2027 Qualified Health Plan (QHP) Filing Instructions in SERFF (5/1/26)

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 should submit a separate binder per market type (individual or small group) for each NAIC Company Code. Also, if an issuer uses two different DBAs (or marketing names) with the same NAIC Company Code, it should submit separate binders for each DBA.

NYSOH Filings: Issuers should file QHP binders 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 submit duplicate plans in a separate off Exchange binder. Issuers should not include any specific HIOS Plan ID in more than one binder.

Off NYSOH Filings: Issuers should only create an off-Exchange binder when an issuer has plans only 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.

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. The following templates are required for QHP Binder filings:

Service Area Template	Information identifying an issuer's geographic service area.
Network Template	Information identifying an issuer's provider network.
Prescription Drug Template	Collects formulary data for plans.
Plans & Benefits Template	Collects plan and benefit information.
Rate Template	Collects rates necessary for display on the web portal.
Business Rules Template	Collects rules to explain the rating tables.
Transparency in Coverage Template	Collects information on claims and appeals.

Submission Requirements on the Supporting Documentation Tab. Each issuer must submit the following attachments on the Supporting Documentation Tab:

1. Program Attestations for State Based Marketplace Issuers (required for on Exchange binders only);
2. Logo File (required for on Exchange binders only); and
3. Administrative Template.

Associate Schedule Items Tab. 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 should also associate the actuarial value (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.

Network Adequacy Review, Accreditation & Quality Assurance Information. The Service Area

Template and Network Template should be submitted but no additional information regarding network adequacy should be submitted through SERFF. See the NYSOH Plan Invitation for submission of information regarding network adequacy, quality assurance, and accreditation. Please note that the Department of Financial Services (DFS) does not collect the Essential Community Providers or Network Adequacy Templates.

URLs. Issuers should submit the NYSOH URL Template to their Plan Manager, along with their Plan Invitation, for on-Exchange binders. URLs are not needed for off-Exchange binders.

Technical Requirements

1. **Form and Rate Filings.** Issuers should 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. The form and rate filing instructions, checklists, and model form language can be found on the DFS website.
2. **SERFF Instance.** Issuers must submit the binder using the same SERFF instance as the previously submitted form and rate filings.
3. **Apostrophes.** None of the content in any of the SERFF templates fields can contain apostrophes for binders to be transmitted to the NYSOH. The transmission will fail for the entire binder.

Template Instructions

Issuers must use the 2027 template versions when submitting their 2027 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 is available on the CMS QHP Certification website. 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.

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 two out of the five counties within their overall service area, the issuer must create two 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, select each 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. Verify that 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 on the Associated Schedule Items Tab.

11. An issuer must create separate service area IDs for Individual market service areas and SHOP market service areas. An issuer must use the same Service Area Template across all binders or ensure that no service area IDs repeat across binders.
12. If an issuer is a dual-product issuer (QHPs and QDPs), it must create two different service area IDs, one each for QHPs and QDPs, regardless of whether the service area is intended to serve both plan types. For example, **if an issuer offers QHP, SHOP, and QDP, they must have three different service area ID's, even if the service area is the same for all three products.**

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. **Include the word "Marketplace" in the network name for all Marketplace binders.**
4. Select a Network ID that was generated by the template to associate with the Network Name.
5. If the issuer has more than one network, repeat steps 2-4 for each network. One Network Template may include multiple networks.
6. If an issuer participates in both the Individual and SHOP markets, and unique networks are used in each market, do not use the same network ID for both networks. An issuer should use the same Network Template across all binders or ensure that no network IDs repeat across the binders.
7. If an issuer is a dual-product issuer (QHPs and QDPs), it must create two different network IDs, one each for QHPs and QDPs, regardless of whether the specific network is intended to serve both product types. For example**, if an issuer offers QHP, SHOP, and QDP, they must have three different network ID's, even if the network is the same for all three products.** For example, the Individual Market network ID should be NYN001, the SHOP network ID should be NYN002, and the QDP network ID should be NYN003.

