Ideon Benefit Grammar

A Guide to Major Medical Rules and Conventions

Benefits by Field - Metadata

Abortion Rider

ETL Field: abortion_rider **PD Sheet Field:** N/A **API Field:** abortion_rider
Howie Field: Abortion Rider Included

SBC Location

- Common Medical Event: If you are pregnant
- Services You May Need:
    - Childbirth/delivery professional services
    - Childbirth/delivery facility services
- Other:
    - Services Your Plan Generally Does NOT Cover
    - Other Covered Services

Definition: If abortion services are covered by a plan.

Field Logic: Boolean

QHP Builder Mapping

- Benefits Package: Abortion for Which Public Funding is Prohibited
- Cost Share Variances: N/A

Unique Building Rules

A QHP value of "Yes" should be kept as such if an SBC does not mention this type of benefit in any way; however, if noted at all in the SBC, the SBC value should be used.

Coverage for abortions only when medically necessary should be marked True (Example)
Coverage only for cases of rape or incest should also be marked as True (Example)

- If this rider is present in the Services Your Plan Generally Does NOT Cover section, mark it as True. (Example)

If pregnancy termination language is used, consider this as abortion.

- (Example) This should be marked as True

Coverage for Elective Abortions or similar language is used, should be marked as True (Example)

Actively Marketed

ETL Field: actively_marketed
PD Sheet Field: actively_marketed **API Field:** actively_marketed **Howie Field:** Actively Marketed
Definition: Whether or not a carrier intends to market a plan to customers.

Field Logic: Enum

Information Source

- These are medical plans insurance carriers will file with the state but will decide not to market these plans to customers.
    - If it is difficult to find the plan on the insurance carriers website or an easy way to purchase the plan, it may not be actively marketed.
- This is typically only known for Carrier Direct issuers.

- If a carrier sends less plans than are found via acquisition, non carrier-provided plans are assumed to be not Actively Marketed.
- If a carrier sends differing numbers of plans for benefits/rates, Carrier Operations will reach out

to confirm that “extra” benefits or rates are for plans that are not Actively Marketed.

- If this is the case, Data Operations will scope for the missing data for these plans (with

tickets often marked “NAM”).

- Ideon currently captures this value in the ETL with the following statuses at the plan level:
  - TRUE: The plan is actively marketed and should appear in the customer's API and bulk flat files.
  - FALSE: The plan is not actively marketed. Not actively marketed plans do not appear in the customer's API but they do appear in the bulk flat files.
  - UNKNOWN: There is no explicit value and the plans will be presented as if the value were TRUE.
  - RENEWAL_ONLY: These plans are not offered to new groups. The status has the same effect as FALSE for new groups and TRUE for renewing groups.

Unique Building Rules

- “Unknown” in Howie returns “True” in the API and ETL.

Actuarial Value

ETL Field: actuarial_value
PD Sheet Field: actuarial_value **API Field:** actuarial_value **Howie Field:** Actuarial Value (%)
Field Logic: Numeric (float)
QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Issuer Actuarial Value

Definition: The percentage of total average costs for covered benefits that a plan will pay for. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.[1]
Information Source

- This information is most commonly found in the URR, QHPs, AV tables, and some Rate Filings.

Unique Building Rules

- Some sources, such QHPs and the URR, provide both AV Metal and AV Price values. Capture AV Metal values, which should be a numeric value between 0 and 1.
- When building Carrier Direct plans, if this information is not provided by a carrier, it should be added from the URR (or other source as applicable). This is only necessary if the plans are easily mappable to the URR via HIOS ID or Plan Name.
  - This benefit should not be added to plans with “fake” HIOS ID’s (-13 variation)

Adult Dental

ETL Field: adult_dental
PD Sheet Field: basic_dental_care_adult
API Field: adult_dental
Howie Field: Adult Dental

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - Services Your Plan Generally Does NOT Cover
    - Other Covered Services

Field Logic: Boolean

QHP Builder Mapping

1 https://www.healthcare.gov/glossary/actuarial-value/

Benefits Package: Routine Dental Services (Adult)

Cost Share Variances: N/A

Definition: If a plan provides coverage for basic/routine adult dental care.

Unique Building Rules

- A QHP value of "Yes" should be kept as such if an SBC does not mention this type of benefit in any way;

  however, if noted at all in the SBC, the SBC value should be used.

- These benefits are sometimes referred to as "Prophylaxis."
- Benefits listed as "most dental care is not covered" should be Ture (Example).
- We only capture if Adult Dental is for routine coverage. Capture as false if coverage is limited to injury of a sound natural tooth or accidental. (Example)
- Ideon currently captures this value in the ETL with the following statuses at the plan level:
    - True - There is coverage. False - There is NO coverage. Null - Coverage is unknown

Audience

ETL Field: N/A

PD Sheet Field: audience

API Field: N/A

Howie Field: Audience

Definition: Who is eligible to purchase a health plan.

Field Logic: Enum

QHP Builder Mapping

- Benefits Package: Market Coverage
- Cost Share Variances: N/A

Information Source

- This information is provided by QHPs, the URR, and many Rate Filings.
- Individual plans may be independently purchased through the Health Insurance Marketplace.
- Small Group plans are offered through one's employer.
    - In most states[2], companies with up to 50 employees may offer Small Group plans.

Unique Building Rules

- Valid benefits for this field include:
    - Individual

- Small Group

Chiropractic Services

ETL Field: chiropractic_services
PD Sheet Field: chiropractic_services

2 http://www.ncsl.org/portals/1/ImageLibrary/WebImages/Health/Small_Group_Ins_Size-2017.gif
API Field: chiropractic_services
Howie Field: Chiropractic Services
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - These details for this benefit are not always laid out in SBCs. If this benefit is included, it is (almost always) included in one of the following sections:
        - Services Your Plan Generally Does NOT Cover
        - Other Covered Services
        - Primary care visit to treat an injury or illness
        - Specialist visit
        - Rehabilitation services
        - Habilitation services
    - This benefit may also be included in one of the following sections (which are not present in every SBC):
        - Other practitioner office visit
        - Chiropractor

Definition: The cost share for services rendered by a chiropractor.
Field Logic: Boolean
QHP Builder Mapping

- Benefits Package: Chiropractic Care
- Cost Share Variances: Chiropractic Care

Unique Building Rules

- A QHP value of “Yes” should be kept as such if an SBC does not mention this type of benefit in any way; however, if noted at all in the SBC, the SBC value should be used.
- Only capture this benefit when “chiropractor” is specifically mentioned.
    - Do not capture benefits that only say “spinal manipulations” however if both “Chiropractor” and “manipulations" are mentioned then it’s acceptable to capture. (Example) (Example 2)
- Ideon currently captures this value in the ETL with the following statuses at the plan level:
    - True - There is coverage. False - There is NO coverage. Null - It’s unknown.

Contract Code

ETL Field: issuer_plan_code
PD Sheet Field: contract_code
API Field: Identifiers: “value” (“type”: “contract_id”)
Howie Field: Contract ID
Definition: A unique code, consisting of letters and/or numbers, that is created by a plan’s carrier. While a single plan code applies to only one plan, one health plan may have multiple plan codes.
Field Logic: String

Information Source

- Plan codes are most commonly found in benefit documents sent directly to Vericred from carriers.
- Plan codes can sometimes be found in Brochures or Rate Filings.
- Some plan names include plan codes (including plan names found in the URR).

Covered Ages

ETL Field: covered_ages
PD Sheet Field: child_only_offering
API Field: covered_ages
Howie Field: Covered Ages
Definition: Whether a plan allows for coverage of adults, children, or both.
Field Logic: Enum
QHP Builder Mapping

- Benefits Package: Child-Only Offering
- Cost Share Variances: N/A

Information Source

- QHPs provide this information in the "Benefits Package" tab under the header "Child-Only Offering."
- Plan names may contain a "Child-Only" indicator.
- New York Rate Filings may contain a table that indicates if a plan is child-only.

Unique Building Rules:

- Valid benefits for this field include the following:
    - Allows Adult and Child-Only
        - Any combination of adults and/or children may enroll.
    - Allows Adult-Only
        - Only adults may enroll.
    - Allows Child-Only
        - Only children may enroll.
    - Requires Adult
        - Adults or children may enroll, as long as the family contains at least 1 adult.
- In the absence of any information, default to Allows Adult and Child-Only.
- Child-only plans are only offered in the New York Individual market.

Drug Formulary URL

ETL Field: drug_formulary_url **PD Sheet Field:** drug_formulary **API Field:** drug_formulary_url **Howie Field:** Drug Formulary
SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: N/A
- Other:
    - URL will be posted directly in the "Common Medical Event" column
        - Ex: "More information about prescription drug coverage is available at https://www11.empireblue.com/pharmacyinformation/"

Definition: A URL that leads to a carrier's formulary information page. This area of the carrier's website will

provide detailed information about prescription drug coverage.

Field Logic: String

Unique Building Rules

- Remove any spaces or invalid characters, such as parentheses, to create a functioning URL.
- SBC Formulary URLs should be replace CMS URLs, if different.
- Some URL's redirect to another website once opened; always open the URL and use the re-directed link.
    - Provide the URL even if the website does not seem to be currently working (ie. "The page you are looking for is no longer in service").
    - When opening the URL, if the URL changes each time you open it, use the original link and not the redirect link. Example - Note: Humana is not a case for this, those are valid links.
- If PUF files bring in this field for an IND issuer then it does NOT need to be overwritten by the SBC value and there should be no manual changes.
- If there is no URL and only a phone number, don't capture it. Example

Effective Date

ETL Field: effective_date **PD Sheet Field:** N/A **API Field:** effective_date **Howie Field:** N/A

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - The top right corner of the SBC should state the "Coverage Period." The first date listed here is

      the effective date. (Page 1)

Definition: The date when a plan begins to offer coverage.

Field Logic: Date

QHP Builder Mapping

- Benefits Package: Plan Effective Date*
- Cost Share Variances: N/A

Information Source

- This information can be found in all SBCs, QHPs, and most Rate Filing documents.
- This field needs the expiration date field to make a plan publishable and should only be built out manually for LG. For SG/IND it should be brought in from QHP builder. It's not necessary to be built manually otherwise.
- Formatted as year-month-day. Example: 2021-01-01

Embedded Deductible

ETL Field: embedded_deductible

PD Sheet Field: embedded_deductible **API Field:** embedded_deductible **Howie Field:** Embedded Deductible

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - This can be found on the first page of an SBC under Why This Matters for Important Questions: What is the overall deductible? (Page 1)

Definition: Embedded deductible means that each member of a family must meet their own individual deductible before receiving coverage. For non-embedded deductibles, the family as a whole needs to meet the overall family-level deductible

before receiving coverage. However, one person could potentially meet the family deductible by themselves, triggering coverage for all family members.[3]

Field Logic: Enum

Unique Building Rules

- The valid benefits for this field are:
    - embedded
    - non_embedded
    - Unknown
    - Null
- If there is no mention of the Family Medical Deductible, this field should be built as "Unknown."
    - When both embedded OR non embedded apply, we leave it blank or as "Unknown"
- Plans with a non-embedded deductible may be listed as "aggregate."
- If there is no mention of an embedded deductible in a document, but the document does say "individual deductible within a family" or similar language, we can capture this field as "embedded" (Example).
- If this benefit has different values present for In-Network and Out-of-Network, capture the In-Network values (Example).

[3] https://www.healthinsurance.org/glossary/embedded-deductible/

Est. Actuarial Value

ETL Field: estimated_actuarial_value

PD Sheet Field:

API Field:

Howie Field: EST. Actuarial Value (%)

Field Logic: Numeric (float)

Definition: The percentage of total average costs for covered benefits that a plan will pay for. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits.[4] Vericred does an automatic internal calculation for this field with the data ingested.

Information Source

- Ideon calculates this so the source is Ideon.

Expiration Date

ETL Field: expiration_date

PD Sheet Field: N/A

API Field: expiration_date

Howie Field: N/A

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - The top right corner of the SBC should state the "Coverage Period." The second date listed here

is the expiration date. (Page 1) **Definition:** The final date of coverage by a health plan. **Field Logic:** Date

QHP Builder Mapping

- Benefits Package: Plan Expiration Date
- Cost Share Variances: N/A

Information Source

- This information can be found in all SBCs, QHPs, and most Rate Filing documents.
- This field needs the effective date field to make a plan publishable and should only be built out manually for LG. For SG/IND it should be brought in from QHP builder. It's not necessary to be built manually otherwise.
- Formatted as year-month-day. Example: 2021-12-31

4 https://www.healthcare.gov/glossary/actuarial-value/

Gated

ETL Field: gated
PD Sheet Field: gated **API Field:** gated **Howie Field:** Gated
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: Do you need a referral to see a specialist? (Page 1)

Definition: Gated plans require a referral (written or electronic) in order to see a specialist. Plans that are not gated allow consumers to see a specialist without first receiving a referral.
Field Logic: Enum
QHP Builder Mapping

- Benefits Package: Is a Referral Required for Specialist?*
- Cost Share Variances: N/A

Unique Building Rules

- When an SBC requires referral out-of-network, but no referral is required in-network, capture as Not Gated. (Example)

HSA Eligible

ETL Field: hsa_eligible
PD Sheet Field: hsa_eligible **API Field:** hsa_eligible **Howie Field:** HSA Eligible
Definition: Whether or not a plan makes the consumer eligible to create and use a Health Savings Account (HSA), which allows them to put money away pre-tax to pay for a variety of medical expenses.[5]
Field Logic: Enum
QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: HSA Eligible*

Information Source

As of June 2021 HSA Eligible flag is now automatically populated. Please do not populate manually.

5 https://www.healthcare.gov/glossary/health-savings-account-hsa/

Parameters for HSA eligibility are determined by the IRS[6] and adjusted yearly.

Benefit QHPs provide eligibility information, along with some rate filings.
Many HSA eligible plans contain "HSA" or "Health Savings" in the plan name.

