Qualified Health Plan (QHP) Filing Instructions in SERFF (4/24/15)

Each QHP filing contains a binder with all the data necessary for plans offered inside and outside the New York State of Health (NYSOH). Issuers must submit a separate binder per market type (individual or small group) for each NAIC Company Code that they will be using to offer QHPs. Also, if an issuer uses two different DBAs (or marketing name) within the same NAIC Company Code, it must submit separate binders for each DBA. Issuers must also submit their traditional form and rate filing in SERFF before creating their binder so that they can associate schedule items such as forms to their QHP filing. Each binder includes several data templates that are required for the NYSOH web portal, the review process, and reports to HHS.

**NYSOH Filings:** Issuers are required to file QHP Filing with all required templates in SERFF. Due to guaranteed availability requirements, issuers must offer the same plans inside and outside the NYSOH and should indicate that the HIOS Plan IDs are available both inside and outside the NYSOH under the QHP/Non-QHP field. Issuers should not duplicate that plan on a separate off exchange binder. Issuers should not include any specific HIOS ID number on more than one binder. **Please note:** None of the content in any of the SERFF templates can contain apostrophes for binders intending to be transmitted to the NYSOH. The transmission will fail for the entire binder.

**Off NYSOH Filings:** Issuers should only create an off exchange binder when an issuer has additional plans available outside the NYSOH, or when an issuer only offers plans outside the NYSOH in the individual or small group market. A separate binder should be submitted per licensee, per market.

The form and rate filing instructions, checklists, and model form language can be found on the Department of Financial Services’ website at [http://www.dfs.ny.gov/insurance/ihealth.htm](http://www.dfs.ny.gov/insurance/ihealth.htm).

**General Instructions for QHP Filing**

Build your QHP filing according to any instructions provided by SERFF. Follow the instructions below for the submission of QHP filings to New York. Issuers must submit the binder using the same instance as the previously submitted form and rate filing.

**Associated Schedule Items:** When building the QHP filing, use the Associated Schedule Items feature to pull policy forms and any variable material associated with the policy forms. If a QHP is a unique plan design, an issuer must also associate to the uploaded AV calculator screen shots from the filing side of SERFF. Do not associate any other items from the form and rate filing, such as the rate manual, any certification forms, readability certification, or checklists. Issuers may only associate schedule items submitted using the same SERFF instance.

**Submission Requirements:** Each issuer must submit the following attachments: Program Attestations for State Based Marketplace Issuers; the Unified Rate Review Template; Actuarial Memorandum; and the Logo File. The Unified Rate Review Template and HHS actuarial memorandum are submission requirements on the form and rate filing in SERFF and on the binder filing in Plan Management and must be identical.
The following templates are required for QHP Binder filings:

<table>
<thead>
<tr>
<th>Template</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Template</td>
<td>Collects general company and contact information.</td>
</tr>
<tr>
<td>Plan/Benefit Template</td>
<td>Collects plan and benefit data.</td>
</tr>
<tr>
<td>Prescription Drug Template</td>
<td>Collects formulary data for plans.</td>
</tr>
<tr>
<td>Network Template</td>
<td>Information identifying an issuer’s provider network.</td>
</tr>
<tr>
<td>Service Area Template</td>
<td>Information identifying an issuer’s geographic service area.</td>
</tr>
<tr>
<td>Rate Template</td>
<td>Collects rates necessary for display on the web portal.</td>
</tr>
<tr>
<td>Business Rules Template</td>
<td>Collects rules to explain the rating tables.</td>
</tr>
</tbody>
</table>

**Network Adequacy Review, Accreditation & Quality Assurance Information:** New York is requiring the submission of the Service Area Template and Network Template but no additional information regarding network adequacy. Please see the NYSOH Application available at [http://info.nysothealth.ny.gov/invitation](http://info.nysothealth.ny.gov/invitation) for submission of network adequacy information and quality assurance data.

**Template Instructions**

Issuers must use the 2016 templates when submitting their 2016 binder filings through SERFF. Copies of templates, instructions provided by CCIIO including explanations of fields, data dictionary, and other technical information regarding the data templates can be found at [http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html](http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html). The specific instructions below are intended to assist issuers when submitting QHP binders to New York. Before submitting a binder through SERFF, issuers are strongly encouraged to run their templates through the Data Integrity Tool to avoid data submission errors.