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. On the Drug List sheet, enter the RXCUI and indicate the tier level of the drug. Indicate whether the drug requires preauthorization or step therapy. Add as many drug lists as needed.
5. On the Formulary Tiers sheet, select the Drug List ID from the drop-down menu.
6. Indicate the number of tiers on the formulary. Please note that a formulary may not contain more than three tiers of cost-sharing. The zero-cost preventive tier does not count as a tier.
7. Indicate the drug tier type from the menu of choices. Select all that apply.
8. 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.
9. The Prescription Drug Template accepts decimal points. Enter the exact cost-sharing, including any cents if applicable.
10. Drug Count Tool: Issuers should run the Drug Count Tool prior to binder submission from QHP Certification website. If an issuer determines that the formulary they are submitting has an inadequate

number of prescription drugs in a category or class, the issuer should provide an explanation for each deficiency. The explanations may be submitted as a separate document attached on the Supporting Documentation Tab.

11. **An issuer must create separate formulary IDs for Individual market and SHOP market.** An issuer must use the same Prescription Drug Template across all binders or ensure that no formulary IDs repeat across binders.

Plans & Benefits Template

General Information

1. The Service Area, Network, and Prescription Drug Templates should be completed prior to completing the Plans and Benefits Template.
2. All fields indicated with a red asterisk are required.
3. Download the most recent versions of the 2027 Plans & Benefits Add-In file and AV calculator.

HIOS Plan IDs (Standard Component IDs)

1. 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 2026 (e.g., the standard gold plan) must keep the same HIOS Plan ID in 2027. New HIOS Plan IDs may only be assigned when a new QHP is being submitted for certification.
2. The issuer must register its HIOS Plan IDs (Standard Component IDs) via HIOS.
3. Any variation in benefits or cost-sharing must be submitted using separate HIOS Plan IDs.
4. A HIOS Plan ID should only be submitted to the State in one binder.
5. HIOS Plan ID Limitations: The current limit of HIOS Plan IDs in a single binder is 350. If an issuer has a binder that exceeds that limit, contact the SERFF Help Desk. SERFF can temporarily increase the limit to allow the submission of the binder. Do not split the binder up into multiple binders.
6. Individual Coverage: Issuers must submit one QHP with dependent coverage through age 25 and the identical QHP with dependent coverage through age 29.
7. Small Group Coverage: Issuers must submit a QHP with each permutation, including:
    a. Dependent coverage through 25 and age 29;
    b. Contraceptive & Family Planning coverage included and excluded;
    c. Domestic partner coverage included and excluded.
8. See page 8 for a description for instructions regarding family planning and domestic partner coverage. See page 14 for instructions on dependent coverage.

Benefits Package Tab

1. A Benefits Package Tab consists of all QHPs that have the identical plan structure (including any quantitative limits and exclusions). **QHPs should be grouped together as much as possible to minimize added Benefit Package Tabs.** Added Benefit Package Tabs may be needed if the explanation provided for the "Design" box is different among plans.
2. **Place all the 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. *If the "Design" explanation is different among standard plans, an issuer may separate the standard plans in different Benefit Package Tabs.*

3. **Non-standard QHPs should be grouped together in a similar manner to reduce the amount of added Benefit Package Tabs, as long as the "Design" explanation is consistent among all grouped plans.**
4. Complete the top section of each Benefits Package worksheet that contains the HIOS Issuer ID, Issuer State, Market Coverage, and Dental Only Plan.