2024[7] HSA Eligible plans must:

- Be a High Deductible Health Plan (HDHP) with:
  - An in-network Individual Medical Deductible of at least $1,650.
  - An in-network Family Medical Deductible of at least $3,300.
  - An in-network Individual Medical MOOP of no more than $8,300.
  - An in-network Family Medical MOOP of no more than $16,600.
- Have the deductible apply to **all** benefits (medical + drug) except Preventative Care.[8]
  - Pediatric vision and dental benefits are excluded from this requirement.
  - Prenatal/Postnatal benefits may be covered before the deductible, as some carriers consider these visits to be preventative care; a value of $0 for either of these fields should not be solely used to deem a plan as ineligible.
- Have all deductibles, copays, and coinsurance for in-network benefits must count towards the plan's MOOP.[9]

- 2020 HSA Eligible requirements can be found here
- 2021 HSA Eligible requirements can be found here
- 2022 HSA Eligible requirements can be found here
- 2023 HSA Eligible requirements can be found here
- 2024 HSA Eligible requirements can be found here
- 2025 HSA Eligible requirements can be found here
  - Changes: 1,650 IND 3,300 FAM – Deductibles (up 50, up 100)
  - Changes: 8,300 IND 16,600 FAM – MOOPs (up 150, up 500)
  -

An HDHP may provide preventive care benefits without a deductible or with a deductible less than the minimum annual deductible. Preventive care includes, but isn't limited to, the following.

1. Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals.
2. Routine prenatal and well-child care.
3. Child and adult immunizations.
4. Tobacco cessation programs.
5. Obesity weight-loss programs.
6. Screening services. This includes screening services for the following.
   a. Cancer.
   b. Heart and vascular diseases.
   c. Infectious diseases.
   d. Mental health conditions. - OP
   e. Substance abuse. - OP

6 https://www.law.cornell.edu/uscode/text/26/223
7 https://www.irs.gov/pub/irs-irbs/irb19-22.pdf (page 26)
8 https://money.usnews.com/money/blogs/my-money/articles/how-to-know-if-your-health-insurance-is-hsa-qualified
9 https://www.uhc.com/content/dam/uhcdotcom/en/HealthReform/PDF/Provisions/reform-hsa-external-flier-guidelines.pdf

   f. Metabolic, nutritional, and endocrine conditions.

Musculoskeletal disorders.

Obstetric and gynecological conditions.

Pediatric conditions.

Vision and hearing disorders.

Infertility Treatment Rider

ETL Field: infertility_treatment_rider
PD Sheet Field: N/A
API Field: infertility_treatment_rider
Howie Field: Infertility Treatment Rider Included
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - Services Your Plan Generally Does NOT Cover
    - Other Covered Services

Definition: If a plan covers services related to infertility treatment.
Field Logic: Boolean
QHP Builder Mapping

- Benefits Package: Infertility Treatment
- Cost Share Variances: N/A

Unique Building Rules

- This should be marked true when the rider is available for a plan.
- Some plan names include “INF” if this rider is included.
- A QHP value of “Yes” should be kept as such if an SBC does not mention this type of benefit in any way;

  however, if noted at all in the SBC, the SBC value should be used.

- We take infertility treatment as true even if it is limited to artificial insemination, limited to the diagnosis & treatment of underlying medical condition, or potentially other examples ; generally we’re saying if there is some type of coverage listed in the SBC we would mark this field as true.
    - Example: Treatment of the underlying medical condition
    - Example: Limited to artificial insemination; requires pre approval
    - Example: Testing only
    - Example: If it’s both True and False, capture it as True
- We take infertility treatment as true even if it is limited to certain ages (Example).

Level

ETL Field: level
PD Sheet Field: level_of_coverage
API Field: level
Howie Field: Level
Definition: A plan’s corresponding metal level, which provides an estimation as to the division of costs between the consumer and the healthcare provider.[10]
Field Logic: Enum
QHP Builder Mapping

- Benefits Package: Level of Coverage*
- Cost Share Variances: "Level of Coverage* (Metal Level)

Information Source:

- This information can be found in QHPs, the URR, and some Rate Filings.
- Some plan names contain metal information.

Unique Building Rules

- Valid benefits for this field include the following:
    - Bronze
    - Expanded Bronze
    - Silver
    - Gold
    - Platinum
    - Catastrophic
- When there is a discrepancy between an SBC name or Plan Name and the URR, capture the metal level listed in the URR.
- Follow actuarial value to determine which plans to manually update for expanded bronze.
    - If AV is above > 62%, plan should be marked as expanded bronze.
    - If plan is at or below <= 62%, plan can be kept as bronze.
    - If a carrier file has an AV below 62% and lists the plans expanded bronze, plan can be kept as expanded bronze
        - 62% is not a set rule in ACA medical insurance and is rather an indicator to us.

10 https://www.healthcare.gov/choose-a-plan/plans-categories/

Mail Order Rx

ETL Field: mail_order_rx

PD Sheet Field: mail_order_rx **API Field:** mail_order_rx **Howie Field:** Mail Order RX

SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: (All)
- Other: N/A

Definition: A multiplier that can be used to determine in-network Mail Order pricing for prescription drugs, based on the drug's Retail price.

Field Logic: Numeric (float)

Unique Building Rules

- The drug tier with the lowest non-zero copay should be used to calculate this benefit (Example).
- In cases where Retail and Mail Order drugs have equal coinsurance amounts (in all applicable drug tiers), this benefit should be captured as "1.0" (Example).
    - In instances where mail order is mentioned but does not show multiplier it can be assumed to be 1.0. (Example)
    - This is true every time there is a coinsurance amount, even if the limit specifies a different mail order value for copays (Example).
    - Relevant prescription types may be noted in the Limitations and Exceptions rather than within the benefit grid (Example).
- Only consider values that specify "Mail Order" or "Home Delivery" or "Mail Service;" "90 day supply"

values should not be considered unless they are also specified as Mail Order prescriptions.

- We do not capture values that only provide mail order values for maintenance drugs (Example).
- In instances where drugs are tiered by pharmacy, capture the Mail Order value for the In-Network-Tier- 1 pharmacy (Example).
- When coinsurance values are listed with an "up to $X amount" and the "up to X amount" goes up by a divisible multiplier, we would take that value and not 1.0. Example mail order rx should be 3.0 . Example 2 mail order rx would be 2.0 and not 1.0
- On the flip side, we ignore minimum copays when calculating the mail order value (Example).
- These values must be non-zero, contain no more than 2 decimal points, and should be rounded down or up in certain cases.
    - (Example) Mail order would be rounded down from 2.5333 to 2.5. 1.666 would rounded up to 1.7.
    - Mail order would be rounded up from 2.5555 to 2.6. 1.6333 rounded down to 1.6
    - Mail order would be captured from 2.545 to 2.5.
- When mail order values are less than their retail counterparts, that indicates the mail order is discounted and, in turn, we do not capture
- When given the option between **30-day supply mail order** vs. **90-day supply mail order**, capture the values for **30-day supply** (Example).

Name

ETL Field: name
PD Sheet Field: plan_marketing_name
API Field: name
Howie Field: Name
Definition: The name of a plan, as defined by the plans carrier.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Plan Marketing Name*
- Cost Share Variances: Plan Variant Marketing Name*

Information Source

- Plan names can be found in QHPs, SOBs, and the URR, along with most Brochures and Rate Filings.

Unique Building Rules

- Different source types may provide names that are slightly, or almost entirely, different.
    - Carrier Direct plans must use the plan names provided in carrier files unless explicitly instructed by the Carrier Operations team.
    - Generally for non Carrier Direct issuers, QHPs are the highest source of truth for plan names, followed by the URR.
        - If a QHP Plan Name seems unusually vague or contains special characters, the URR Plan Name should be reviewed to see if it offers a correction (and can be used above the QHP in these instances).
        - An SOB or Rate Filing may contain more detailed plan names than are present in the URR, and may be considered a higher source on such occasions.

Package Codes

ETL Field: package_codes
PD Sheet Field: N/A

API Field: Identifiers: “value” (“type”: “package_codes”)
Howie Field: Package Codes
Definition: A code which defines groups of plans that may be offered by an employer.
Field Logic: String
Information Source

- This information is provided by the UnitedHealthcare B2B Plans file in the “package_codes” column.

Unique Building Rules

- While Package Codes can be manually entered or edited in Howie, any issues should be brought to the attention of the Product team.

  Any problems found likely indicate issues with processing the B2B Plans file.

If there is multiple package codes for a single plan, there should be no space after the comma separating the package codes (i.e MT55,MT56 is correct and MT55, MT56 is incorrect)

Plan Calendar

ETL Field: plan_calendar
PD Sheet Field: plan_calendar **API Field:** plan_calendar **Howie Field:** Plan Calendar
Definition: Whether accumulations of cost sharing towards deductibles reset with the calendar year or the plan’s year.
Field Logic: Enum
Information Source

- Some SBCs and SOBs define a plan’s Plan Calendar when stating Deductible information (Example).

Unique Building Rules

- Valid benefits for this field include the following:
  - Calendar Year
  - Plan Year
- Individual plans will always have a Plan Calendar of Calendar Year.
  - All audiences for California plans should always be marked as Calendar Year.
- Small Group plans should be marked as Plan Year, unless a source explicitly states that Calendar Year applies (Example).
  - “Deductible resets in January” or “Deductible begins January 1st” should be captured as

    Calendar Year (Example).

  - If no information is given on an SBC (like with $0 deductibles) but every other SBC in a carrier is captured as Calendar Year, the $0 SBC should also be captured as Calendar Year (Example).

Plan Coinsurance

ETL Field: plan_coinsurance
PD Sheet Field: N/A
API Field: plan_coinsurance
Howie Field: Plan Coinsurance
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - What You Will Pay - Network Provider (You will pay the least)

Definition: The percentage of costs a person will pay for covered health services after they have met their deductible.[11]

Field Logic: Numeric

Unique Building Rules

- Should be captured as "##%" (Examples: 20%, 5%).
- This benefit consists of the most common coinsurance amount within the following fields:
- diagnostic_test
- durable_medical_equipment
- habilitation_services
- home_health_care
- hospice_service
- imaging_center
- imaging_physician
- inpatient_birth
- inpatient_birth_physician
- inpatient_facility
- inpatient_mental_health
- inpatient_physician
- inpatient_substance
- lab_test
- outpatient_ambulatory_care_center
- outpatient_facility
- outpatient_mental_health
- outpatient_physician
- outpatient_substance
- postnatal_care
- prenatal_care
- primary_care_physician
- rehabilitation_services
- skilled_nursing
- specialist
- For plans where none of the above fields contain coinsurance benefits, Not Applicable should be used. This includes OON HMO/EPO plans where Not Covered is the main value, capture it as Not Applicable.
- A 0% Plan Coinsurance is used when 4 or more of the above fields contain "$0 after deductible."
- This field is calculated in Howie based on the above criteria, but can be overwritten as necessary.
- In cases of a 50/50 split the higher value will be taken.
- If a (non-QHP) document specifically notes coinsurance values, they should be built manually (even if these values differ from how Howie would calculate the benefit).

[11] https://www.healthcare.gov/glossary/co-insurance/

Plan Market

ETL Field: plan_market **PD Sheet Field:** market **API Field:** plan_market **Howie Field:** Market

Definition: In what market(s) a plan is available for purchase.

Field Logic: Enum

QHP Builder Mapping

- Benefits Package: N/A

- Cost Share Variances: HIOS Plan ID
    - Based on Plan Variations

Information Source

- This information is available in the QHPs, the URR, the URRT, and some Rate filings.

Unique Building Rules

- Valid benefits for this field include:
    - Both
    - Off Market
    - On Market
- When a source file does not have the ability to display "both markets" as an option (i.e. "Exchange? = yes/no"), capture "Exchange = Yes" plans as Both.
    - For example, when the market field is marked "yes" on the URR or URRT, we would capture this as "Both" in Howie because we only know the plan is On market, it may also be off market, but we don't know for sure . QHPs bring more clarity to this field because on the cost variance tabs they identify plans that are Off Market as -00 and plans that are On market as -01. If the Hios ID only ends with -01, then we would switch the plan as On market. If the QHP displays the Hios Id as having both -00 and -01, then it should remain Both.

Plan Type

ETL Field: plan_type
PD Sheet Field: plan_type **API Field:** plan_type **Howie Field:** Plan Type
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - The top right corner of an SBC should state "Plan Type"

Definition: The type of medical plan as designated by CMS. DIfferent types of plans offer different benefit structures.[12]

Field Logic: Enum

QHP Builder Mapping

- Benefits Package: Plan Type*
- Cost Share Variances: N/A

Unique Building Rules

- Valid benefits for this field include:
    - EPO
    - HMO
    - Indemnity
    - POS
    - PPO
- When there is a discrepancy between an SBC and the URR, capture the plan type listed in the URR.
    - Some SBCs may not list a valid Plan Type; in these instances, use the Plan Type listed in the URR.
- When the plan type is HMP, plan type should be captured as **POS** (Example)

Plan Year

ETL Field: N/A
PD Sheet Field: plan_year
API Field: N/A
Howie Field: Plan Year
Definition: The calendar year in which a plan is being offered.
Field Logic: String
Information Source

- This information can be found in nearly all source types, including SBCs, QHPs, Rate Filings, and the URR (often through the plan's Effective Date).

Privileged Data

ETL Field: privileged_data
PD Sheet Field: N/A
API Field: privileged_data
Howie Field: Privileged Data
Definition: If a plan is available to all medical benefit customers. Special licenses are provided to customers who are allowed to access the data for these plans.

[12] https://www.healthcare.gov/choose-a-plan/plan-types/
Field Logic: Boolean
Information Source

- Privileged plan information is provided by the UnitedHealthcare B2B.

Unique Building Rules

- The addition of "-99" to a HIOS ID is used to designate UnitedHealthcare privileged plans.
- On rare occasions, this flag is used to hide a subset of plans from customers. Non -99 plans should only be marked "Yes" with approval from the Director of Data Operations and the Product Management team.

SBC Name

ETL Field: sbc_name
PD Sheet Field: sbc_name **API Field:** sbc_name **Howie Field:** SBC Name
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: The top left corner of an SBC should state the SBC Name under "Summary of Benefits and Coverage" (page 1).

Definition: A plans name as stated on an SBC.
Field Logic: String
Unique Building Rules

- Generally, carrier names should not be captured as part of an SBC name.
    - Carrier names and SBC plan names are often separated by a colon, indicating that the carrier name should not be captured (Example: "Platinum 2 Plan").