**Administrative Template**

1. All fields indicated with a red asterisk are required.
2. For NYSOH filings, include the customer service number that customers who have selected your plan can call. If you have distinct customer service phone numbers for prospective enrollees and current enrollees (or any other variation), send the listing to your plan manager.

**Service Area Template**

1. Enter the HIOS Issuer ID and State.
2. Click the Create Service Area IDs button. Create as many Service Areas as necessary to indicate the various areas where the QHPs will be available. For example, if the issuer has a limited network plan available in 2 out of the 5 counties within their overall service area, the issuer must create 2 Service Area IDs. The issuer will then use the Service Area IDs in the Plans & Benefits Template to associate QHPs to a particular Service Area.
3. Select a Service Area ID that was generated by the template.
4. Enter the Service Area Name.
5. Indicate whether the Service Area covers the entire state.
6. If the Service Area does not cover the entire state, then select a county that is within the Service Area.
7. Repeat steps 4-6 for every county within the Service Area.
8. If the issuer has more than one Service Area, repeat steps 3-7 for each Service Area.
9. One Service Area Template may include multiple Service Areas.
10. Make certain each Service Area matches the Service Area outlined in the Definitions section of the Certificate, Contract and Policy associated with that specific HIOS Plan ID in the Associated Schedule Items Tab.

**Network Template**

1. Enter the HIOS Issuer ID and State.
2. Click the Create Network IDs button. Indicate the number of networks the issuer has.
3. Enter the Network Name.
4. Select a Network ID that was generated by the template to associate with the Network Name.
5. Enter the URL for the provider directory associated with that network. If a working URL has not yet been developed for the particular network identified, a URL for a general directory will be sufficient as long as the URL provided will allow navigation to the provider directory for that plan. For the NYSOH filings, the URL must clearly identify the network is for the Marketplace and/or the Marketplace QHPs per the Invitation, and must be functional prior to certification.
6. If the issuer has more than one network, repeat steps 2-4 for each network. One Network Template may include multiple networks.

**Prescription Drug Template**

1. Enter the HIOS Issuer ID and State.
2. Click the Create Formulary IDs button. A pop up box will ask the issuer to indicate the number of formularies it has. An issuer can create as many Formulary IDs as needed to reflect the varying cost-sharing for prescription drugs. The cost-sharing has a one to one match with the Formulary ID. The same drug list can be reused for each formulary or additional drug lists can be created for different Formulary IDs.
3. Select the Formulary ID in the first box from the drop down menu.
4. Enter the URL for the Formulary on the issuer’s website. If a working URL has not yet been developed for the particular Formulary identified, a test link URL will be sufficient for the SERFF submission. For the NYSOH filings, the URL must clearly identify the formulary is for the Marketplace and/or the Marketplace QHPs, and a working URL will be needed prior to certification.
5. Switch to the Drug List sheet. Enter the RXCUI on the drug list and indicate the tier level of the drug. Indicate whether the drug requires preauthorization or step therapy.
6. Add as many drug lists as needed.
7. Switch back to the Formulary Tiers sheet. Select the Drug List ID from the drop down menu.
8. Indicate the number of tiers on the formulary. A formulary may not contain more than three tiers.
9. Indicate the drug tier type from the menu of choices. Select all that apply.
10. Fill in the remaining cost sharing information as appropriate. Leave any cost sharing fields (out-of-network fields for example) blank that do not apply.
11. The Prescription Drug template was updated to accept decimal points. Enter the exact cost-sharing, including any cents if applicable. Note that for the standard plan design, the mail order copayments may use a decimal point for tier 2 cost-sharing.
12. Inadequate Count in a Category or Class of Prescription Drugs: Issuers are strongly encouraged to run the Category Class Drug Count Tool prior to binder submission. The tool is available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html. If the issuer determines that the formulary they are submitting has an inadequate number of prescription drugs in a category or class, then the issuer must provide an explanation. The explanation may be submitted as a separate document attached on the Supporting Documentation Tab.

