. Plan Type—Network design for the product: indemnity, preferred provider organization (PPO), health maintenance organization (HMO), point of service (POS), or exclusive provider organization (EPO).
15. URL for Summary of Benefits & Coverage—URL that provides a link to the Summary of Benefits and Coverage document that is required to be posted on the plan's website.
16. URL for Enrollment Payment—URL for the location on the plan website where the enrollee will effectuate payment.
17. New or Existing Plan Indicator—Indicator of whether the proposed plan is a new or existing plan. Note: We expect most proposed plans submitted for the 2014 coverage year to be new plans.
18. Plan Effective Date—Effective date of the plan.
19. Plan Expiration Date—Date that a plan becomes closed and no longer accepts new enrollments.
20. Out–of–Country Coverage—A yes/no indication of whether care obtained outside the country is covered under the plan. This information may be critically important to consumers who travel internationally.
21. Out–of–Country Coverage Description—A short description of whether care obtained outside the country is covered under the plan. This information may be critically important to consumers who travel internationally.
22. Out–of–Service Area Coverage—A yes/no indication of whether care obtained outside the service area is covered under the plan.
23. Out–of–Service Area Coverage Description—A short description of whether care obtained outside the service area is covered under the plan.
24. National Network—A yes/no indication of whether a national network is available.
25. Maximum Out–of–Pocket Individual In–Network for EHBs—Maximum out–of–pocket (in–network) for EHBs. Enter for integrated or, if separate, enter for drug and medical.
26. Maximum Out–of–Pocket Family In–Network for EHBs—Maximum out–of–pocket (in–network) for EHBs. Enter for integrated or, if separate, enter for drug and medical.
27. In and Out–of–Network Maximum Out–of–Pocket Individual for EHBs—Individual maximum out–of–pocket for EHBs combined for in– and out–of–network. Enter for integrated or, if separate, enter for drug and medical.

28. In and Out–of–Network Maximum Out–of–Pocket Family for EHBs—Family maximum out–of–pocket for EHBs combined for in and out–of–network. Enter for integrated or, if separate, enter for drug and medical.
29. Maximum Out–of–Pocket Individual In–Network Total—Overall maximum out–of–pocket (in–network) total. Enter for integrated or, if separate, enter for medical.
30. Maximum Out–of–Pocket Family In–Network Total—Overall maximum out–of–pocket (in–network) total. Enter for integrated or, if separate, enter for medical.
31. Maximum Out–of–Pocket—Individual Out–of–Network Total—Overall maximum out–of–pocket (out–of–network) total. Enter for integrated or, if separate, enter for medical.
32. Maximum Out–of–Pocket Family Out–of–Network Total—Overall maximum out–of–pocket (out–of–network) total. Enter for integrated or, if separate, enter for medical.
33. Maximum Out–of–Pocket Individual In– and Out–of–Network Total—Individual combined maximum out–of–pocket total. Enter for integrated or, if separate, enter for medical.
34. Maximum Out–of–Pocket Family In– and Out–of–Network Total—Family combined maximum out–of–pocket total. Enter for integrated or, if separate, enter for medical.
35. Is the out–of–pocket maximum for the in–network medical and drug integrated or separate for EHBs?—Options are integrated and separate.
36. If separate, enter the separate out–of–pocket maximum for the in–network medical for EHBs—Dollar amount will be entered. If plan has multiple tiers with separate out–of–pocket maximums, enter for Tier 1 and Tier 2.
37. If separate, enter the separate out–of–pocket maximum for the in–network drug for EHBs—Dollar amount will be entered. If plan has multiple tiers with separate out–of–pocket maximums, enter for Tier 1 and Tier 2.
38. If integrated, enter the out–of–pocket maximum for the in–network medical and drug for EHBs—Dollar amount will be entered. If plan has multiple tiers with separate out–of–pocket maximums, enter for Tier 1 and Tier 2.
39. Wellness Program Offered (Y/N)?—A yes/no response indicating whether the plan offers wellness programs according to Section 2705 of the Public Health Service Act.
40. Identify disease management programs offered—Select from dropdown: asthma, heart disease, depression, diabetes, high blood pressure and high cholesterol, low back pain, pain management, pregnancy.
41. Multiple In–Network Provider Tiers (Y/N)?—Do you have multiple in–network provider tiers?
42. Expected Utilization for Tier 1?—What is the expected percentage of utilization for Tier 1?