    - However, if a (text) Carrier Name is present without a colon or other dividing character, it should be captured (Example: “UnitedHealthcare Core BJMV /685”)
    - If a Carrier Name is present both before and after the colon, capture the carrier name after the colon, but not the one before (Example: “TIRE DISCOUNTERS, INC. : Aetna Choice POS II - CHOICE POS II”)
    - Sometimes an SBC name will have the carrier name after the colon, not before. In this case, we will take the plan name before the colon (Example: “SilverPlus (S4) SHOP”). (Example 2: “Silver Copay Select 70”)
- Logos are not captured as part of an SBC name; only regular text should be considered (Example:

  “Silver Access+ HMO 1975/55 OffEx”).

- Unique characters should be removed from SBC names (Example: “Gold Access+ HMO 500/35 OffEx”).

  However, in limited circumstances we may keep a special character in the SBC name, commonly “™”

- Large Group Custom SBC Names should have the name of the SBC’s employer, if one is applicable

  (Example: “Coast Property Management: H.S.A. High Deductible Option”).

    - However, the carrier names should still not be captured, and the above rules still apply as normal.
    - Names of Third-Party Administrators (TPAs) count as carrier names and should be excluded (Example: “M & W LOGISTICS GROUP, INC.: 7670-00-413943 001, 002”).
- SBC names may appear as two levels or layers of text; be sure to capture the complete name (Example:

  “CLSSSM - Standard BCN Healthy Blue Living Gold $2000”).

- When SBC names are populated in Howie via the SBC Parser, be sure to verify that the results follow these conventions and make corrections as necessary.
- This field often differs in some way from the Name field.

Telemedicine

ETL Field: telemedicine **PD Sheet Field:** N/A **API Field:** telemedicine
Howie Field: Telemedicine

SBC Location

- Common Medical Event: If you visit a health care provider’s office or clinic
- Services You May Need: Primary care visit to treat an injury or illness
- Other:
    - Other Covered Services

Definition: If a plan covers virtual visits with a Primary Care Physician.

Field Logic: Boolean

Unique Building Rules

- May appear as “telehealth,” “telemedicine,” "virtuwell", “video,” or “virtual visits.” Note: any mention of

  healthcare provided over the phone or internet can be considered True for telemedicine.

- A QHP value of “Yes” should be kept as such if an SBC does not mention this type of benefit in any way;

  however, if noted at all in the SBC, the SBC value should be used.

- The SBC value can be used if it is listed in “other covered services” at the bottom of the SBC (Example) and (Example), or in the deductible box at the top of the SBC (Example).
- A mention that telemedicine “may be available” should be ignored (Example).
- If the SBC only mentions telemedicine for fields that are NOT for a PCP, the benefit should be ignored (Example: Telepsychiatry)

Benefits by Field - Medical

Ambulance

ETL Field: ambulance
PD Sheet Field: ambulance **API Field**: ambulance **Howie Field:** Ambulance
SBC Location

- Common Medical Event: If you need immediate medical attention
- Services You May Need: Emergency medical transportation
- Other: N/A

Definition: The costshare for a one-way ambulance ride due to an emergency.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Emergency Transportation/Ambulance
- Cost Share Variances: Emergency Transportation/Ambulance

Assumed Base Unit: per trip

Units to Capture:
Units to Ignore: per procedure, per transport

Unique Building Rules

- In-Network and Out-of-Network benefits will often mirror each other, but if an SBC presents different benefits for In-Network and Out-of-Network, capture the values as they are listed in the SBC.
- In the absence of an SBC, these values can be assumed to be mirrored if Out-of-Network values are not specified in the source document.
- “Out-of-Network emergency services are covered at the Network benefit level” or similar language

  indicates Out-of-Network benefits should mirror those given for In-Network.

- If benefits are specified for **Ground** vs. **Air** or **Water Transportation**, capture the values for

  Ground Transportation.

Limits/Conditions

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There is a maximum number of trips that will be covered

limit: waived if admitted	• Invalid grammar for this field; this is only captured for Emergency Room

Child Dental

ETL Field: child_dental
PD Sheet Field: child_dental **API Field:** child_dental **Howie Field:** Child Dental
SBC Location

- Common Medical Event: If your child needs dental or eye care
- Services You May Need: Children's dental check-up
- Other: N/A

Definition: The cost share for routine dental exams/cleanings for individuals under age 19.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Basic Dental Care – Child
- Cost Share Variances: Basic Dental Care – Child
    - If benefits are not present or not applicable for the above field, benefits for "Dental Check-Up for Children" are taken instead.

Assumed Base Unit: per visit (exam)

Units to Capture: N/A
Units to Ignore: per exam

Unique Building Rules

- When tiers or types of services are specified, capture the values for **Diagnostic/Preventative** or **Tier 1.**
    - Ignore the separate pediatric dental deductible, generally it applies to Basic/Major . (Example)
- When the limit states benefits are provided by an "add on or a separate service", this should be captured as Not Covered. (Example)
- When the limit states "Routine screenings covered as defined under the Patient Protection and Affordable Care Act of 2010.", capture what's listed in the box. (Example)
- When benefits are written out between **Exams** vs **Cleanings**, capture the values for **Exams** (Example).
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.

Limits/Conditions

Grammar	Use Case/Common Errors
limit: 2 exam(s) per benefit period	• There is a maximum number of exams a child

	can receive in a given period of time (Example) • The unit of "exam(s)" is always used, even if QHP brings in a different unit
Separate pediatric dental deductibles listed in "*Are there other deductibles for specific services?*"	• Don't add "see carrier doc" to limit regardless if exam benefit has deductible application
limit: see carrier documentation for more information	• No specific examples

Child Eye Exam

ETL Field: child_eye_exam
PD Sheet Field: child_eye_exam **API Field:** child_eye_exam **Howie Field:** Child Eye Exam
SBC Location

- Common Medical Event: If your child needs dental or eye care
- Services You May Need: Children's eye exam
- Other: N/A

Definition: The cost share for a routine eye exam for individuals under age 19.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Routine Eye Exam for Children
- Cost Share Variances: Routine Eye Exam for Children

Assumed Base Unit: per visit (exam)
Units to Capture: N/A
Units to Ignore: per exam
Unique Building Rules

- When benefits are specified for **Optometrist** vs. **Ophthalmologist**, capture the values for **Optometrist** (Example).
- When benefits are specified for **Primary Care** vs. **Specialist** , capture the value for **Primary Care** (Example).
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
- Allowances are common for this benefit.
- If the SBC tells you to "refer to preventive care benefit" or similar language, mirror this benefit under preventive care (Example).

If the SBC tells you that this benefit is "applicable to provider type," capture this benefit as unknown

(Example).

Limits

Grammar	Use Case/Common Errors
limit: 1 exam(s) per year	• There is a maximum amount of exams a child may receive in a given period of time (Example)
limit: see carrier documentation for more information	• There is an opportunity for reimbursal (Example 1, Example 2)
limit: 1 visit(s) per year	• "visit(s)" is not valid grammar for this field • Should be translated to "exam(s)"
limit: see carrier documentation for more information	• A particular provider group is specified (Example) • There is an unspecified allowance or "difference bill" for out-of-network providers (Example 1, Example 2) • There are different benefits for Optometrist vs. Ophthalmologist (Example)
limit: 1 exam(s) per 365 day(s)	• "Per 365 day(s) is not valid grammar for any field (we translate this to "per year")
limit: ignore limits that are too specific	• Example

Child Eyewear

ETL Field: child_eyewear
PD Sheet Field: child_eyewear **API Field:** child_eyewear **Howie Field:** Child Eyewear
SBC Location

- Common Medical Event: If your child needs dental or eye care
- Services You May Need: Children's glasses
- Other: N/A

Definition: The cost share for medically necessary eyewear for individuals under age 19.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Eye Glasses for Children
- Cost Share Variances: Eye Glasses for Children

Assumed Base Unit: per item
Units to Capture: N/A
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **Glasses** vs. **Contacts**, capture the values for **Glasses**
    - If benefits are further specified for **Frames** vs. **Lenses**, capture the values for **Frames**
- When benefits are specified for **Collection** vs **Non-Collection Frames**, capture **Non-Collection**

(Example)

- Allowances are common for this benefit.
    - A 0% coinsurance applies to an Allowance (Example - Child Eyewear). We could capture this as

$0 after deductible after $150 allowance

Limits

Grammar	Use Case/Common Errors
limit: 1 item(s) per year	• There is a maximum amount of glasses a child can receive in a given period of time (Example)
limit: 1 item(s) per 2 benefit period(s)	• Frames are allowed once every other benefit period (Example)
limit: see carrier documentation for more information	• There is an opportunity for reimbursement (Example)
Limit: 1 exam(s) per year	• "exam(s)" is not valid grammar for this field • Should be translated to "item(s)"
limit: see carrier documentation for more information	• There is an unspecified allowance or "difference bill" (Example 1, Example 2) • Items are only covered if from specific retailers/collections (Example) • Prices may increase depending on the frames selected (Example)
limit: ignore limits that are too specific	• Example

Diagnostic Test

ETL Field: diagnostic_test
PD Sheet Field: diagnostic_test **API Field:** diagnostic_test **Howie Field:** Diagnostic Test
SBC Location

- Common Medical Event: If you have a test
- Services You May Need: Diagnostic test (x-ray, blood work)

Other: N/A

Definition: The cost share for diagnostic testing, such as x-rays.

Field Logic: String

QHP Builder Mapping

- Benefits Package: X-rays and Diagnostic Imaging

- Cost Share Variances: X-rays and Diagnostic Imaging

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **X-ray** vs. **Lab Work**, capture the values for **X-ray** (Example).
- When benefits are specified for **Inpatient** vs. **Outpatient**, capture the values for **Outpatient**

  (Example).

- When benefits are specified for **Office** vs. **Outpatient**, capture the values for **Outpatient** (Example).
- When benefits are specified for **Freestanding** vs. **Hospital**, capture the values for **Freestanding**

  (Example).

- When benefits are specified for **Hospital** vs. **Non-Hospital** setting, capture the values for **Non- Hospital** setting (Example). (Example 2)
- When benefits are specified for **Hospital** vs. **Other Providers**, capture the values for **Other Providers** (Example)
- When benefits are specified for **Facility** vs. **Physician**, capture the values for **Facility**
- When benefits are specified for **Independent Clinical Lab** vs. **Independent Diagnostic Testing**

  Center, capture the values for **Independent Diagnostic Testing Center** (Example)

- When benefits are specified for **Office** vs. **Facility**, capture the values for **Facility** (Example 1, Example 2).
- When benefits are specified for **Primary Care** vs. **Specialist**, capture the **Specialist** value (Example).
- "Per Procedure" is common in this field
- "Up to" limits are common in this field
- "Out-of-Network Cost-share Limits" are common for this field.

Limits

Grammar	To Be Used When
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Durable Medical Equipment

ETL Field: durable_medical_equipment

PD Sheet Field: durable_medical_equipment **API Field:** durable_medical_equipment **Howie Field:** Durable Medical Equipment

SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Durable medical equipment
- Other: N/A

Definition: The costshare to purchase durable medical equipment.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Durable Medical Equipment
- Cost Share Variances: Durable Medical Equipment

Assumed Base Unit: per item
Units to Capture: N/A
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for a **certain type of equipment** vs. **everything else**, capture the values for **everything else (or a similarly broad benefit)** (Example).
- Do not capture up to language when the limit states "for certain items" as they are too specific of a limit.

(Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: 1 item(s) per 3 year(s)	• There is a maximum number of items that will be covered over a certain period of time (Example)
limit: 1 item(s) per benefit period	• There is a maximum number of "similar" items that will be covered (Example)
limits: we do not capture	• There is a maximum supply size per purchase (Example) • There is a maximum coverage amount that applies to a certain period of time (Example 1, Example 2)

	• The limit is too specific (Example)

Emergency Room

ETL Field: emergency_room
PD Sheet Field: emergency_share **API Field:** emergency_room **Howie Field:** Emergency Room
SBC Location

- Common Medical Event: If you need immediate medical attention
- Services You May Need: Emergency room care
- Other: N/A

Definition: The costshare for visiting an emergency room due to a medical emergency.
Field Logic: String

QHP Builder Mapping

- Benefits Package: Emergency Room Services
- Cost Share Variances: Emergency Room Services

Assumed Base Unit: per visit
Units to Capture:
Units to Ignore: per procedure
Unique Building Rules

- Benefits should be mirrored for In-Network and Out-of-Network coverage, for all plan types, unless explicitly stated otherwise on an SBC.
    - Benefits should also be mirrored for documents that do not specify Out-of-Network benefits (such as Brochures or Rate Filings).
- When benefits are specified for **Facility** vs. **Physician**, capture the values for **Facility** (Example).
- Common for this field, if copay and coinsurance values are listed (Example) it should be captured as "$x plus y%" .

Limits

Grammar	Use Case/Common Errors
limit: waived if admitted	• When the copay/costshare does not need to be paid if the individual is admitted to the hospital from the emergency room (Example 1, Example 2) • This limit is valid even if the SBC says
	"may be waived if admitted" (Example) • This limit is valid even if there is a coinsurance value. (Example)

Family Drug Deductible

ETL Field: family_drug_deductible **PD Sheet Field:** ddct_fam_drug **API Field:** family_drug_deductible
Howie Field: Family Drug Deductible
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other:
    - Important Questions: Are there other deductibles for specific services? (Page 1)

Definition: The amount a family needs to spend on covered prescription drugs before the plan's coverage will go into effect.[13]
Field Logic: String
QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Drug EHB Deductible
    - If above is blank or not applicable, "Combined Medical and Drug EHB Deductible" is used.

Unique Building Rules

- If no specific drug deductible is provided and at least one drug tier includes "after deductible," it should be captured as "Included in Medical."
- If the given drug deductible is $0, "after deductible" should be removed from all drug fields in the applicable medical tier (if present).
- For plans with no Out-of-Network drug coverage (i.e. all values are 100% or Not Applicable), it should be captured as "Not Covered" Out-of-Network.
- If a value is not specified as being per an individual or family group, the value should be captured for both individual and family drug deductibles and "per person" should be added to the family benefit.
    - This applies for non-zero In-Network and Out-of-Network values.
- If the SBC captures drugs as sold through an outside vendor, this benefit should be "Not Covered" (Example).
    - This applies both for In-Network and Out-of-Network values.
- If the plan is an HSA Eligible plan, then the value for this costshare should always be "Included in Medical" (Example).