**Plans & Benefits Template**

**General Information**

1. The Service Area Template and the Network and Prescription Drug Template must be completed prior to completing the Plans and Benefits Template.
2. The issuer must register its HIOS Plan IDs (Standard Component IDs) via HIOS.
3. The HIOS Plan ID is the key identifier used by the NYSOH to populate the QHPs on the web portal, associate the corresponding provider network, associate the corresponding quality information, and complete enrollment. QHPs that were sold in 2015 (for example, the standard gold plan) must keep the same HIOS Plan ID in 2016. New HIOS Plan IDs may only be assigned when a new QHP is being submitted for certification.
4. HIOS Plan ID Limitations: The current limit of HIOS Plan IDs in a single binder is 350. If an issuer has a binder that will exceed that limit, contact the SERFF Help Desk. They can temporarily increase the limit in order to allow the submission of the binder. Do not split the binder up into multiple binders as it makes it more difficult to review and duplicates the submission of other information.

**Benefits Package Worksheet Tab**

1. A Benefits Package Tab consists of ALL QHPs that have the identical plan structure (including any quantitative limits and exclusions). The goal is to group QHPs together as much as possible to minimize the use of added Benefit Package Tabs.
2. Place the all standard plans (Bronze, Silver, Gold, Platinum & Catastrophic if applicable) in one Benefit Package Tab. Since the subject to deductible questions have been removed from the Benefit Package Tab, it is no longer necessary to separate the standard Bronze and Catastrophic plans from the standard Platinum, Gold, and Silver plans.
3. Non-standard QHPs must also be grouped together in a similar manner in order to reduce the amount of added Benefit Package Tabs.
4. Cost-sharing variations will be defined in the Cost Share Variances Tab.
5. Complete the top section of each Benefits Package worksheet that contains the HIOS Issuer ID, Issuer State, Market Coverage, Dental Only Plan and TIN.

**Plan Identifiers**

1. Complete this section for each Benefit Package.
2. Complete a line per each HIOS Plan ID (Standard Component ID) for each QHP.
3. For further information & instructions regarding riders and additional or variation in benefits see page 14.
4. Complete all required fields indicated with red asterisk.

**Plan Attributes**

1. Indicate whether this is a new or existing plan.
2. Select Plan Type and Level of Coverage.
3. Indicate whether the QHP is a Unique Plan Design for the Actuarial Calculator purposes. For the QHP/non-QHP field, indicate whether the plan will be offered inside and outside the NYSOH or only outside the NYSOH. Due to guaranteed availability requirements, an issuer cannot state a plan is available inside the NYSOH only. The issuer must mark that particular HIOS ID number as available both inside and outside the NYSOH under the QHP/Non-QHP field.
4. The field “Is a Referral Required for Specialist” is a required field. If the Certificate, Contract or Policy associated with the specific HIOS ID number states the policy has a gatekeeper, the answer to this question should be “yes.”
5. Child Only Plans: Use a separate line (HIOS Plan ID) for each Child Only plan. Indicate on the Child Only Offering field that the plan is child only. Enter the child only plan’s HIOS Plan ID in the Child Only Plan ID for the corresponding adult only offering. A Child Only Plan ID is not required for Catastrophic plans.
6. Composite Rating Indicator is required for small group coverage. Select “no.”
7. EHB Percent of Total Premium is required for all individual plans except Catastrophic plans. The value entered must match the Unified Rate Review template.

**Plan Dates**

1. Enter the appropriate Plan Effective Date and Plan Expiration Date. For NYSOH filings, the Plan Effective Date must be 1/1/2016 and the Plan Expiration Date must be 12/31/2016 for both the Individual Marketplace and the SHOP Marketplace.

**Geographic Coverage**

1. Indicate whether the plans provide coverage outside the U.S. or outside the Service Area.
2. If the only coverage that is offered outside the U.S. or the Service Area is for Emergency Services, then indicate “Yes” in the Out of Country Coverage and Out of Service Area Coverage. In the Out of the Country Coverage Description and Out of Service Area Description, enter “Emergency Only.”
3. If broader coverage is offered, explain in the two description fields.
Standard Plan Design Benefit

After clicking the Refresh EHB data button, follow these instructions for the standard plan design.