Plan Identifiers

1. Complete this section for each Benefit Package.
2. Complete a line per each HIOS Plan ID for each QHP.

Plan Attributes

1. Indicate whether the plan is a new or existing plan.
2. Select Plan Type and Level of Coverage.
3. Design Type field: Select "Not Applicable."
4. Indicate whether the QHP is a Unique Plan Design for the AV calculator.
5. 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, a plan must be available outside the NYSOH if it is available inside the NYSOH. The issuer should mark that particular HIOS Plan ID number as available both inside and outside the NYSOH under the QHP/Non-QHP field. Do not assign separate HIOS Plan IDs to the same plan that is offered both inside and outside the NYSOH.
6. Notice Required for Pregnancy: Select "no."
7. Composite Rating Indicator is required for small group coverage. Select "no."
8. 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 HIOS Plan ID for the corresponding adult only offering. A Child Only HIOS Plan ID is not required for Catastrophic coverage.
9. Tobacco Wellness Program Offered: Indicate whether the plan offers a wellness program designed to prevent or reduce tobacco use that meets the standards of Section 2705 of the Public Health Service (PHS) Act, as required to rate for tobacco use in the SHOP Market. (This is unrelated to whether the plan provides benefits for recommended preventive services, including tobacco-use counseling and interventions, under Section 2713 of the PHS Act.) Choose from the following:

Yes—if the plan offers a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act.

No—if the plan does not offer a wellness program designed to prevent or reduce tobacco use in accordance with Section 2705 of the PHS Act. In addition, enter **No** if either of the following applies:

- The plan is offered in the Individual Market.
- The plan is offered in the SHOP Market and does not rate for tobacco use.

10. EHB Percent of Total Premium is required for all individual plans except for Catastrophic coverage. The value entered must match the value on 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 1/1/2027 and the Plan Expiration Date must be 12/31/2027 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 Benefits (applicable to Individual NYSOH Coverage). After clicking the Refresh EHB data button follow these instructions for the standard plan design.

1. The following preset benefits are not marked as covered after the EHB add-in file has run. Leave the benefit cells blank or mark the following benefits as "Not Covered" for the standard plan design:
   a. All Adult Dental Services
   b. Long Term Care
   c. Private Duty Nursing
   d. Routine Eye Exams (Adult)
   e. Cosmetic Surgery
   f. Routine Foot Care
   g. Acupuncture
   h. Weight Loss Programs
   i. Basic Dental Care – Adult
   j. Orthodontia – Adult
   k. Major Dental Care – Adult
   l. Nutritional Counseling
2. Infertility: Add "Excludes IVF, GIFT and ZIFT" to the Exclusions box. Delete the sentence regarding age limits from the Benefit Explanation box.
3. As applicable, 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.
4. Prosthetics: Add "One external prosthetic device per limb per lifetime with coverage for repairs and replacements (limit does not apply to internal devices)" in the Benefit Explanation box.
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 the limit information provided below in the Benefit Explanation Box.
   a. Applied Behavior Analysis Based Therapies
   b. Breast Reconstructive Surgery
   c. Cardiac Rehabilitation
   d. Cochlear Implants: Input "One per ear per time covered" in the Benefit Explanation Box.
   e. Second Opinion
6. Added Benefits Using Custom Benefit Feature: The following benefits included in New York's essential health benefits (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 Benefit Explanation Box.
   a. Assistive Communication Devices

b. Autologous Blood Banking
c. 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.
d. Diabetic Equipment and Supplies
e. Family Planning Services
f. Inpatient Rehabilitation Services: Answer "Yes" to a Quantitate Limit on Service. Enter "60" in Limit Quantity. Enter "Days per Year" in the Limit Unit.
g. Medical Supplies
h. Preadmission Testing
i. Prostate Cancer Screening
j. Sterilization Procedures for Men
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. Telemedicine: If the issuer offers a telemedicine program, it may add a custom benefit.
m. Design. 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. Limit your explanation to 1,500 characters. If more characters are needed, contact your Plan Manager. Be sure to select "NO" for the Quantitative Limit. **Include the following description in the design field:**
    - Referrals requirements to access care (i.e., gatekeeper) or lack thereof;
    - Custom network features (e.g., tiered network, network limited to a particular hospital system, QHP using the patient centered or PCP medical home models) (NOTE: The Marketplace currently is designed to only display the 1st tier of cost-sharing); and
    - The type of deductible the plans have, either embedded or family. This may mean that issuers may need to add more "Benefit Package" tabs so that the type of deductible is the same for all plans on the tab.
    - Other features of the benefit design that will aid consumers in making their plan selection decisions. For non-standard plans, the issuer should describe the unique features of the non-standard plan so consumers understand how it is different from standard plans.