13 https://www.healthcare.gov/glossary/deductible/

Limits

- There are no valid limits for this field.

Family Drug MOOP

ETL Field: family_drug_moop **PD Sheet Field:** moop_fam_drug **API Field:** family_drug_moop **Howie Field:** Family Drug MOOP

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the out-of-pocket limit for this plan? (Page 1)

Definition: The maximum amount a family can spend on covered prescription drugs during a plan's benefit period. After this limit is hit (includes deductibles, copays, and coinsurance), the health plan pays for 100% of covered prescription drugs.

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Maximum Out of Pocket for Drug EHB Benefits
    - If above is blank or not applicable, "Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)" is used.

Unique Building Rules

- If no specific Drug MOOP is provided (medical and drug/Rx MOOPs are combined/integrated), capture as Included in Medical
- For plans with no Out-of-Network drug coverage (i.e. all values are 100% or Not Covered), it should be captured as Not Covered
- For plans with Out-of-Network drug coverage and Medical MOOPs are Unlimited, it should be captured as Unlimited
- If a value is not specified as being per an individual or family group, the value should be captured for

  both individual and family drug MOOPs and "per person" should be added to the family benefit.

  - This applies both for In-Network and Out-of-Network values.
- If the SBC captures drugs as sold through an outside vendor, this benefit should be "Not Covered"

  (Example).

  - This applies both for In-Network and Out-of-Network values.
- If the plan is an HSA Eligible plan, then the value for this costshare should always be "Included in Medical" (Example).
- When given different levels of MOOP (i.e. coinsurance vs copayments), take the highest Drug value (Example).

Limits

There are no valid limits for this field.

Family Medical Deductible

ETL Field: family_medical_deductible **PD Sheet Field:** ddct_family_med **API Field:** family_medical_deductible
Howie Field: Family Medical Deductible

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the overall deductible? (Page 1)

Definition: The amount a family needs to spend on covered medical services before the plan's coverage will go into effect.[14]

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Medical EHB Deductible
  - If above is blank or not applicable, "Combined Medical and Drug EHB Deductible" is used.

Unique Building Rules

- For plans with no out-of-network coverage, the Out-of-Network deductible should be captured as "Not Covered."
  - "Not Covered" should also be used for plans that do not have an Out-of-Network deductible

  (often written as "Out-of-Network: Unlimited" in source documents).

- If a value is not specified as being per an individual or family group, the value should be captured for both individual and family drug deductibles and "per person" should be added to the family benefit. (Example)
  - This applies for non-zero In-Network and Out-of-Network values.
- If a single value is given for a PPO or POS plan (i.e. a plan with Out-of-Network coverage), this value should be captured for both In-Network and Out-of-Network.

- If a plan only displays a value Out-of-Network with no value In-Network, the In-Network deductible should be $0 (Example).
- If different values are given depending on the plan's start date, capture the highest value (Example).
- If different values are given between "family deductible per person" and "full family deductible," take the full family deductible (Example), (Example).
    - Similarly, "Individual within a family" deductibles should be ignored.

Limits

- There are no valid limits for this field.

14 https://www.healthcare.gov/glossary/deductible/

Family Medical MOOP

ETL Field: family_medical_moop **PD Sheet Field:** moop_fam_med **API Field:** family_medical_moop **Howie Field:** Family Medical MOOP

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the out-of-pocket limit for this plan? (Page 1)

Definition: The maximum amount a family can spend on covered medical services during a plan's benefit period. After this limit is hit (includes deductibles, copays, and coinsurance), the health plan pays for 100% of covered medical services.[15]

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Maximum Out of Pocket for Medical EHB Benefits
    - If above is blank or not applicable, "Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)" is used.

Unique Building Rules

- For plans with no Out-of-Network coverage, it should be captured as "Not Covered" Out-of-Network.
- For plans with stated Unlimited MOOPs, or PPO and POS plans that have no specifically given OON MOOP, it should be captured as "Unlimited"
- If a single value is given for a PPO or POS plan (i.e. a plan with Out-of-Network coverage), this value should be captured for both In-Network and Out-of-Network.
- When given different levels of MOOP (i.e. coinsurance vs copayments), take the highest Medical value (Example).
    - Similarly, if different values are given depending on the plan's start date, capture the highest value (Example).

Limits

- There are no valid limits for this field.
- MOOP maximum amounts for 2024/2025 can be found here. We cannot input higher than the amount listed here in Howie.
    - 2025 IND: 9,200

- 2025 Family: 18,400

15 https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

Generic Drugs

ETL Field: generic_drugs
PD Sheet Field: generic_drug_share
API Field: generic_drugs
Howie Field: Preferred Generic Drugs
SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Generic drugs (wording varies)
- Other: N/A

Definition: The costshare for buying preferred generic prescription drugs from a retail pharmacy.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Generic Drugs
- Cost Share Variances: Generic Drugs

Assumed Base Unit: per fill
Units to Capture: per script
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **Preferred** vs. **Non-Preferred generic drugs**, capture the value for **Preferred generic drugs** for this field (Example).
- When benefits are specified for **30-Day Supply** vs. **90-Day Supply**, capture the values for a **30-Day Supply** (Example).
- When benefits are specified for **Preferred** vs. **Non-Preferred** (within this specific, preferred tier), capture the values for **Preferred** (Example).
- If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
- Do not consider drug tiers listed as "preventative," as these are covered under Preventative Care.
- "Per script" is common language for this field.
- If this benefit is written out with a minimum or maximum value, capture the maximum value with an "up to" limit and ignore the minimum value (Example).
- If the SBC captures this benefit as sold through an outside vendor, capture it as "Not Covered" (Example).
    - This applies both for In-Network and Out-of-Network values.
- Relatively common in OON fields are additional charges/multiple values Multiple Costshare Options

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example 1) • There is an opportunity for reimbursement (Example)
limit: see carrier documentation for more information	• There are multiple price options (often a copay and coinsurance) that are not tiers (Example)

Habilitation Services

ETL Field: habilitation_services
PD Sheet Field: habilitation_services **API Field:** habilitation_services **Howie Field:** Habilitation Services
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Habilitation services
- Other: N/A

Definition: The cost share for outpatient habilitation services.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Habilitation Services
- Cost Share Variances: Habilitation Services

Assumed Base Unit: per visit

Units to Capture: per day

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **Outpatient** vs. **Inpatient**, capture the values for **Outpatient**

  (Example).

  - May be written as Hospital (inpatient) vs. Non-Hospital (outpatient).
  - If only inpatient values are given, the benefit should remain unknown (Example).
    - Similarly, limits that only apply to inpatient benefits should not be captured.
- When benefits are specified for **Office** vs. **Facility**, capture the values for **Office** (Example).
- When benefits are specified for different types of therapy (i.e. speech, occupational), capture the values for Physical Therapy (Example).
  - *Only capture limits that apply to Physical Therapy*.
- When benefits are specified for **PCP** vs. **Specialist**, capture the value for **Specialist** (Example)

  If the SBC has language saying that limits are combined with Rehabilitation Services, the limits for Rehabilitation and Habilitation should mirror each other (Example).

This benefit might have limits or benefits sandwiched in other areas of the SBC.

- Example: Home Health Care limit for Habilitative care
- Example: Outpatient physical therapy is in “Other Practitioner Office Visit”

We do not capture manipulative treatment limits for this field. (Example)
We do not capture OON limits for this field. (Example)

Limits

Grammar	Use Case/Common Errors
limit: 40 visit(s) per year	• There is a maximum number of visits to a Physical Therapist for habilitation services allowed in a given period of time (Example)
limit: 60 visit(s) per condition per benefit period	• The maximum number of visits is specified as being per condition, rather than a single annual limit. (Example) • “Per disability” should be translated to “per condition”
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: 20 visit(s) per therapy per year	• “per therapy” is not valid grammar for this field, and should not be translated to “per condition” (Example)
limit: 60 visit(s) per lifetime	• “Per lifetime” is not considered valid grammar for this field; use “per benefit period” if this comes up

Home Health Care

ETL Field: home_health_care
PD Sheet Field: home_health_care **API Field:** home_health_care **Howie Field:** Home Health Care
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Home health care
- Other: N/A

Definition: The cost share for medical services received in one’s home due to injury or illness.

Field Logic: String
QHP Builder Mapping

- Benefits Package: Home Health Care Services
- Cost Share Variances: Home Health Care Services

Assumed Base Unit: per visit

Units to Capture: per day
Units to Ignore: per admission

Unique Building Rules

- This field is considered part of "Professional Services" if the SBC uses this language
- When benefits are specified for **Primary** vs. **Speciality**, capture the values for **Speciality**. (Example)
- Capture the limit, but always ignore "but not less than" language (Example)

Limits

Grammar	Use Case/Common Errors
limit: 100 visit(s) per year	• There is a maximum amount of visits a home health care provider can make to a consumer in a given period of time (Example) • "day(s)" is also a valid unit for this field (Example)
limit: 60 day(s) per condition per year	• The maximum number of visits is specified as being per condition, rather than a single annual limit. (Example) • "Per disability" should be translated to "per condition"
limit: 28 hour(s) per week	• There is a maximum number of hours per week that a planholder can receive home health care services. (Example)
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: 90 visit(s) per episode	• "per episode" limits are not captured for any field (Example) (Example 2)
Limit: 3 visit(s) per benefit period	• "Educational visits" are not captured

Hospice

ETL Field: hospice_service
PD Sheet Field: hospice_service **API Field:** hospice_service **Howie Field:** Hospice Service
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Hospice services
- Other: N/A

Definition: The costshare for inpatient hospice services.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Hospice Services
- Cost Share Variances: Hospice Services

Assumed Base Unit: per admission
Units to Capture: per day
Units to Ignore: per stay (translates to per admission)
Unique Building Rules

- When benefits are specified for **Outpatient** vs. **Inpatient**, capture the values for **Inpatient**.
    - If only outpatient values are given, the benefit should remain unknown.
        - Similarly, limits that only apply to outpatient benefits should not be captured.
- Some SBCs note in the Limits and Exceptions that inpatient hospice care is subject to the inpatient hospital cost share. In these cases, Hospice benefits should mirror those for Inpatient Facility (Example). (Example 2)
- When benefits are specified for Medicare providers only, this benefit should remain unknown (Example).

Limits

Grammar	Use Case/Common Errors
limit: 185 day(s) per benefit period	• There is a maximum number of day(s) a consumer may reside in hospice in a given period of time (Example) • Do not capture limits related to Respite care or Continuous care
limit: 180 day(s) per lifetime	• There is a maximum number of day(s) a consumer may reside in hospice throughout their lifetime (Example) • Do not capture limits related to Respite care or Continuous care • "Per lifetime" is a time-period that is exclusive to Hospice limits and is not valid in any other field.
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

limit: see carrier documentation for more information	• Inpatient hospice care is subject to the inpatient hospital costshare (Example)
limit: 6 month(s) per episode limit: 15 visit(s) per 6 month(s)	• "Bereavement benefits", "per episode" limits are not captured for any field (Example) • Are not captured because it's too specific with the patient's passing date

Imaging Center

ETL Field: imaging_center
PD Sheet Field: imaging_center **API Field:** imaging_center **Howie Field:** Imaging Center
SBC Location

- Common Medical Event: If you have a test

- Services You May Need: Imaging (CT/PET scans, MRIs)
- Other: N/A

Definition: The cost share for advanced imaging procedures, such as MRI's or CT scans, that are conducted in an outpatient testing facility.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Imaging (CT/PET Scans, MRIs)
- Cost Share Variances: Imaging (CT/PET Scans, MRIs)

Assumed Base Unit: per visit

Units to Capture: per procedure

Units to Ignore: per admission

Unique Building Rules

- When benefits are specified for **Freestanding Facility** or **Independent Testing Center** vs. **Hospital**, capture the values for **Freestanding Facility** or **Independent Testing Center** (or similar outpatient, non-hospital center) (Example).
- When benefits are specified for **Office** vs. **Facility/Outpatient**, capture the values for **Facility**

(Example)

- When benefits are specified for **Outpatient Radiology Center** vs **Outpatient Hospital**, capture the values for **Radiology Center**. (Example)
- When benefits or limits are specified for different types of procedures, capture the values and information that is relevant to MRI scans (Example).
- We do accept limits for OON only values. This includes "up to" maximums.

(Example) OON would just be 50% after deductible, up to $800 per procedure

"Per procedure" is common language for this field.

"Up to" limits are common for this field.

"Out-of-Network Cost-share Limits" are common for this field.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Imaging Physician

ETL Field: imaging_physician

PD Sheet Field: imaging_physician **API Field:** imaging_physician **Howie Field:** Imaging Physician

SBC Location

- Common Medical Event: If you have a test
- Services You May Need: Imaging (CT/PET scans, MRIs)
- Other: N/A

Definition: The costshare for advanced imaging procedures, such as MRI's or CT scans, that are conducted in a physician's office.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Imaging (CT/PET Scans, MRIs)
- Cost Share Variances: Imaging (CT/PET Scans, MRIs)

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: per admission

Unique Building Rules

- This field should only differ from Imaging Center when benefits are specified for procedures that take place in a physician's office. When such benefits are not specified, this field should mirror Imaging Center.
- When benefits are specified for **Office** vs. **Facility**, capture the values for **Office** (Example).
- When benefits are specified for **Primary Care** vs. **Specialist**, capture the values for **Specialist**.
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
- We do accept limits for OON only values. This includes "up to" maximums.

(Example) OON would just be 50% after deductible, up to $800 per procedure

"Out-of-Network Cost-share Limits" are common for this field.

Individual Drug Deductible

ETL Field: individual_drug_deductible

PD Sheet Field: ddct_ind_drug

API Field: individual_drug_deductible

Howie Field: Individual Drug Deductible

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: Are there other deductibles for specific services? (Page 1)

Definition: The amount an individual needs to spend on covered prescription drugs before the plan's coverage will go into effect.[16]

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Drug EHB Deductible
    - If above is blank or not applicable, "Combined Medical and Drug EHB Deductible" is used.