43. Plan Level Exclusions—List all plan level exclusions.
44. Cost–Sharing Reduction Plan Variation—Changes in cost sharing—Issuer must submit reductions in cost sharing for silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations at the plan and benefit cost sharing level.
45. Limited Cost Sharing Plan Variation—Estimated Advanced Payment Amount per Enrollee—Estimated amount of cost–sharing reductions for eligible enrollees to be provided in the form of an advance payment to the issuer. This amount is estimated by the issuer. Applies to limited cost sharing plan variations described in Section 156.420(b)(2).
46. Supporting Documentation—Upload required supporting documentation.
47. Is a Referral Required to See a Specialist?—Select "yes" if a referral is required to see a specialist; otherwise, select "no."
48. Type of Specialists Requiring a Referral—Enter the specialists by service and indicate whether the specialist or service is in or Out–of–Network—for example, "Specialist (IN), Diagnostic X–Ray (OON)"—separated by commas.
49. Is notice required for Pregnancy?—Select "yes" if notice is required for pregnancy, otherwise select "no."
50. Plan Brochure—Enter the Plan Brochure URL.
51. Federal Tax ID—Enter the federal tax ID.
52. Associated HPID—Enter the associated HPID.
53. Employee choice in SHOP-Identify if the issuer's SHOP QHPs will be available to employees buying up a single level from the employer's choice of metal level
54. Guaranteed / Not Guaranteed – Indicate if the Stand-alone dental plan rate is guaranteed or not guaranteed. Guaranteed rates mean that the stand-alone dental plan issuer will only charge the rates reported in the rating tables. Not guaranteed rates mean that the stand-alone dental plan issuer is reserving the option to charge additional premiums as permitted for excepted benefits.
55. EHB allocation – For each stand-alone dental plan offered or intended to be offered, in the individual market on the Exchange, indicate a dollar allocation of the expected premium for the plan, to: (1) The pediatric dental essential health benefit, and (2) Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit. This allocation must meet the standards specified in 45 CFR 156.470(d).

Plan Cost–Sharing Data Elements

This list of data elements describes the overall plan cost–sharing information, such as in–network, out–of–network, or deductible.

1. Is the in–network medical and drug deductible integrated or separate?—Indicate whether the in–network medical and drug deductible is integrated or separated.

2. Deductible—Individual—In–Network—Enter if integrated or, if separate, enter for drug and medical.
3. Deductible—Family—In–Network—Enter if integrated or, if separate, enter for drug and medical.
4. Deductible—Individual—Out–of–Network—Enter if integrated or, if separate, enter for drug and medical.
5. Deductible—Family—Out–of–Network—Enter if integrated or, if separate, enter for drug and medical.
6. Deductible—Individual—In and Out–of–Network—Enter if integrated or, if separate, enter for drug and medical.
7. Deductible—Family—In and Out–of–Network—Enter if integrated or, if separate, enter for drug and medical.
8. If separate, enter the separate in–network medical deductible—Dollar amount will be entered. If plan has multiple tiers with separate deductibles, enter for Tier 1 and Tier 2.
9. If separate, enter the separate in–network drug deductible—Indicate separate deductible for in–network drug if applicable. If plan has multiple tiers with separate deductibles, enter for Tier 1 and Tier 2.
10. If integrated, enter the combined in–network medical and drug deductible—Dollar amount will be entered. If plan has multiple tiers with separate deductibles, enter for Tier 1 and Tier 2.
11. If separate, enter the separate coinsurance for in–network medical default—Indicate separate coinsurance for in–network medical default if applicable. If plan has multiple tiers with separate coinsurance, enter for Tier 1 and Tier 2.
12. If separate, enter the separate coinsurance for in–network drug default—Indicate separate coinsurance for in–network drug default if applicable. If plan has multiple tiers with separate coinsurance, enter for Tier 1 and Tier 2.
13. If integrated, enter the coinsurance for in–network medical and drug default—Indicate integrated coinsurance for in–network medical and drug default if applicable. If plan has multiple tiers with separate coinsurance, enter for Tier 1 and Tier 2.
14. Other Deductible—Enter a service for which there is a separate deductible.
15. Other Deductible In–Network—Enter the in–network deductible for this service.
16. Other Deductible Out–of–Network—Enter the out–of–network deductible for this service.