7. For each change from the EHB Add-in file, indicate the EHB Variance Reason by selecting the appropriate reason (e.g., Additional EHB Benefit).
8. Do not add any other benefits to the standard plans, except for substituted wellness benefits, telemedicine, or retail health clinics if offered. This ensures that all standard plans display the same for each issuer.

Non-Standard QHPs or SHOP QHPs

1. Issuers may substitute EHB in accordance with guidance found in NYSOH Plan Invitation 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 any of 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. Acupuncture: Use the "Acupuncture" benefit on the main list.

b. Adult Dental Care: Use the benefits (Routine Dental Services (Adult); Basic Dental Care – Adult; Major Dental Care –Adult; Orthodontia – Adult), as applicable, available on the main benefit list. Any waiting periods or benefit maximums for adult dental care benefits must be clearly listed in the Benefit Explanation box and should be included in the description in the Design field.
c. Adult Vision Care: 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: "Eye Glasses for Adults" "Contact Lenses". Indicate that the benefits are covered in the Is This Benefit Covered Box. Any waiting periods or benefit maximums for adult dental care benefits must be clearly listed in the Benefit Explanation box.
d. 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.
e. 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.

Reminders for SHOP/Small Group Issuers

1. Family Planning Services: For the plans that offer family planning services, the HIOS Plan IDs must list the following services as COVERED:
   a. Abortion for Which Public Funding is Prohibited;
   b. Family Planning Services; and
   c. Sterilization Procedures for Men.
2. Domestic Partner Coverage: For QHPs that cover domestic partners, the HIOS Plan IDs on the Business Rules Template 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."
3. SHOP Certification: Issuers seeking SHOP certification must submit their QHPs as "Both" in the QHP/non-QHP field on the Plan & Benefits Template. There is no limit on the number of HIOS Plan IDs that may be submitted for SHOP certification.
4. Healthy NY and SHOP Certification: Healthy NY may be submitted for SHOP certification for 2027. If seeking SHOP certification, the Healthy NY HIOS Plan IDs must be marked as "Both" in the QHP/non-QHP field on the Plan & Benefits Template.

Cost Share Variance Tab

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. 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.
3. 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
02 - Open to Indians below 300% FPL
03 - Open to Indians above 300% FPL
04 - 73% AV Silver Enhanced Plan *
05 - 87% AV Silver Supreme Plan **
06 - 94% AV Silver Plan

Note: ST and NS Silver Plans
* Issuers are to input "Enhanced" in the plan name for the 73% AV products
** Issuers are to input "Supreme" in the plan name for the 87% AV products

***The naming conventions for 04 and 05 are subject to the availability of funding for PY 2027.

Cost Sharing Attributes

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

SBC Scenario Information

1. The SBC scenario information is required. Fill out the deductible, copayment, coinsurance, and limits accordingly.

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.
2. Family Maximum Out-of-Pocket and Family Deductible: If a plan embeds a maximum out-of-pocket or deductible for each person within the family, enter the number as the per person amount. Check the "Not applicable" box when the plan does not embed an amount for each person within the family. Enter the dollar amount that applies to the family collectively as the per group amount.

HSA/HRA Detail

1. Indicate whether the plan is designed to be used with an HSA/HRA. For small group market binders, indicate whether an employer contribution is made towards the HSA and enter the amount as applicable in the boxes under current federal regulations and guidance. Leave the HSA Employer Contribution boxes field blank for individual market binders.

AV Calculator Additional Benefit Design

1. Respond to the questions as applicable. The responses are used when running the AV calculator within the Plans & Benefits Template.