Unique Building Rules

- If no specific drug deductible is provided and at least one drug tier includes "after deductible," it should be captured as "Included in Medical."
- If the given drug deductible is $0, "after deductible" should be removed from all drug fields in the applicable medical tier (if present).
- For plans with no Out-of-Network drug coverage (i.e. all values are 100% or Not Applicable), it should

be captured as “Not Covered” Out-of-Network.

- If a value is not specified as being per an individual or family group, the value should be captured for both individual and family drug deductibles.
    - This applies both for In-Network and Out-of-Network values.
- If the SBC captures drugs as sold through an outside vendor, this benefit should be “Not Covered”

(Example).

    - This applies both for In-Network and Out-of-Network values.
- If the plan is an HSA Eligible plan, then the value for this costshare should always be “Included in Medical” (Example).

Limits

- There are no valid limits for this field.

16 https://www.healthcare.gov/glossary/deductible/

Individual Drug MOOP

ETL Field: individual_drug_moop **PD Sheet Field:** moop_ind_drug **API Field:** individual_drug_moop
Howie Field: Individual Drug MOOP

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the out-of-pocket limit for this plan? (Page 1)

Definition: The maximum amount an individual can spend on covered prescription drugs during a plan’s benefit period. After this limit is hit (includes deductibles, copays, and coinsurance), the health plan pays for 100% of covered prescription drugs.
Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Maximum Out of Pocket for Drug EHB Benefits
    - If above is blank or not applicable, “Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)” is used.

Unique Building Rules

- If no specific Drug MOOP is provided (medical and drug/Rx MOOPs are combined/integrated), capture as Included in Medical
- For plans with no Out-of-Network drug coverage (i.e. all values are 100% or Not Covered), it should be captured as Not Covered
- For plans with Out-of-Network drug coverage and Medical MOOPs are Unlimited, it should be captured as Unlimited
- If a value is not specified as being per an individual or family group, the value should be captured for both individual and family drug MOOPs.
    - This applies both for In-Network and Out-of-Network values.
- If the SBC captures drugs as sold through an outside vendor, this benefit should be “Not Covered”

(Example).

    - This applies both for In-Network and Out-of-Network values.
- If the plan is an HSA Eligible plan, then the value for this costshare should always be "Included in Medical" (Example).
- When given different levels of MOOP (i.e. coinsurance vs copayments), take the highest Drug value (Example).

Limits

- There are no valid limits for this field.

Individual Medical Deductible

ETL Field: individual_medical_deductible
PD Sheet Field: ddct_ind_med
API Field: individual_medical_deductible
Howie Field: Individual Medical Deductible
SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the overall deductible? (Page 1)

Definition: The amount an individual needs to spend on covered medical services before the plan's coverage will go into effect.[17]
Field Logic: String
QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Medical EHB Deductible
    - If above is blank or not applicable, "Combined Medical and Drug EHB Deductible" is used.

Unique Building Rules

- For plans with no out-of-network coverage, the out-of-network deductible should be captured as "Not Covered."
    - "Not Covered" should also be used for plans that do not have an Out-of-Network deductible

      (often written as "Out-of-Network: Unlimited" in source documents).

- If a value is not specified as being per an individual or family group, the value should be captured for both individual and family drug deductibles.
    - This applies both for In-Network and Out-of-Network values.
- If a single value is given for a PPO or POS plan (i.e. a plan with Out-of-Network coverage), this value should be captured for both In-Network and Out-of-Network.
- If a plan only displays a value Out-of-Network with no value In-Network, the In-Network deductible should be $0 (Example).
- The Individual coverage should be captured over the "individual within a family" coverage (Example).
- If different values are given depending on the plan's start date, capture the highest value (Example).

Limits

- There are no valid limits for this field.

Individual Medical MOOP

ETL Field: individual_medical_moop **PD Sheet Field:** moop_ind_med **API Field:** individual_medical_moop

[17]https://www.healthcare.gov/glossary/deductible/

Howie Field: Individual Medical MOOP

SBC Location

- Common Medical Event: N/A
- Services You May Need: N/A
- Other: Important Questions: What is the out-of-pocket limit for this plan? (Page 1)

Definition: The maximum amount an individual can spend on covered medical services during a plan's benefit period. After this limit is hit (includes deductibles, copays, and coinsurance), the health plan pays for 100% of covered medical services.[18]

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Maximum Out of Pocket for Medical EHB Benefits
    - If above is blank or not applicable, "Maximum Out of Pocket for Medical and Drug EHB Benefits (Total)" is used.

Unique Building Rules

- For plans with no Out-of-Network coverage, it should be captured as "Not Covered" Out-of-Network.
- For plans with stated Unlimited MOOPs, or PPO and POS plans that have no specifically given OON

  MOOP, it should be captured as "Unlimited"

- If a single value is given for a PPO or POS plan (i.e. a plan with Out-of-Network coverage), this value should be captured for both In-Network and Out-of-Network.
- When given different levels of MOOP (i.e. coinsurance vs copayments), take the highest Medical value (Example).
    - Similarly, if different values are given depending on the plan's start date, capture the highest

      value (Example).

Limits

- There are no valid limits for this field.
- MOOP maximum amounts for 2024/2025 can be found here. We cannot input higher than the amount listed here in Howie.
    - 2025 IND: 9,200
    - 2025 Family: 18,400

Inpatient Birth

ETL Field: inpatient_birth

PD Sheet Field: inpatient_birth **API Field:** inpatient_birth **Howie Field:** Inpatient Birth

[18] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

SBC Location

- Common Medical Event: If you are pregnant
- Services You May Need: Childbirth/delivery facility services
- Other: N/A

Definition: Facility fees for child-delivery services in an inpatient hospital.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Delivery and All Inpatient Services for Maternity Care
- Cost Share Variances: Delivery and All Inpatient Services for Maternity Care

Assumed Base Unit: per admission

Units to Capture: per day

Units to Ignore: per stay (translates to per admission)

Unique Building Rules

- "Up to" limits are common for this field.
- Costshare may vary depending on the number of days one is admitted.
- When benefits are covered "the same as any other illness," capture the Inpatient Facility costshare (Example).
- This field is considered part of "Inpatient Services" when provided by an SOB or Brochure.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: see carrier documentation for more information	• There is a maximum number of hours covered per admission (Example) • Newborns are subject to their own set of charges (Example)

Inpatient Birth Physician

ETL Field: inpatient_birth_physician
PD Sheet Field: N/A
API Field: inpatient_birth_physician
Howie Field: Inpatient Birth Physician
SBC Location

- Common Medical Event: If you are pregnant
- Services You May Need: Childbirth/delivery professional services
- Other: N/A

Definition: Physician fees for child-delivery services in an inpatient hospital.

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Inpatient Physician and Surgical Services

Assumed Base Unit: per admission

Units to Capture: per procedure, per day, per pregnancy
Units to Ignore: per stay (translates to per admission)

Unique Building Rules

- When benefits are noted to be "included in facility fee," "see facility fee," "Not Applicable," or similar language, they should be captured as $0 (Example), (Example).

- When benefits are specified for **Physician** vs. **Surgeon**, capture the values for **Surgeon** (Example).
- When benefits are specified for **Cutting** vs. **Non-Cutting**, capture the values for **Cutting** (Example).
- When benefits are covered "the same as any other illness," capture the Inpatient Physician costshare (Example).
- This field is considered part of "Professional Services" if the SBC uses this language.
- If the limit mentions "initial visit" and "Global Maternity Fee," capture prenatal as first 1 visit(s) and postnatal and inpatient birth as $0. (Example)

- We would capture instances of $/pregnancy as such for all fields that state it. (Example)
    - We would capture /delivery as per pregnancy. (Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Inpatient Facility

ETL Field: inpatient_facility
PD Sheet Field: inpatient_hospital_share
API Field: inpatient_facility
Howie Field: Inpatient Facility
SBC Location
Common Medical Event: If you have a hospital stay
Services You May Need: Facility fee (e.g., hospital room)
Other: N/A
Definition: Facility fees for inpatient hospital stays.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Inpatient Hospital Services (e.g., Hospital Stay)
- Cost Share Variances: Inpatient Hospital Services (e.g., Hospital Stay)

Assumed Base Unit: per admission
Units to Capture: per day
Units to Ignore: per stay (translates to per admission)
Unique Building Rules

- "Up to" limits are common for this field.
- Costshare may vary depending on the number of days one is admitted.
- Do not capture # per day limits for this field. (Example)
- Limitations and exceptions may note limits for other inpatient fields, such as Skilled Nursing Facility.
- This field is considered part of "Inpatient Services" when provided by an SOB or Brochure.

- This field should be captured as “Not Covered” if benefits are only available for accidental injury

(Example).

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Inpatient Mental Health

ETL Field: inpatient_mental_health
PD Sheet Field: inpatient_mental_health **API Field:** inpatient_mental_health **Howie Field:** Inpatient Mental Health
SBC Location

- Common Medical Event: If you need mental health, behavioral health, or substance abuse services
- Services You May Need: Inpatient services
- Other: N/A

Definition: The cost share for inpatient hospitalization to address mental health concerns.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Mental/Behavioral Health Inpatient Services
- Cost Share Variances: Mental/Behavioral Health Inpatient Services

Assumed Base Unit: per admission
Units to Capture: per day
Units to Ignore: per stay (translates to per admission)
Unique Building Rules

- When benefits are specified for **Hospital Care** vs. **Residential Services**, capture the values for **Hospital Care** (Example).
- When benefits are specified for **Facility** vs. **Physician**, capture the values for **Facility** (Example).
- “Up to” limits are common for this field.
- Costshare may vary depending on the number of days one is admitted.
- This field is considered part of “Inpatient Services” when provided by an SOB or Brochure.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Inpatient Physician

ETL Field: inpatient_physician
PD Sheet Field: inpatient_physician_share

API Field: inpatient_physician
Howie Field: Inpatient Physician
SBC Location

- Common Medical Event: If you have a hospital stay
- Services You May Need: Physician/surgeon fees
- Other: N/A

Definition: The cost share for physician services during an inpatient hospital stay.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Inpatient Physician and Surgical Services
- Cost Share Variances: Inpatient Physician and Surgical Services

Assumed Base Unit: per admission
Units to Capture: per procedure, per day
Units to Ignore: per stay (translates to per admission)
Unique Building Rules

- When benefits are noted to be "included in facility fee," "see facility fee," "Not Applicable," or similar language, they should be captured as $0 (Example), (Example).
- When benefits are specified for **Physician** vs. **Surgeon**, capture the values for **Surgeon** (Example).
- When benefits are specified for **Cutting** vs. **Non-Cutting**, capture the values for **Cutting** (Example).
- This field is considered part of "Professional Services" if the SBC uses this language.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Inpatient Substance

ETL Field: inpatient_substance
PD Sheet Field: inpatient_substance **API Field:** inpatient_substance **Howie Field:** Inpatient Substance
SBC Location

- Common Medical Event: If you need mental health, behavioral health, or substance abuse services
- Services You May Need: Inpatient services
- Other: N/A

Definition: The costshare for inpatient hospitalization to address alcohol and/or drug use.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Substance Abuse Disorder Inpatient Services
- Cost Share Variances: Substance Abuse Disorder Inpatient Services

Assumed Base Unit: per admission

Units to Capture: per day

Units to Ignore: per stay (translates to per admission)

Unique Building Rules

When benefits are specified for **Hospital Care** vs. **Residential Services**, capture the values for **Hospital Care** (Example).

- When benefits are specified for **Facility** vs. **Physician**, capture the values for **Facility** (Example).
- "Up to" limits are common for this field.
- Costshare may vary depending on the number of days one is admitted.
- This field is considered part of "Inpatient Services" when provided by an SOB or Brochure.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Last Updated: June 18, 2019

Lab Test

ETL Field: lab_test
PD Sheet Field: lab_test **API Field:** lab_test **Howie Field:** Lab Test
SBC Location

- Common Medical Event: If you have a test
- Services You May Need: Diagnostic test (x-ray, blood work)
- Other: N/A

Definition: The cost share for routine blood work from a freestanding lab or testing facility.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Laboratory Outpatient and Professional Services
- Cost Share Variances: Laboratory Outpatient and Professional Services

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: N/A

Unique Building Rules

- May be referred to as "Lab," "Blood work," or similar language.
- When benefits are specified for **Office** vs. **Facility**, capture the values for **Facility** (Example).
- When benefits are specified for **Freestanding** vs. **Hospital**, capture the values for **Freestanding** (Example).

When benefits are specified for **Hospital** vs. **Non-Hospital** setting, capture the values for **Non-Hospital** setting (Example)

When benefits are specified for **Hospital** vs. **Other Providers**, capture the values for **Other Providers** (Example)

When benefits are specified for **Independent Clinical Lab** vs. **Independent Diagnostic Testing Center**, capture the values for **Independent Clinical Lab** (Example).
When benefits are specified for **Facility Owned Lab** vs. **Independent Clinical Lab**, capture the values for **Independent Clinical Lab** (Example).
When benefits are specified for **Blood Work** vs. **Independent Lab**, capture the values for **Independent Lab** (Example).

- When benefits are specified for **Primary Care** vs. **Specialist**, capture the values for **Specialist** (Example).

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Non Preferred Brand Drugs

ETL Field: non_preferred_brand_drugs
PD Sheet Field: nonpreferred_brand_drug_share
API Field: non_preferred_brand_drugs
Howie Field: Non-Preferred Brand Drugs
SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Non-preferred brand drugs (wording varies)
- Other: N/A

Definition: The costshare for buying non-preferred brand prescription drugs from a retail pharmacy.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Non-Preferred Brand Drugs
- Cost Share Variances: Non-Preferred Brand Drugs

Assumed Base Unit: per fill
Units to Capture: per script
Units to Ignore: N/A
Unique Building Rules

When benefits are specified for **30-Day Supply** vs. **90-Day Supply**, capture the values for a **30-Day Supply** (Example).
When benefits are specified as **Preferred** vs. **Non-Preferred** (within this specific, non-preferred tier), capture the values for **Preferred** (Example).
If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
If this benefit is written out with a minimum or maximum value, capture the maximum value with an "up to" limit and ignore the minimum value (Example).

- "Per script" is common language for this field.
- Relatively common in OON fields are additional charges/multiple values Multiple Costshare Options
    - This often appears as out-of-network as "[coinsurance], after network coinsurance" (Example).