1. Mark the following benefits as “Not Covered” for the standard plan design:
   a. Non-Emergency Care When Traveling Outside the US
   b. All Adult Dental Services
   c. Long Term Care
   d. Private Duty Nursing
   e. Routine Eye Exams (Adult)
   f. Cosmetic Surgery
   g. Routine Foot Care
   h. Acupuncture
   i. Weight Loss Programs
   j. Basic Dental Care – Adult
   k. Orthodontia – Adult
   l. Major Dental Care - Adult

2. Mark “Abortion for Which Public Funding is Prohibited” as “Covered.” Answer “Yes” to a Quantitate Limit on Service. Insert one (1) in the Limit Quantity box and “procedure per year” in the Limit Unit box.

3. Remove “680 Hours Per Year” from the Limit Quality and the Limit Unit boxes for the “Autism Spectrum Disorders” benefit. Remove the “Yes” from the Quantitative Limit on Service box.

4. Add the following in the Benefit Explanation Box for the “Transplant” benefit:
   “Transplants determined to be non-experimental and non-investigational are covered, including but not limited to: kidney, corneal, liver, heart and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.”

5. Added Benefits Using Drop Down Menu: Add the following EHB benefits using the Add Benefit Button and then selecting the benefit from the drop down menu. Add in any limit information provided below in the Explanation Box.
   m. Cardiac Rehabilitation
   n. Second Opinion
   o. Cochlear Implants: Input “one per ear per lifetime” in the Explanation Box.

6. Added Benefits Using Custom Benefit Feature: The following benefits included in New York’s EHB must be added using the Custom Benefit feature on the Add Benefits Button. For each of the benefits listed below, click the Add Benefits Button, and then click Custom. Type the benefit exactly as it is stated below. If any spelling errors occur in the benefit name, the template will need to be resubmitted. Indicate the benefit is Covered in the Is This Benefit Covered Box. Add in any limit information provided below in the Explanation Box.
   a. Assistive Communication Devices
   b. Sterilization Procedures for Men
   c. Prostate Cancer Screening
d. Anesthesia Services

e. Autologous Blood Banking

f. Preadmission Testing

g. Diabetic Equipment & Supplies

h. Medical Supplies

i. Observation Stay

j. Inpatient Rehabilitation Services: Input “60 consecutive days per condition per lifetime” in the Explanation Box.

k. Gym Membership Reimbursement (or insert Wellness benefit label as applicable for substituted benefits). In the event you add a substituted or custom benefit, and you want this benefit displayed on the Marketplace, notify your Plan Manager as this information needs to be coded into the Marketplace system.

l. Contact Lenses for Children: Answer “Yes” to a Quantitate Limit on Service. Enter “One” in Limit Quantity. Enter “item per year” in the Limit Unit.

m. Benefit Design Description. For NYSOH filings, add a custom benefit called “Design”. This field will be used to describe the benefit design features that are not otherwise obvious to the consumer. Include the following description:

- Referrals requirements to access care (i.e. gatekeeper) or lack thereof;
- Custom network features (e.g., tiered network (NOTE: The Marketplace currently is designed to only display the 1st tier cost-sharing), network limited to a particular hospital system, QHP using the patient centered or PCP medical home models); and
- Other features of the benefit design that will aid consumers in making their plan selection decisions.

Limit your explanation to 1500 characters. If more characters are needed, contact your Plan Manager. Be sure to select “NO” for the Quantitative Limit and do not include any apostrophes.

**Non-Standard QHPs**

1. Issuers may substitute EHB in accordance with guidance found in NYSOH Application and in the product checklists found on the DFS website. Issuers may add benefits to a non-standard QHP in accordance with guidance found in the NYSOH Application and in the product checklists found on the DFS website.