Pharmacy Benefit Data Elements

This list of data elements describes the pharmacy benefit characteristics including cost sharing, copayment and coinsurance details.

1. Formulary ID—Unique identifier for formulary to link tables.
2. Drug Tier ID—Drop–down values will be 1, 2, 3, 4, 5, 6, or 7.
3. Drug Tier Type—Tier drug types (select all that apply). Provide drug tier number (1 through 7) for each, then describe: Only select brands. All generics. All preferred generics. All non–preferred generics. Only select generics. All brands. All preferred brands. All non–preferred brands.
4. Up to 1 Month In–Network Retail Pharmacy Cost–Sharing Type—Indicate cost–sharing type for Up to 1 Month In–Network Retail Pharmacy.
5. Up to 1 Month In–Network Retail Pharmacy Copayment—Indicate copayment for Up to 1 Month In–Network Retail Pharmacy.
6. Up to 1 Month In–Network Retail Pharmacy Coinsurance—Indicate coinsurance for Up to 1 Month In–Network Retail Pharmacy.
7. 1 Month Out–of–Network Retail Pharmacy Offered?—Indicate whether 1 Month Out–of–Network Retail Pharmacy is offered.
8. Up to 1 Month Out–of–Network Retail Pharmacy Cost–Sharing Type—Indicate cost–sharing type for Up to 1 Month Out–of–Network Retail Pharmacy.
9. Up to 1 Month Out–of–Network Retail Pharmacy Copayment—Indicate copayment for Up to 1 Month Out–of–Network Retail Pharmacy.
10. Up to 1 Month Out–of–Network Retail Pharmacy Coinsurance—Indicate coinsurance for Up to 1 Month Out–of–Network Retail Pharmacy.
11. 3 Month In–Network Mail Order Pharmacy Benefit Offered?—Indicate whether 3 Month In–Network Mail Order Pharmacy Benefit is offered?
12. 3 Month In–Network Mail Order Pharmacy Cost–Sharing Type—Indicate cost–sharing type for 3 Month In–Network Mail Order Pharmacy.
13. 3 Month Out–of–Network Mail Order Pharmacy Benefit Offered?—Indicate whether 3 Month Out–of–Network Mail Order Pharmacy Benefit is offered?
14. 3 Month Out–of–Network Mail Order Pharmacy Cost–Sharing Type—Indicate cost–sharing type for 3 Month Out–of–Network Mail Order Pharmacy.
15. 3 Month Coinsurance Mail Order Pharmacy—In–Network—Indicate coinsurance percentage for mail order pharmacy 3–month supply In–Network.
16. 3 Month Coinsurance Mail Order Pharmacy—Out–of–Network—Indicate coinsurance percentage for mail order pharmacy 3–month supply Out–of–Network.
17. 3 Month Copayment Mail Order Pharmacy—In–Network—Indicate copayment amount for mail order pharmacy 3–month supply In–Network.
18. 3 Month Copayment Mail Order Pharmacy—Out–of–Network—Indicate copayment amount for mail order pharmacy 3–month supply Out–of–Network.
19. Formulary URL—Enter the URL (web address) for your formulary document.

Drug Data Elements

This list of data elements identifies the drugs covered by the plan and cost sharing tier levels.

1. RxCUI—Enter RxCUI.
2. Tier Level—Cost–sharing tier level.
3. Prior Authorization Required—Prior authorization required? (Yes/No)
4. Step Therapy Required—Is step therapy required? (Yes/No)

Service Area Data Elements

This list of data elements identifies a plan's geographic service area.

1. Service Area ID—An ID automatically generated by the system to identify each geographic service area in which the applicant intends to offer one or more QHPs.
2. Service Area Name—The name associated with a specific Service Area ID.
3. State—The state in which a specific geographic service area is located, and in which QHPs associated with the service area may be offered. One service area associated with one Service Area ID must be contained in a single state.
4. County Name—The name of a county that is included in a geographic service area. One service area may contain multiple counties.
5. Partial County Indicator—An indicator of whether a service area contains any partial counties.
6. Service Area ZIP Code—For any partial counties included in a service area, each ZIP code from that county included in the service area.
7. Partial County Exceptions Narrative—Free text to justify request to serve a partial county.

Network ID

This list of data elements identifies a provider network(s).

1. Network Name—Enter network name.
2. Network ID—Enter network ID.
3. Network URL—Enter network URL.