Entering Cost Sharing Information for Specific Services

1. The cost-sharing on the Plans & Benefits Template reflects the cost-sharing the consumer typically pays for the service.
2. Cost-Sharing for Specific Services.
   a. "Other Practitioner Office Visit (Nurse, Physician Assistant)" should be the same cost sharing as "Primary Care Visit to Treat an Injury or Illness."
   b. "Hospice Services" should reflect the outpatient cost sharing.
   c. "Treatment for Temporomandibular Joint Disorders" should reflect the specialist cost-sharing.
3. Enter "Not Applicable" for the cost-sharing for the following services:
   a. Infertility Treatment
   b. Design
   c. Accidental Dental
4. 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.
5. Multiple Cost-Sharing Amounts for One Benefit. If a benefit has more than one cost-sharing (e.g., depending on where the service is received), enter the highest cost-sharing amount. In the alternative, issuers may also choose to enter the predominant cost-sharing amount for a given service. DFS reviewers may ask issuers to make changes to cost-sharing so that all benefits display the same for standard plans across all issuers. For non-standard plans, issuers have more flexibility to determine how they would like their cost-sharing to be displayed on the NYSOH portal, but issuers should carefully review the cost-sharing amounts entered and verify that they are accurate and not misleading.
6. Surgical Benefits – Adding of Multiple Copayments. 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, breast 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.
7. Copy/Paste for Certain Benefits. For Inpatient Hospital Services (e.g., Hospital Stay) and Skilled Nursing Facility covered benefits, do not copy and paste cost-sharing values entered for other benefits (e.g., $25 copay). The entered values should have the "per day" or "per stay" qualifiers. Copying and pasting any other cost sharing values could negatively affect the AV calculation.
8. Cost-Sharing for Plans without OON Coverage. If the QHP does not have out-of-network benefits for a given category, enter "Not Applicable" for the out-of-network copay fields and 100% for the out-of-network coinsurance fields. All cost-sharing fields must be completed to pass validation.
9. Subject to the Deductible. The subject to the deductible information must be entered in for each cost-sharing amount on the Cost Share Variance Sheet. Select the correct option when selecting the cost-sharing amount on the Cost Variance Sheet.
   a. Plans with No Deductible: If a QHP does not have a deductible, indicate the cost-sharing using "$X Coinsurance" or "$X Copay" without any reference to a deductible (e.g., $20 Copay).
   b. Plans with Deductibles: If the cost sharing for a specific benefit is subject to a deductible, note the cost-sharing is applied after the deductible. (e.g., $20 Copay after deductible). If a QHP has a deductible with some benefits subject to the deductible and others not subject to the deductible, note the benefits subject to the deductible using the after deductible language (e.g., $20 Copay after deductible) Note benefits with cost-sharing before the deductible using "$X Copay with deductible" option. The cost-sharing drop-down "$X copay with deductible," will now take the place of the option "$X copay before deductible" that was shown in previous years.
10. Preventive Care. If a benefit is not subject to any cost sharing (e.g., preventive services), indicate "No Charge." The following benefits are considered preventive:
    a. Prenatal Care.

b. Preventive Care/Screening/Immunization
c. Well Baby Visits and Care
d. Family Planning Services

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 variant of the plan.

Actuarial Value (AV) Calculator

1. The CMS QHP Application Instructions provides detailed information regarding running the Actuarial Calculator inside the Plans & Benefits Template. It contains a cross walk of the fields between the stand-alone calculator and the Plans & Benefits Template. Please review the instructions available at https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Plans-and-Benefits.
2. Default Coinsurance for Standard Plan Design: For platinum, gold and silver, the default coinsurance is 0%. For bronze, the default coinsurance is 50%.

Rates Template

1. The Rate Template must be completed 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.
4. For Rating Method, select Family-Tiered Rates for a sheet containing HIOS Plan IDs other than Child Only HIOS Plan IDs.
5. Complete HIOS Plan ID and Rating Area. Only one Rating Area can be selected per line.
6. Select No Preference for Tobacco.
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 in 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 in 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. For Rating Method, select Age-Based Rates.
    c. Complete Plan ID and Rating Area.
    d. For Tobacco, select No Preference.
    e. Enter the child only monthly premium rate in the Individual Rate box.
13. Validation Issue: QHPs must enter a value above $0.00 for all age bands under the Individual Rate column unless the response Allows Child-Only under Child-Only Offering in the Plans & Benefits