2. If only varying the limits on the above named benefits, edit the limits without adding a new benefit.

3. If adding the benefits below, follow the instructions below. For any additional benefit, indicate the EHB Variance Reason by selecting the appropriate reason (substitution, above EHB, etc.)

   a. Shoe Inserts: Use the Custom Benefit feature to add in “Shoe Inserts” if necessary. Indicate the benefit is covered in the Is This Benefit Covered Box. Enter the appropriate limits if applicable.

   b. Adult Dental Care: To add adult dental care benefits, use the benefits (Routine Dental Services (Adult); Basic Dental Care – Adult; Major Dental
c. **Adult Vision Care**: To add adult vision care benefits, use the “Routine Eye Exam – Adult” benefit on the main list. If also covering frames & lenses and contact lenses, add a custom benefit using the Add Benefits button to add the following: “Frames & Lenses” “Contact Lenses”. Indicate that the benefits are covered in the Is This Benefit Covered Box.

d. **Any Other Additional Benefits**: If the issuer wants to add a benefit that is not listed, use the Add Benefits Button. Use the drop down list of benefits to see if it matches a benefit. If not, issuers may add a Custom Benefit using the Add Benefits Button. For NYSOH filings, if you add a Custom Benefit that you would like displayed on the Marketplace, notify your Plan Manager as the information needs to be coded into the Marketplace system.

**Reminder for SHOP Issuers:**

1. For the plans that offer family planning services, the HIOS Plan IDs must list the following services as COVERED in order for the plan to display during the employer search:
   a. Abortion for Which Public Funding is Prohibited;
   b. Family Planning Services; and
   c. Sterilization Procedures for Men.

2. For QHPs that cover domestic partners, the HIOS Plan IDs on the Business Rules Template must indicate YES under the question “Are domestic partners treated the same as secondary subscribers AND you must select “Life Partner, Yes” under the question “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber.”

**Cost Share Variance Worksheet**

**General Information**

1. Confirm all the QHPs are listed on the Benefits Package sheet before creating the Cost Share Variance Sheet.
2. Once the Benefits Package Sheet is complete, click the Create Cost Share Variance Sheet button. This will create all the necessary cost share variant plans.
3. Variant plans are required under Federal law for Individual Coverage. The Cost-Sharing Reductions for the Silver metal level and the two Indian variant plans for all metal levels will be automatically created.
4. When the Create Cost Share Variance Sheet is created, it will automatically create each of the necessary variant plans by adding a hyphen and a two digit number to the HIOS Plan ID. Enter data (cost-sharing amounts, deductible & out-of-pocket amounts) for the standard plans (-01) first before entering information for any of the required cost sharing information for the variant plans. The two digit numbers indicate the following:
   - 00 - Standard Off Exchange Plan
   - 01 - Standard On Exchange Plan
5. The 87% AV Silver Plan and 94% AV Silver Plan are being replaced with the Basic Health Plan for 2016. Insert “Not Applicable” for the cost-sharing for these plan variants. In order to avoid having the AV Calculator run on these plan variants that are not being used in New York, the issuer must indicate that these plans are unique plan designs by setting the “Unique Plan Design?” field equal to “Yes” on the Benefits Package worksheet. For the standard plan and the silver plan 73% AV CSR variation, the issuer must manually enter the AV obtained from the stand-alone AV Calculator in the “Issuer Actuarial Value” field on the Cost Sharing Variance worksheet. For the plan variants not being used (87% and 94% AV Silver Plans), the issuer must enter a dummy AV in the “Issuer Actuarial Value” field that is within one percentage point of the plan variant’s AV in order to validate the template. The Data Integrity Tool will flag “Not Applicable” as an error for tier one and out-of-network benefits. Issuers should ignore these errors.

**Cost Sharing Attributes**

1. Complete all information and respond to all the questions regarding deductibles and the Out-of-Pocket Limit before completing the cost-sharing information. Do not run the AV calculator until all cost-sharing information is entered.

2. Indicate whether the plan is designed to be used with an HSA/HRA. If the binder is for the small group market, indicate the employer contribution amount towards the HSA as applicable under current federal regulations and guidance. Leave the HSA Employer Contribution field blank if the binder is for the Individual Market.

**SBC Scenario Information**

1. The SBC scenario information is no longer optional. All dollar amounts for SBC scenarios will be required for medical QHPs. Fill out the deductible, copayment, coinsurance, and limit accordingly.