- If the SBC captures drugs as sold through an outside vendor, this benefit should be “Not Covered” (Example).
    - This applies both for In-Network and Out-of-Network values.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example) • There is an opportunity for reimbursal (Example) • Multiple coinsurance values apply for a single out-of-network benefit (Example)
limit: see carrier documentation for more information	• There are multiple price options (often a copay and coinsurance) that are not tiers (Example)

Non Preferred Generic Drugs

ETL Field: nonpreferred_generic_drug_share
PD Sheet Field: nonpreferred_generic_drug_share **API Field:** nonpreferred_generic_drug_share **Howie Field:** Non-Preferred Generic Drugs
SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Generic drugs (wording varies)
- Other: N/A

Definition: The cost share for buying non-preferred generic prescription drugs from a retail pharmacy.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Non Preferred Generic Drugs
- Cost Share Variances: Non Preferred Generic Drugs

This field is not present in many QHPs

Assumed Base Unit: per fill
Units to Capture: per script
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **30-Day Supply** vs. **90-Day Supply**, capture the values for a **30-Day Supply.**
- When benefits are specified as **Preferred** vs. **Non-Preferred** (within this specific, non-preferred tier), capture the values for **Non-Preferred** (Example).
- If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
- This drug tier may be combined with Preferred Brand Drugs, or other tiers; capture values wherever “Non-Preferred Generic” is specifically listed.

- Do not consider drug tiers listed as “preventative,” as these are covered under Preventative Care.
- If this benefit is written out with a minimum or maximum value, capture the maximum value with an

  “up to” limit and ignore the minimum value (Example).

- “Per script” is common language for this field.
- It is not uncommon for this tier to be built as “Not Applicable.”
- Relatively common in OON fields are additional charges/multiple values Multiple Costshare Options
- When benefits are specified as **Tier 2 Non-Preferred Generic** vs **Tier 3 Non-Preferred Generic**

  capture the values for **Tier 2** (Example).

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example) • There is an opportunity for reimbursal (Example)

Non Preferred Specialty Drugs

ETL Field: nonpreferred_specialty_drug_share

PD Sheet Field: nonpreferred_specialty_drug_share **API Field:** nonpreferred_specialty_drug_share **Howie Field:** Non-Preferred Specialty Drugs

SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Specialty drugs (wording varies)
- Other: N/A

Definition: The costshare for buying non-preferred specialty prescription drugs from a retail or specialty pharmacy.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Non Preferred Specialty Drugs
- Cost Share Variances: Non Preferred Specialty Drugs
  - This field is not present in many QHPs

Assumed Base Unit: per fill

Units to Capture: per script

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for retail **30-Day Supply** vs. **90-Day Supply**, capture the values for a

  30-Day Supply.

- We can capture the values for this benefit even if the values specify “self-administered” or “self- injectables.”
- If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
- “Per script” is common language for this field.

- It is not uncommon for this tier to be built as “Not Applicable.”
    - This tier should be built as “Not Applicable” if an SBC only mentions “Specialty Drugs” without differentiating between preferred and non-preferred (Example), (Example).

- Relatively common in OON fields are additional charges/multiple values Multiple Costshare Options
- If the SBC describes this benefit as “applicable cost as noted for generic/brand drugs” or “paid the same as generic/brand drugs,” this benefit should be ranged on the NON preferred drug values. Coinsurance values cannot be ranged and we take the highest value if there are multiple options.
    - (Example) Would be captured as $40 per script
    - (Example) Would be captured as $50
- If the SBC offers copay options in this tier that mirror exactly the costshare options in the other drug tiers, this benefit should be ranged on the preferred drug values.
    - (Example) $60 per script
- If the SBC offers a list of copay and coinsurance values/options then take the 2nd highest value for preferred specialty drugs and the highest value for non preferred specialty drugs. (Example).

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example) • There is an opportunity for reimbursal (Example)
limit: see carrier documentation for more information	• Prescriptions must be filled at a specialty pharmacy

Outpatient Ambulatory Care Center

ETL Field: outpatient_ambulatory_care_center
PD Sheet Field: outpatient_ambulatory_care_center **API Field:** outpatient_ambulatory_care_center **Howie Field:** Outpatient Ambulatory Care Center
SBC Location

- Common Medical Event: If you have outpatient surgery
- Services You May Need: Facility fee (e.g., ambulatory surgery center)
- Other: N/A

Definition: The facility fees for surgery that takes place in an outpatient ambulatory surgical center.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
- Cost Share Variances: Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

Assumed Base Unit: per visit

Units to Capture: per procedure, per day, per admission
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **Hospital** vs. **Freestanding Facility**, capture the values for **Freestanding Facility** (Example).
- When benefits are specified for **Hospital** vs. **Independent Facility**, capture the values for **Independent Facility** (Example).
- When benefits are specified for **Surgical** vs. **Non-Surgical**, capture the values for **Surgical** (Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Outpatient Facility

ETL Field: outpatient_facility
PD Sheet Field: outpatient_facility **API Field:** outpatient_facility **Howie Field:** Outpatient Facility
SBC Location

- Common Medical Event: If you have outpatient surgery
- Services You May Need: Facility fee (e.g., ambulatory surgery center)
- Other: N/A

Definition: The facility fees for surgery that takes place in a hospital.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
- Cost Share Variances: Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

Assumed Base Unit: per visit
Units to Capture: per procedure, per day, per admission
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **Hospital** vs. **Freestanding/Independent Facility**, capture the values for **Hospital** (Example 1, Example 2).
- When benefits are specified for **Surgical** vs. **Non-Surgical**, capture the values for **Surgical** (Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Outpatient Mental Health

ETL Field: outpatient_mental_health
PD Sheet Field: outpatient_mental_health **API Field:** outpatient_mental_health **Howie Field:** Outpatient Mental Health
SBC Location

Common Medical Event: If you need mental health, behavioral health, or substance abuse services

Services You May Need: Outpatient services

Other: N/A

Definition: The cost share for an individual's office visit with a mental health professional.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Mental/Behavioral Health Outpatient Services
- Cost Share Variances: Mental/Behavioral Health Outpatient Services

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: per admission

Unique Building Rules

- When benefits are specified for **Office Visit** vs. **Other Outpatient Services**, capture the values for

  Office Visit (Example).

  - When office visit cost share/copay language is used without any specific value mentioned, take the Specialist value. (Example)
- When benefits are specified for **Individual** vs. **Group**, capture the values for **Individual** (Example)
- When benefits are specified for **Therapy** vs **Other Outpatient Services**, capture the values for

  Therapy (Example) or **Psychotherapy** (Example)

- Ignore benefits for partial hospitalization or intensive outpatient treatment
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language
- "Out-of-Network Cost-share Limits" are common for this field.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• Cost Share differs when following a hospital discharge (Example)

Outpatient Physician

ETL Field: outpatient_physician

PD Sheet Field: outpatient_physician **API Field:** outpatient_physician **Howie Field:** Outpatient Physician
SBC Location

- Common Medical Event: If you have outpatient surgery
- Services You May Need: Physician/surgeon fees

Other: N/A

Definition: The cost share for physician services related to outpatient surgery.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Outpatient Surgery Physician/Surgical Services
- Cost Share Variances: Outpatient Surgery Physician/Surgical Services

Assumed Base Unit: per visit

Units to Capture: per procedure

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **Ambulatory Surgical Center** vs. **Hospital**, capture the values for **Hospital** (Example).
- When benefits are noted to be "included in facility fee," "see facility fee," "Not Applicable," or similar language, they should be captured as $0 (Example), (Example).
- When benefits are specified for **Physician** vs. **Surgeon**, capture the values for **Surgeon** (Example).
- When benefits are specified for **Cutting** vs. **Non-Cutting**, capture the values for **Cutting** (Example).
- This field is considered part of "Professional Services" if the SBC uses this language.
- We can ignore cost shares for Outpatient Observation (Example).

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Outpatient Substance

ETL Field: outpatient_substance
PD Sheet Field: outpatient_substance **API Field:** outpatient_substance **Howie Field:** Outpatient Substance
SBC Location

- Common Medical Event: If you need mental health, behavioral health, or substance abuse services
- Services You May Need: Outpatient services
- Other: N/A

Definition: The costshare for an individual's office visit with a mental health professional to address issues related to alcohol and/or drug use.
Field Logic: String

QHP Builder Mapping

- Benefits Package: Substance Abuse Disorder Outpatient Services
- Cost Share Variances: Substance Abuse Disorder Outpatient Services

Assumed Base Unit: per visit
Units to Capture: per procedure, per day
Units to Ignore: per admission
Unique Building Rules

- When benefits are specified for **Office Visit** vs. **Other Outpatient Services**, capture the values for

  Office Visit (Example).

  - When office visit cost share/copay language is used without any specific value mentioned, take the Specialist value. (Example)
- When benefits are specified for **Individual** vs. **Group**, capture the values for **Individual** (Example).
- Do not consider values for partial hospitalization or intensive outpatient treatment.
- When benefits are specified for **Therapy** vs **Other Outpatient Services**, capture the values for

  Therapy or **Psychotherapy** (Example), (Example).

- This field is considered part of "Office Visits," if the SBC uses this language.
- "Out-of-Network Cost-share Limits" are common for this field.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.

Postnatal Care

ETL Field: postnatal_care
PD Sheet Field: postnatal_care **API Field:** postnatal_care **Howie Field:** Postnatal Care
SBC Location

- Common Medical Event: If you are pregnant
- Services You May Need: Office visits
- Other: N/A

Definition: The costshare for routine postnatal office visits.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Prenatal and Postnatal Care
- Cost Share Variances: Prenatal and Postnatal Care

Assumed Base Unit: per visit
Units to Capture: per per pregnancy, per day
Units to Ignore: per admission

Unique Building Rules

- When benefits are listed simply as "Office Visit Costshare," capture the values for Specialist.
- When benefits are covered "the same as any other illness," capture the Specialist costshare (Example).
- Multiple costshare options are common in this field.
    - If the limit mentions "initial visit" and "Global Maternity Fee," capture prenatal as first 1 visit(s)

      and postnatal/inpatient birth physician as $0. (Example)

- Costshares may vary depending on the number of visits one makes.
    - If costshares vary by visit for Maternity Office Visits, the variance should only apply to prenatal care; postnatal care should be ignored (Example).
- When benefits are specified as "first visit is covered [at a certain level]", this only applies to Prenatal

  visits. In these cases, capture the applicable costshare for visits 2+ (Example).

- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
- When benefits are listed as **routine** vs **for complications**, capture the values for **routine care** and ignore complications of pregnancy (Example), (Example).
- We would capture the office visit value and not the preventative limit value. (Example)
- We would capture instances of $/pregnancy as such for all fields that state it. (Example)
- We translate "Included in delivery" as $0 for these fields. (Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There is a maximum cost per pregnancy (Example)

Preferred Brand Drugs

ETL Field: preferred_brand_drugs
PD Sheet Field: preferred_brand_drug_share
API Field: preferred_brand_drugs
Howie Field: Preferred Brand Drugs
SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Preferred brand drugs (wording varies)

  Other: N/A

Definition: The cost share for buying preferred brand prescription drugs from a retail pharmacy.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Preferred Brand Drugs
- Cost Share Variances: Preferred Brand Drugs

Assumed Base Unit: per fill
Units to Capture: per script
Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **30-Day Supply** vs. **90-Day Supply**, capture the values for a **30-Day Supply**.
- When benefits are specified as **Preferred** vs. **Non-Preferred** (within this specific, preferred tier), capture the values for **Preferred** (Example).
- If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
- If this benefit is written out with a minimum or maximum value, capture the maximum value with an

  "up to" limit and ignore the minimum value. (Example).

- "Per script" is common language for this field.
- This drug tier should never be built as "Not Applicable."
- If the SBC captures drugs as sold through an outside vendor, this benefit should be "Not Covered"

  (Example).

  - This applies both for In-Network and Out-of-Network values.
- Relatively common in OON fields are additional charges/multiple values Multiple Costshare Options

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example) • There is an opportunity for reimbursal (Example)
limit: see carrier documentation for more information	• There are multiple price options (often a copay and coinsurance) that are not tiers (Example)

Prenatal Care

ETL Field: prenatal_care
PD Sheet Field: prenatal_care
API Field: prenatal_care
Howie Field: Prenatal Care
SBC Location

- Common Medical Event: If you are pregnant
- Services You May Need: Office visits
- Other: N/A

Definition: The costshare for routine prenatal office visits.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Prenatal and Postnatal Care
- Cost Share Variances: Prenatal and Postnatal Care

Assumed Base Unit: per visit

Units to Capture: per pregnancy, per day

Units to Ignore: per admission

Unique Building Rules

- When benefits are listed simply as "Office Visit Costshare," capture the values for Specialist.
- Multiple costshare options are common in this field.
    - If the limit mentions "initial visit" and "Global Maternity Fee," capture prenatal as first 1 visit(s) and postnatal and inpatient birth physician as $0. (Example)
- Coststares may vary depending on the number of visits one makes.
    - If costshares vary by visit for Maternity Office Visits, the variance should only apply to prenatal care; postnatal care should be ignored (Example).
- When benefits are listed as **routine** vs **for complications**, capture the values for **routine care** and ignore complications of pregnancy (Example), (Example).
- When benefits are covered "the same as any other illness," capture the Specialist costshare (Example).
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
- We would capture the office visit value and not the preventative limit value. (Example)
- We would capture instances of $/pregnancy as such for all fields that state it. (Example)
- We translate "Included in delivery" as $0 for these fields. (Example)

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There is a maximum cost per pregnancy (Example)

Preventive Care

ETL Field: preventative_care

PD Sheet Field: preventative_care **API Field:** preventative_care **Howie Field:** Preventative Care

SBC Location

- Common Medical Event: If you visit a health care provider's office or clinic
- Services You May Need: Preventive care/screening/immunization
- Other: N/A

Definition: The costshare for preventative healthcare services, such as screenings and immunizations.[19]

Field Logic: String

QHP Builder Mapping

- Benefits Package: N/A
- Cost Share Variances: Preventive Care/Screening/Immunization

Assumed Base Unit: per visit

Units to Capture: per pregnancy

Units to Ignore: N/A

Unique Building Rules

- While in-network preventative care services are required by law to be fully covered by all health plans, some SBCs will state costshare amounts other than "$0." In these cases, capture the values present on the SBC.
    - This is more common in Large Group Custom plans than in Small Group or Individual plans.
- When given the choice between **Immunizations**, **Screenings** and **Well-Child physicals**, please capture the values for **Screenings** (Example).