Template. QHP Child-Only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19,and 20 age bands and are allowed to enter a value of $0.00 for adult age bands 21 through 64 and over. None of this information over age 20 will be used but is necessary to pass validations. Note that the premiums entered for the age bands from 0-20 should be the same number

14. Small Group & Rolling Rates: For all small group binders, the issuer should 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 2027 would enter a rate effective date of 1/1/2027 and a rate expiration date of 3/31/2027. Do not include an expiration date of 12/31/2027 for the first, second, or third quarters. The purpose of the effective dates is to show what the rates will be for each quarter of the plan year.
15. Rating Regions: See the DFS website for a listing of the counties within these rating regions:
    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 should complete the Business Rules 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 indicate that the template is "Medical."
4. Complete the first line to indicate the General Business Rules. The following questions must be answered:
    a. Maximum Number of Underage Dependents: 1 child
    b. Maximum Age of Child: 25
    c. How is Age Determined: Age on effective date
    d. Tobacco: Marked as Not Applicable.
    e. Dependent Relationships (column H): The following relationships are required to be checked and the residing question answered "No": spouse, child, and stepson or stepdaughter. A "Life Partner" is a domestic partner. Individual coverage should check the Life Partner box and respond "Yes" to the residency question. Group coverage should enter the applicable answer.
5. List **each** HIOS Plan ID in the binder and respond to each question, even if it duplicates the general business rules line, as 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 "Not Applicable."
7. Domestic Partner Coverage & SHOP: Issuers should 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 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."

Transparency in Coverage Template

1. Issuers should complete the Transparency in Coverage Template using the instructions available at https://www.qhpcertification.cms.gov/QHP/applicationmaterials/Transparency-in-Coverage.

HIOS Plan IDs (Standard Component IDs)

Issuers should submit at least the following HIOS Plan IDs for individual standard plans.

Individual Standard Benefit Design HIOS Plan IDs	
Bronze QHPs	Bronze with Dependent Age 25 Bronze with Dependent Age 29
Silver QHPs	Silver with Dependent Age 25 Silver with Dependent Age 29
Gold QHPs	Gold with Dependent Age 25 Gold with Dependent Age 29
Platinum QHPs	Platinum with Dependent Age 25 Platinum with Dependent Age 29
Catastrophic Coverage	Catastrophic with Dependent Age 25
Child-Only Coverage	Child-Only Bronze Child-Only Silver Child-Only Gold Child-Only Platinum
Total HIOS Plan IDs	**13**

Issuers should follow the guide below regarding HIOS Plan IDs for small group plans.

Small Group HIOS Plan IDs Examples	
Bronze QHPs	Dependent Age 25, Domestic Partner & Family Planning Dependent Age 29, Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & Family Planning Dependent Age 29, No Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & No Family Planning Dependent Age 29, No Domestic Partner & No Family Planning
	Dependent Age 25, Domestic Partner & No Family Planning Dependent Age 29, Domestic Partner & No Family Planning
Silver QHPs	Dependent Age 25, Domestic Partner & Family Planning Dependent Age 29, Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & Family Planning Dependent Age 29, No Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & No Family Planning Dependent Age 29, No Domestic Partner & No Family Planning
	Dependent Age 25, Domestic Partner & No Family Planning Dependent Age 29, Domestic Partner & No Family Planning
Gold QHPs	Dependent Age 25, Domestic Partner & Family Planning Dependent Age 29, Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & Family Planning Dependent Age 29, No Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & No Family Planning Dependent Age 29, No Domestic Partner & No Family Planning
	Dependent Age 25, Domestic Partner & No Family Planning Dependent Age 29, Domestic Partner & No Family Planning
Platinum QHPs	Dependent Age 25, Domestic Partner & Family Planning Dependent Age 29, Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & Family Planning Dependent Age 29, No Domestic Partner & Family Planning
	Dependent Age 25, No Domestic Partner & No Family Planning Dependent Age 29, No Domestic Partner & No Family Planning
	Dependent Age 25, Domestic Partner & No Family Planning Dependent Age 29, Domestic Partner & No Family Planning