**Plan Variant URLs**

1. Provide a URL for Summary of Benefits and Coverage (SBC). Issuers must follow the federal rules regarding the SBC but are not required to file it with the state. A link to the SBC is sufficient. If the SBC link is not yet available, enter a URL so the template may be validated but finalize the URL prior to certification.

2. Provide URL for Plan Brochure, if applicable. If Plan Brochure is not yet complete upon submission, the issuer may submit a general URL website or marketing page.

**Maximum Out-of-Pocket & Deductible Information**
1. Complete all information as required. Based on the answers in the Cost Sharing Attributes section, the deductible or out-of-pocket fields that are not applicable to a particular QHP will be grayed out.

**Cost Sharing Information**

1. Enter “Not Applicable” for the cost-sharing for the following services:
   a. Specialty Drugs
   b. Experimental or Investigational Services
   c. Eating Disorder Treatment (SHOP/Small Group Coverage Only)

2. Enter the appropriate in-network cost-sharing. If the QHP charges a copayment, enter “Not Applicable” in the In-Network Coinsurance fields. If the QHP charges coinsurance, enter “Not Applicable” in the In-Network Copayment fields. All cost-sharing fields must be completed to pass validation.

3. If a benefit has more than one cost-sharing (e.g., depending on where the service is received) enter the highest cost-sharing amount.

4. If the cost-sharing for a benefit is typically the result of adding two cost-sharing amounts together (e.g., surgical benefits such as transplants, reconstructive surgery, bariatric surgery, delivery and all inpatient services for maternity care), combine the total cost-sharing amounts and enter in the appropriate cost-sharing box.

5. If the QHP does not have out-of-network benefits for a given category, enter “Not Applicable” for the out-of-network copay fields and 100% for the out-of-network coinsurance fields. All cost-sharing fields must be completed to pass validation.

6. The subject to the deductible information must be entered in for each cost-sharing amount on the Cost Share Variance Sheet. Select the correct option when selecting the cost-sharing amount on the Cost Variance Sheet.
   a. If a QHP does not have a deductible, indicate the cost-sharing using “$X Coinsurance” or “$X Copay” without any reference to a deductible (e.g., $20 Copay).
   b. If the cost sharing for a specific benefit is subject to a deductible, note the deductible accordingly. (e.g., $20 Copay after deductible).
   c. If a QHP has a deductible with some benefits subject to the deductible and other not subject to the deductible, note the benefits subject to the deductible using the after deductible language (e.g., $20 Copay after deductible). Additionally, indicate benefits not subject to the deductible using the before deductible language (e.g., $20 Copay before deductible).

7. If a benefit is not subject to any cost sharing (i.e. preventive services), indicate “No Charge.”

8. Family Maximum Out of Pocket (MOOP) – per person and per group MOOP and deductible will both be captured in a pop-up and stored in a single cell in the template. Values must be entered in both per person and per group fields. (Either a dollar amount or “Not Applicable.”)

**Limited or Zero Cost Sharing Plan Information**
1. Copays and coinsurance values for all limited cost-sharing plan variations equal the associated standard plan values. This standard plan values will auto-populate and should not be changed.
2. All zero cost-sharing plan variations should be $0 copays and 0% coinsurance. Zeros will auto-populate and should not be changed for EHB. For non-EHB, the cost-sharing for the benefit must be the same as the full cost metal level version.

**Actuarial Value (AV) Calculator**

2. Troubleshooting the AV Calculator in the Plans & Benefits Template: The AV Calculator within the Plans & Benefits Template has known issues. Please review Chapter 11 Actuarial Value Calculator for instructions regarding the field mapping from the Plans & Benefits Template to the AV Calculator. A few issues to be aware of are the following:
   b. Default Coinsurance for Standard Plan Design: For platinum, gold and silver, the default coinsurance is 0%. For bronze, the default coinsurance is 50%.
   c. Copayments in Outpatient Facility Fee or Outpatient Surgery Physician/Surgical Services. The AV Calculator does not support copayments in these benefit fields. If the QHP being submitted uses copayments for either of these benefits, the QHP must be marked a Unique Plan Design with screen shots of the AV calculator associated from the traditional filing side of SERFF.