- When given the choice between **most services** and **other services**, please capture the values for

  Most Services (Example).

Limits

- There are no valid limits for this field.

Primary Care Physician

ETL Field: primary_care_physician **PD Sheet Field:** primary_share **API Field:** primary_care_physician
Howie Field: Primary Care Physician

[19] https://www.healthcare.gov/coverage/preventive-care-benefits/

SBC Location

- Common Medical Event: If you visit a health care provider's office or clinic
- Services You May Need: Primary care visit to treat an injury or illness
- Other: N/A

Definition: The costshare for an office visit to a primary care physician.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Primary Care Visit to Treat an Injury or Illness
- Cost Share Variances: Primary Care Visit to Treat an Injury or Illness

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified as **Carrier-Specific Providers** vs. **All Other Providers**, the plan should be built as **tiered** (Example).
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
  - When benefits are specified as "Office visits" vs retail clinic vs all other services, the plan should just take office visits. (Example)
- Coststares may vary depending on the number of visits one makes.
  - Some plan names indicate a certain number of free PCP visits; this should be captured even if it is not present in the benefit grid.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There is a maximum number of covered visits per month (Example)

limit: 3 visit(s) per year	• This should be captured in-network using varying costshare per visit formatting

Rehabilitation Services

ETL Field: rehabilitation_services
PD Sheet Field: rehabilitation_services **API Field:** rehabilitation_services **Howie Field:** Rehabilitation Services
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Rehabilitation services
- Other: N/A

Definition: The cost share for outpatient rehabilitation services.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Outpatient Rehabilitation Services
- Cost Share Variances: Outpatient Rehabilitation Services

Assumed Base Unit: per visit

Units to Capture: per day

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **Outpatient** vs. **Office**, capture the values for **Office** (Example).
- When benefits are specified for **Outpatient** vs. **Inpatient**, capture the values for **Outpatient**

  (Example).

    - May also be specified as **Hospital** (inpatient) vs. **Non-Hospital** (outpatient)
    - If only inpatient values are given, the benefit should remain unknown (Example).
        - Similarly, limits that only apply to inpatient benefits should not be captured.
- When benefits are specified for **Office** vs. **Facility**, capture the values for **Office** (Example).
- When benefits are specified for **Physician** vs. **Facility**, capture the value for **Physician** (Example)

  Physician Non-PCP (Example)

- When benefits are specified for **PCP** vs. **Specialist**, capture the value for **Specialist** (Example)
- When benefits are specified for different types of therapy (i.e. speech, occupational), capture the values for **Physical Therapy** (Example).
    - *Only capture limits that apply to Physical Therapy*.
- When benefits are specified for **Provider** vs. **Hospital Facility**, capture the values for **Provider**

  (Example)

- When benefits are specified for **Therapy Visit** vs **all other providers**, capture **Therapy visit**. (Example)
- This benefit might have limits or benefits sandwiched in other areas of the SBC.
    - Example: Home Health Care limit for Rehabilitative care
    - Example: Outpatient physical therapy is in “Other Practitioner Office Visit”
- If the SBC has language saying that limits are combined with Habilitation Services, the limits for Rehabilitation and Habilitation should mirror each other (Example).

- We do not capture manipulative treatment limits for this field. (Example)
- We do not capture Extended Care Facility or Rehabilitation Facility limits for this field. (Example)
- We do not capture OON limits for this field. (Example)

Limits

Grammar	Use Case/Common Errors
limit: 20 visit(s) per year	• There is a maximum number of visits to a Physical Therapist for rehabilitation services allowed in a given period of time (Example)
limit: 30 visit(s) per condition per benefit period	• The maximum number of visits is specified as being per condition, rather than a single annual limit. (Example) • "Per disability" should be translated to "per condition"
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: 20 visit(s) per therapy per year	• "per therapy" is not valid grammar for this field, and should not be translated to "per condition" (Example)
limit: 60 visit(s) per lifetime	• "Per lifetime" is not considered valid grammar for this field and should be translated to "per benefit period

Skilled Nursing Facility

ETL Field: skilled_nursing
PD Sheet Field: skilled_nursing **API Field:** skilled_nursing **Howie Field:** Skilled Nursing
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Skilled nursing care
- Other: N/A

Definition: The cost share for an inpatient stay in a skilled nursing facility.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Skilled Nursing Facility
- Cost Share Variances: Skilled Nursing Facility

Assumed Base Unit: per admission

Units to Capture: per day

Units to Ignore: per stay (translates to per admission)
Unique Building Rules

- When benefits are specified for **Outpatient** vs. **Inpatient**, capture the values for **Inpatient**.
    - If only outpatient values are given, the benefit should remain unknown.
        - Similarly, limits that only apply to outpatient benefits should not be captured.
- When benefits are specified for **Independent Facility** vs. **Hospital Facility**, capture the values for **Independent Facility** (Example).

Limits

Grammar	Use Case/Common Errors
limit: 100 day(s) per admission	• There is a maximum number of days allowed per admission (Example) • "Per stay" and "per confinement" should be translated to "per admission" (Example)
limit: 60 day(s) per benefit period	• There is a maximum number of days a consumer may reside in a skilled nursing facility in a given period of time (Example) • "visit(s)" is an uncommon but valid unit for this field.
limit: 60 visit(s) per condition per benefit period	• The maximum number of visits/days is specified as being per condition, rather than a single annual limit. (Example) • "Per illness," "per disability," and "per cause" should be translated to "per condition" (Example 1, Example 2)
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field.
limit: 100 day(s) per stay	• "Per stay" in not valid grammar for any field • Should be translated to "per admission"
Limit: 60 day(s) per year (post-hospitalization)	• Do not capture limits for post-hospitalization (Example)
Limit: 120 episodes per 12 month(s)	• "per episode" limits are not captured for any field (Example)

Specialist

ETL Field: specialist
PD Sheet Field: specialist_share
API Field: specialist
Howie Field: Specialist
SBC Location

- Common Medical Event: If you visit a health care provider's office or clinic

- Services You May Need: Specialist visit

  Other: N/A

Definition: The costshare for an office visit to a specialist.

Field Logic: String

QHP Builder Mapping

- Benefits Package: Specialist Visit
- Cost Share Variances: Specialist Visit

Assumed Base Unit: per visit

Units to Capture: per procedure, per day

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified as **Carrier-Specific Providers** vs. **All Other Providers**, the plan should be built as **tiered** (Example).
- This field is considered part of "Professional Services" or "Office Visits," if the SBC uses this language.
- Coststares may vary depending on the number of visits one makes.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• There are no use cases for this limit that are specific to this field

Specialty Drugs

ETL Field: specialty_drugs

PD Sheet Field: specialty_drug_share

API Field: specialty_drugs

Howie Field: Preferred Specialty Drugs

SBC Location

- Common Medical Event: If you need drugs to treat your illness or condition
- Services You May Need: Speciality drugs (wording varies)
- Other: N/A

Definition: The costshare for buying preferred specialty prescription drugs from a retail or specialty pharmacy.

Field Logic: String

QHP Builder Mapping

Benefits Package: Specialty Drugs

Cost Share Variances: Specialty Drugs

Assumed Base Unit: per fill

Units to Capture: per script

Units to Ignore: N/A

Unique Building Rules

- When benefits are specified for **Preferred** vs. **Non-Preferred specialty drugs**, capture the values for **Preferred Specialty Drugs** (Example).
- When benefits are specified for retail **30-Day Supply** vs. **90-Day Supply**, capture the values for a **30-Day Supply**.

- We can capture the values for this field even if they specify "self-administered" or "self-injectables."
- If the plan is an HSA Eligible plan, then the deductible should always apply to this field (Example).
- "Per script" is common language for this field.
- If the SBC captures drugs as sold through an outside vendor, this benefit should be "Not Covered" (Example).
    - This applies both for In-Network and Out-of-Network values.
- If the SBC describes this benefit as "applicable cost as noted for generic/brand drugs" or "paid the same as generic/brand drugs," this benefit should be ranged on the preferred drug values. Coinsurance values cannot be ranged and we take the highest value if there are multiple options (Example).
    - (Example) Would be captured as $15-$25 per script
    - (Example) Would be captured as $10-$25
- If the SBC offers copay options in this tier that mirror exactly the costshare options in the other drug tiers, this benefit should be ranged on the preferred drug values.
    - (Example) $10-$40 per script
- If the SBC describes this benefit as "covered," this benefit should be captured as "Not Applicable" (Example).

- If the SBC lists a coinsurance or copay value, whichever is greater, we would capture the greater coinsurance value only for preferred speciality drugs. (Example)
- If the SBC offers a list of copay and coinsurance values/options then take the 2nd highest value for preferred specialty drugs and the highest value for non preferred specialty drugs. (Example).
- If specialty drugs are listed in every field then capture the lowest value and the highest value.
    - (Example) This would be captured as $25-$500 per script.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• In addition to out-of-network coinsurance values, a second coinsurance charge applies when using an out-of-network pharmacy (Example) • Multiple coinsurance values apply for a single out-of-network benefit (Example)
limit: see carrier documentation for more information	• Prescriptions must be filled at a specialty pharmacy

Urgent Care

ETL Field: urgent_care
PD Sheet Field: urgent_care **API Field:** urgent_care **Howie Field:** Urgent Care
SBC Location

- Common Medical Event: If you need immediate medical attention
- Services You May Need: Urgent care

- Other: N/A

Definition: The costshare for an office visit to an independent urgent care facility located within a plans Service Area.
Field Logic: String
QHP Builder Mapping

- Benefits Package: Urgent Care Centers or Facilities
- Cost Share Variances: Urgent Care Centers or Facilities

Assumed Base Unit: per visit
Units to Capture: per procedure, per day
Units to Ignore: N/A
Unique Building Rules

- When benefits are specified for **Primary Care** vs. **Specialist**, capture the values for **Specialist**

  (Example).

  - This may also be written as "*Cost Share may vary depending on location*" (Example), or

  "*Covered as a health care provider's office or clinic*" (Example).

- When benefits are specified as **Carrier-Specific Providers** vs. **All Other Providers**, the plan should be built as **tiered** (Example).
- When benefits are specified for **Independent Facilities** vs. **Hospital-Affiliated Facilities**, capture the values for **Independent Facilities**.
- When benefits are specified for **Urgent Care Clinic** vs. **Freestanding Facilities**, capture the values for **Freestanding Facilities** (Example).
- Coststares may vary depending on the number of visits one makes.
- This field is considered part of "Office Visits," if the SBC uses this language.
- Services only covered out of the service area are captured as "Not Applicable" and add a limit "see carrier doc". Example
- We can ignore language that says "no coverage for non-urgent use" since we can assume that any visit to

  urgent care is, in fact, urgent. Example

- "Out-of-Network Cost-share Limits" are common for this field.

Limits

Grammar	Use Case/Common Errors
limit: see carrier documentation for more information	• Out-of-network benefits are only covered when outside of a plan's Service Area (Example) • Out-of-network providers located within a plan's Service Area are not covered (Example)

New York Specific Fields

Age 29 Rider

ETL Field: age29_rider
PD Sheet Field: age29_rider
API Field: age29_rider
Howie Field: Age 29 Rider Included
Definition: This rider, available only in New York, allows eligible young-adults to continue to be covered by their parents' health insurance through the age of 29.[20] Without this rider, young-adults may only be covered through the age of 26.
Field Logic: Boolean
Information Source

- This should be marked true when the rider is available for a plan.
- Rider information is obtained from Rate Filings, often in a table called "Exhibit 23."
    - Exhibit 23 information can be ingested directly from a builder.
- On occasion, plan names can provide rider information.
    - Some issuers include "Age 29" in plan names where this rider applies.

Unique Building Rules

- Rider information that is not builder friendly is built out in a manual sheet.
    - Rider information should never be put into a PD sheet directly, as this could override information in the rider table.
- This rider information must be embedded in the Plan Name per New York law. If this information is not already present, it is added programatically in Howie.

Domestic Partner Rider

ETL Field: dp_rider

[20] https://www.dfs.ny.gov/consumer/S6030_Age29.htm
PD Sheet Field: dp_rider
API Field: dp_rider
Howie Field: Domestic Partner Rider Excluded
Definition: This rider, only available in New York, excludes the plan from the requirement that domestic partners be covered.
Field Logic: Boolean
Information Source

- Rider information is obtained from rate filings, often in a table called "Exhibit 23."
    - Exhibit 23 information can be ingested directly from a builder.
- On occasion, plan names can provide rider information.
    - Some issuers include language such as "DP" or "No DP" in the plan name to indicate if this rider is included.

Unique Building Rules

- This rider should be marked true when rider is not available for a plan.
- Rider information that is not builder friendly is built out with a manual sheet.
    - Rider information should never be input into a PD sheet directly, as this could cause builder problems.

- This rider information must be embedded in a plan's name per New York law. If this information is not already present, it is added programatically in Howie.

Family Planning Rider

ETL Field: fp_rider
PD Sheet Field: fp_rider
API Field: fp_rider
Howie Field: Family Planning Rider Excluded
Definition: This rider, available only in New York, extends a plan's coverage to a variety of medical services related to family planning, such as contraceptives and vasectomies.[21]
Field Logic: Boolean
Information Source

- Rider information is obtained from rate filings, often in a table called "Exhibit 23."
    - Exhibit 23 information can be ingested directly from a builder.

Unique Building Rules

- This rider should be marked true when rider is not available for a plan.
- Rider information that is not builder friendly is built out with a manual sheet.
    - Rider information should never be input into a PD sheet directly, as this could cause builder problems.

[21] https://www.dfs.ny.gov/insurance/health/model/ml_dom_part_rider.doc

This rider information must be embedded in a plan's name per New York law. If this information is not already present, it is added programatically in Howie.