**Rate Template**

1. The Rate Template must be completed in order to provide the NYSOH with the rates for each HIOS Plan ID.
2. All fields indicated with a red asterisk are required.
3. Complete the top portion of the sheet first, inputting HIOS Issuer ID, Federal TIN, Rate Effective Date and Rate Expiration Date.
5. Select No Preference for Tobacco.
6. Select Family Option for Age for sheet containing HIOS Plan IDs other than Child Only.
7. Complete Individual column with the monthly premium rate for the Individual Tier.
8. Complete Couple column with the monthly premium rate for the Individual and Spouse Tier.
9. Complete the following columns with the monthly premium rate for the Parent and Child/Children Tier: Primary Subscriber and One Dependent; Primary Subscriber and Two Dependents; and Primary Subscriber and Three or More Dependents. **The same premium must be entered into all three columns.**

10. Complete the following columns with the monthly premium rate for the Family Tier: Couple and One Dependent; Couple and Two Dependents; and Couple and Three or More Dependents. **The same premium must be entered into all three columns.**

11. Repeat steps 2-8 for each applicable Rating Area.

12. Child Only QHPs must have a separate HIOS Plan ID from its corresponding Adult QHP.
   a. Create a new Rate Table by clicking the Add Sheet button.
   b. Complete Plan ID and Rating Area.
   c. For Tobacco, select No Preference.
   d. For Age, select 0-20.
   e. Enter the rate for the child only monthly premium rate in the Individual Rate box.

13. The template will not validate unless numbers are entered for the other ages from 21 through 65. Enter any number greater than the premium for ages 0-20. None of this information will be used but is necessary to pass validations.

14. **Small Group & Rolling Rates:** For all small group binders, the issuer must submit the rates for each quarter separately, creating a new sheet using the Add Sheet button. The issuer must then enter in the dates for each quarter in the Rate Effective Date and Rate Expiration Date to reflect effective dates for these premium rates. For example, an issuer submitting rates for the first quarter of 2016 would enter a rate effective date of 1/1/16 and a rate expiration date of 3/31/16. Do not include an expiration date of 2017. The purpose of the effective dates is to show what the rate will be on the first effective date of the plan year.

15. Refer to the DFS website at [http://www.dfs.ny.gov/insurance/ihealth.htm](http://www.dfs.ny.gov/insurance/ihealth.htm) for a listing of the counties within each of the rating regions listed below:
   a. Rating Area 1 – Albany Area
   b. Rating Area 2 – Buffalo Area
   c. Rating Area 3 – Mid-Hudson Area
   d. Rating Area 4 – New York City Area
   e. Rating Area 5 – Rochester Area
   f. Rating Area 6 – Syracuse Area
   g. Rating Area 7 – Utica/Watertown Area
   h. Rating Area 8 – Long Island

**Business Rules Template**

1. Issuers must complete the Business Rules Rate Template in order to provide the NYSOH with the rules regarding rates for each HIOS Plan ID.
2. All fields indicated with a red asterisk are required.
3. Enter the HIOS Issuer ID and TIN.
4. Complete the first line to indicate the General Business Rules. The following questions must be answered:
   a. Question 1: There are rates specifically for couples and for families (not just
addition of individual rates)

b. Questions 2 & 3 (Maximum Number of Children): 1 child.
c. Maximum Age of Child: 25
d. Maximum Number of Children for a Child Only Contract: 3 or more children.
e. Domestic Partner Coverage: Marked Yes treated as secondary subscribers.
f. Tobacco: Marked as Not Applicable.
g. All other questions: Answer as appropriate.
h. Dependent Relationships (column L): The following relationships are required to be checked and the residing question answered “No”: spouse, adopted child, stepson or stepdaughter, self & child. A “Life Partner” is a domestic partner. Individual coverage must check the Life Partner box and answer the residency question with the applicable answer. Group coverage should submit one HIOS Plan ID (Standard Component ID) with Life Partners covered and one without.

5. List each HIOS Plan ID in the binder and respond to each question, even if it duplicates the general business rules line. The NYSOH needs each HIOS Plan ID listed separately.

6. Maximum Age of Child: Enter 25 for QHPs that cover dependents to age 25. Enter 29 for QHPs that cover dependents to age 29. For Child-Only coverage, enter 21.

7. Domestic Partner Coverage & SHOP: Issuers must submit QHPs with and without domestic partner coverage. Create two identical QHPs using different HIOS Plan IDs using the same benefits and cost-sharing on the Plans & Benefits template. For QHPs that cover domestic partners, the HIOS Plan IDs on the Business Rules Template must indicate YES under the question “Are domestic partners treated the same as secondary subscribers” AND you must select “Life Partner, Yes” under the question “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber.”
Templates and Riders

The templates do not allow for the use of a separate line to account for rates relating to riders. Any variation in benefits must be accounted for using a separate HIOS Plan IDs.

Individual Coverage: Issuers must submit one QHP with dependent coverage through age 25 and the identical QHP with dependent coverage through age 29.

Small Group Coverage: Issuers must submit a QHP with each permutation, including:
  1. Dependent coverage through 25 and age 29;
  2. Contraceptive & Family Planning coverage included and excluded;
  3. Domestic partner coverage included and excluded.

Dependent Coverage Through Age 29 (Individual and Small Group):
  1. To submit a QHP with dependent coverage through age 25 and the same QHP with dependent coverage through age 29, create two identical QHPs using different HIOS Plan IDs using the same benefits and cost-sharing on the Plans & Benefits template.
  2. On the Business Rules template, enter both HIOS Plan IDs. For the QHP with coverage to age 25, answer the question “Is there a maximum age for a dependent?” with “yes” and enter 25. For the QHP with coverage to age 29, answer the question “Is there a maximum age for a dependent?” with “yes” and enter 29.

Contraceptive & Family Planning Coverage (Small Group Only):
  1. The base contract must include coverage for contraceptives and family planning services.
  2. For each small group QHP, submit a HIOS Plan ID with and without the coverage for the following benefits: Abortion for Which Public Funding is Prohibited, Family Planning Services, and Sterilization Procedures for Men.

Domestic Partner Coverage (Small Group Only):
  1. To submit a QHP with and without domestic partner coverage, create two identical QHPs using different HIOS Plan IDs using the same benefits and cost-sharing on the Plans & Benefits template.
  2. On the Business Rules template, enter the HIOS Plan ID for each QHP. For QHPs that cover domestic partners, the HIOS Plan IDs on the Business Rules Template must indicate YES under the question “Are domestic partners treated the same as secondary subscribers” AND you must select “Life Partner, Yes” under the question “What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber.”
# HIOS Plan IDs (Standard Component IDs)

Based on the instructions above, issuers must submit at least the following HIOS Plan IDs.

<table>
<thead>
<tr>
<th>Individual Standard Benefit Design HIOS Plan IDs</th>
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<tbody>
<tr>
<td>Bronze QHPs</td>
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<tr>
<td>Bronze with Dependent Age 25</td>
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<td>Bronze with Dependent Age 29</td>
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<tr>
<td>Silver QHPs</td>
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<td>Silver with Dependent Age 25</td>
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<td>Silver with Dependent Age 29</td>
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<tr>
<td>Gold QHPs</td>
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<td>Gold with Dependent Age 25</td>
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<tr>
<td>Gold with Dependent Age 29</td>
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<tr>
<td>Platinum QHPs</td>
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<tr>
<td>Platinum with Dependent Age 25</td>
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<td>Platinum with Dependent Age 29</td>
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<tr>
<td>Catastrophic Coverage</td>
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<tr>
<td>Catastrophic with Dependent Age 25</td>
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<tr>
<td>Child-Only Coverage</td>
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<td>Child-Only Bronze</td>
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<td>Child-Only Silver</td>
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<td>Child-Only Gold</td>
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<tr>
<td>Child-Only Platinum</td>
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**Total HIOS Plan IDs**: 13
<table>
<thead>
<tr>
<th>Small Group Standard Benefit Design HIOS Plan IDs</th>
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<tbody>
<tr>
<td><strong>Bronze QHPs</strong></td>
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<td><strong>Platinum QHPs</strong></td>
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