Skilled Nursing Facility 365

ETL Field: skilled_nursing_facility_365
PD Sheet Field: skilled_nursing_facility_365 **API Field:** skilled_nursing_facility_365 **Howie Field:** Skilled Nursing Facility 365
SBC Location

- Common Medical Event: If you need help recovering or have other special health needs
- Services You May Need: Skilled nursing care
- Other: N/A

Definition: This rider, available only in New York, indicates that there is no limit to the number of days one may reside in a skilled nursing facility.
Field Logic: Enum
Information Source

- This information is most commonly found in Rate Filings under a label of "Skilled Nursing 365" or similar language.

- Some SBCs and QHPs provide this information by listing Skilled Nursing Facility's limit as "365 day(s) per [year/ benefit period]".

Unique Building Rules

- Valid benefits for this field include:
    - Unlimited
    - The field is left blank
        - This will only appear in the ETL/API; Unknown is not a valid unit to be built into Howie.
- Only New York plans should be marked "Unlimited."
- Skilled Nursing Facility limits of "365 day(s) per [year/benefit period]" indicate that this rider should be captured as "Unlimited" (Example).

Benefits By Category

This section discusses groups or types of benefits and their associated building conventions.

Inpatient Services (Non-SBC)

Some non-SBC sources, such as SOB's or Brochures, provide generalized benefit information for "Inpatient Services" or "Inpatient Facility" (or a similarly vague "inpatient" benefit). The following fields can be built with such benefits:

Howie Field	Applicable ETL Field(s)
Inpatient Birth	inpatient_birth
Inpatient Facility	inpatient_facility
Inpatient Mental Health	inpatient_mental_health
Inpatient Substance	inpatient_substance

Limits

Benefit limits that are captured apply to In-Network coverage. If a plan has multiple tiers, only Tier 1 limits are captured.

- Example: Skilled Nursing Facility

Units present in limits are usually captured using the exact language present in a source document. Some common units (and language that should be translated, if applicable) are:

- Per year
    - "Calendar year" should be translated.
    - Per year(s) if the limit is per 2 or more years.
- Per benefit period
    - "Annual max", "contract year", "benefit year", "policy year", "policy period", and "plan year"

      should be translated

    - 20 visits PT/OT/ST will translate to "per benefit period"
- Per # month(s)
    - Look for keyword "months" in the limit regardless of number of months
- Per admission
    - "Per stay" and "per period of confinement" should be translated.

Minimum Publishing Standard

A list of benefit fields that are required for a medical plan to be Publishable. This standard was introduced in July 2019[22], and differs slightly between Audiences. Required benefits are highlighted in Blue in Howie Benefit Sets and IPA pages.

Required Field	Applicable Audience(s)
Emergency Room	Individual & Small Group
Family Drug Deductible	Individual & Small Group

22 https://vericred.atlassian.net/wiki/spaces/PROD/pages/193134623/2020+ACA+Medical+-+Minimum+Publishing+Standard

Family Drug MOOP	Individual & Small Group
Family Medical Deductible	Individual & Small Group
Family Medical MOOP	Individual & Small Group
Generic Drugs	Individual & Small Group
Individual Drug Deductible	Individual & Small Group
Individual Drug MOOP	Individual & Small Group
Individual Medical Deductible	Individual & Small Group
Individual Medical MOOP	Individual & Small Group
Non-Preferred Brand Drugs	Individual
Non-Preferred Specialty Drugs	Individual
Preferred Brand Drugs	Individual & Small Group
Preventative Care	Individual & Small Group
Primary Care Physician	Individual & Small Group
Specialist	Individual & Small Group
Specialty Drugs	Individual

Office Visits

An SBC may say that the deductible does or does not apply for "Office Visits." The following benefits are considered to be Office Visits:

Service	Applicable ETL Field(s)
Child Dental	child_dental
Child Eye Exam	child_eye_exam
Imaging Physician	imaging_physician
Outpatient Mental Health	outpatient_mental_health

Outpatient Substance	outpatient_substance
Postnatal Care	prenatal_postnatal_care, postnatal_care
Prenatal Care	prenatal_postnatal_care, prenatal_care
Primary Care Physician	primary_care_physician

Specialist	specialist
Urgent Care	urgent_care

Plan Variations

Certain types of plans can be identified by an addition to the end of their HIOS ID in the form of "-##"

Variation	Meaning	Captured in HIOS ID?
-00	Standard Off-Exchange plan	No, captured by Market(off)
-01	Standard On-Exchange plan	No, captured by Market(on)
-02	Zero Cost Sharing (-s only) (IHCP) (Indian Health Care Provider)	No - This benefit tier should always be ignored if present on SBC
-03	Limited Cost Sharing (Native Americans only) (IHCP) (Indian Health Care Provider)	No - This benefit tier should always be ignored if present on SBC
-04	73% AV Level Silver Plan	Yes, Individual On-Market plans only
-05	87% AV Level Silver Plan	Yes, Individual On-Market plans only
-06	94% AV Level Silver Plan	Yes, Individual On-Market plans only
-07	77% AV Level Silver Plan	Yes, BlueCross BlueShield of Vermont (VT) and MVP Health Plans (VT) only
-10	Infertility Rider	Yes, Anthem (CA) plans only
-11	"With Association" designation	Yes, Anthem (IN & OH) plans only
-12	Healthy Blue Living, Standard designation	Yes, BlueCross BlueShield of Michigan plans only
-13	Internally created HIOS ID	Yes
-14, -15, -16, -17	Essential Health Plans	Yes, NY plans only
-22	Service Area designation for "duplicate" plan	Yes, Oscar (TX) plans only

-33	Chiropractic rider	Yes, Health Net plans only
-77	Private Exchange plan (CA & NY)	Yes
-88	Age 29 rider	Yes, Oxford (NY) plans only
-94	Association health plans with qualification questions	Yes, Decent (TX) plans only
-95	-05 CSR Variation for New Mexico SOPA Plans	Yes

-98		Yes, Neighborhood Health Plan (MA) plans only
-99	• Privileged UnitedHealthcare plan • -06 CSR Variation for New Mexico SOPA Plans	Yes

Professional Services

An SBC may say that the deductible does or does not apply for "Professional Services." The following benefits are considered to be Professional Services:

Service/Professional	Applicable ETL Field(s)
Child Dental	child_dental
Child Eye Exam	child_eye_exam
Home Health Care	home_health_care
Imaging Physician	imaging_physician
Inpatient Birth Physician	inpatient_birth_physician
Inpatient Physician	inpatient_physician
Outpatient Mental Health	outpatient_mental_health
Outpatient Physician	outpatient_physician
Outpatient Substance	outpatient_substance
Postnatal Care	prenatal_postnatal_care, postnatal_care
Prenatal Care	prenatal_postnatal_care, prenatal_care
Primary Care Physician	primary_care_physician
Specialist	specialist

Tiered Plans

Tiered plans provide multiple levels of coverage under different networks of providers. The price of a service will vary depending on the tier a specific provider falls under, with lower tiers often providing lower prices than higher tiers.
We are only tiering by individual fields for 2021 instead of mirroring all fields. If there is no different value, then there is no need in repeating the same value in our data set. This would also affect Tier 2 medical/drug deductibles/moops. We would not mirror these fields either if they mirror In network tier 1.

- Insert into URL: %2C584

Information Source

- SBCs often show tiers by adding columns to the benefit grid, each labeled with the network or tier name (Example).
- Sometimes tier information is embedded within the benefit grid by providing different prices for different groups or networks (Example).

Tiering Examples

- If it is unclear if a plan should be tiered, please share the SBC with a member of QA via the Format Feedback channel on slack.
- Example: From this SBC we would only have Preferred Generic Drugs, Non-Preferred Generic Drugs, Preferred Brand Drugs, and Non-Preferred Brand Drugs Tier 2 values. The In Network Provider values in this SBC would shift over to Tier 1 in Howie. Generally Not Applicable in Tier 1 means we do this shift.
- Example: Similar to above, but Preferred Speciality Drugs would need to have a Tier 2 value.
- Example: Almost all values from this SBC should have a Tier 2 value except for drug values, Emergency Room, Ambulance, and Pediatric values.
- Example: SBC only has Designated Lab value that is different and should be Tiered. Meaning that the only Tier 2 value built out in Howie would be $50 for Lab Test.
- Example: This example would only have Specialist and Lab Test as having tier 2 values because those are the only 2 fields with differing values from Tier 1.
- Example: An example of a tiered SBC without the columns being labeled as tiered. The KP values would be Tier 1 and the non KP values would be Tier 2.
- Example: Despite Not Applicable being present for many Preferred Network provider values there are also legitimate values as well. In this case the In Network values would be captured for Tier 1 in Howie where it says Not Applicable but the values listed with Preferred values and In Network values would be captured as Tier 1 and Tier 2 in Howie. Another example.
- If within a single issuer there are plans with differing numbers of tiers (i.e. 2 tier and 3 tier plans).
    - Do not take the network/tier name into account when building plans.
    - Build plans with as many tiers that are apparent in the document, regardless of the structure of other tiered plans for that issuer. Lowest value should generally always be the lowest tier.
- Example: This SBC would only have Medical deductibles tiered out because all tiered values are the same.
- Harvard Pilgrim tier breakdown with multiple examples and logic
- **Example: We do not tier out on Indian Health Care providers. Ignore that column. (-02/- 03)**

Benefits By Grammar/Convention

This section defines broader conventions or rules that may apply to a variety of benefit fields.

Adult vs Child benefits

We do not capture child values outside of the 3 fields - child eye exam, child eyewear, child dental - but if the SBC mentions a child value and an adult value for a field, we would only capture the adult value. Ignore the other child value.

- In PCP “First 6 Office Visits: $10 Copayment (Child up to age 26), $45 Copayment (Adult). After 6th visit, member pays 20% coinsurance after deductible” (Example) Would be captured as “first 6 visit(s)

$45 then 20%” without the see carrier doc

Allowances

May be explicitly called “allowances” or appear as a charge “up to $ maximum.”

- “Coverage up to a maximum allowance of $30; Calendar year medical deductible does not apply”

  (Example).

  - Captured as: 100% after $30 allowance
- “18 & Under: No cost for vision services up to $130 per Calendar Year. Amounts in excess of $130: 80% for frames/ lenses or 85% for contact lenses” (Example).
  - Captured as: 80% after $130 allowance
- Child Eyewear field states “Allowances available for glasses/lenses” (Example)
  - Captured as: 100%, see carrier doc
- Children’s glasses - “No charge up to $150 maximum, deductible does not apply, then subject to in- network provider medical deductible and coinsurance”
  - Example 1
    - Captured as: 30% after deductible after $150 allowance
- Children’s glasses - “No charge up to $150 maximum, deductible does not apply, then subject to in- network provider medical deductible and co-insurance”
  - Example 2
    - Captured as: $0 after deductible after $150 allowance
- Children’s glasses - “$25; $150 will be allowed toward the purchase of frames, lenses, or contacts”
  - Example 3
    - Captured as: $25 after $150 allowance
- Children’s eye exam - “No charge up to $40 maximum, deductible does not apply, then Deductible then

  100% co-insurance”

  - Example 4
    - Captured as: 100% after $40 allowance
- Child glasses - “No charge. $150 allowance for Lenses and Frames, or Contact Lenses.”
  - Example 5
    - Captured as: 100% after $150 allowance
- “25% coinsurance visit. Deductible applies first. | Limit: Maximum cost allowed $150” (Example)
  - Captured as: 100% after $150 allowance | limit: see carrier documentation for more information
- “$25 | Limit: $150 will be allowed toward the purchase of frames, lenses, lens options or contacts”

  (Example)

  - Captured as: 100% after $150 allowance | limit: see carrier documentation for more information
- Imaging Center/Imaging Physician
  - (Example) we would capture this as “20% after deductible after $400 allowance”
- Child Eye Exam/Eye Wear - “All charges less $x plan payment; deductible does not apply”
  - (Example) - Captured as 100% after $x allowance

If an allowance is captured as a range, capture the range (Example).

If an allowance applies after a reimbursement, ignore the allowance and only capture the reimbursement (Example), (Example).

Allowed Amount

Generally when allowed amount is seen in the SBC in the OON section. We do not add “see carrier doc” in the limits for these situations.

An allowed amount can either be written out as an unknown allowance, or as a cap on what the plan will pay for a service (also called a Usual and Customary rate). We leave unknown allowances as unknown, but we capture the Usual and Customary rates as is. *(in 2021 we would capture the allowed amounts)*

- "Member pays expenses in the excess of the pediatric vision allowed benefit of $40."
    - Example 1, Captured as **100% after $40 allowance**
- "Equal to 40% of negotiated fee"
    - Example 1, captured as **40% after deductible**
- Example 2, Child Eyewear Out-of-Network - "*For children under age 19 you will pay expenses beyond allowed amounts.*"
    - Since the allowed amount isn't listed, we wouldn't capture it. Captured as :

      blank/unknown

- Example 3, Child Vision Out-of-Network - "*$0 copayment up to the plan's Maximum Allowed Amount.*"
    - Since we don't know the allowed amount, we would capture this as: **$0**
- Example 4, Outpatient Mental Health - "100% of allowed benefit."
    - Since the allowed benefit isn't specified, we can ignore this. Captured as:

      blank/unknown

Reimbursements

A reimbursement occurs when a member is asked to pay the full cost of a health benefit up front, and receive some money from their insurance company afterwards. Because we capture the upfront cost of a health care service, reimbursements should always be captured as "**100%** | limit: **see carrier documentation for more information**".

- Benefits written as "Member must file claim" should be captured as reimbursements (Example).
- There is one exception to this rule; if every benefit is written out as a reimbursement, then we can ignore the reimbursements to allow for more granularity when capturing benefits (Example).

"limit: see carrier documentation for more information"

This limit is used to bring a customers attention to important information that is not otherwise captured. Use this limit when:

A medical credit may apply to reduce the deductible (Example - Primary Care Physician, etc.).
There is a separate deductible for a field that is not otherwise captured (Home Health Care).
There is an opportunity for reimbursement.
A 0% coinsurance applies to an Allowance (Example - Child Eyewear).
There are multiple costshare options (Example - Preferred Generic Drugs).
This limit is not necessary when:

- Preauthorization is required (Example - Imaging).
    - May be written as "pre-approval" or "pre-certification."Common in SBC limits, ignore them.
- There are limits that apply to out-of-network coverage (Example - Home Health Care).

Multiple Costshare Options

Some SBCs list two different costshare amounts that may apply to a single benefit. Which costshare applies may be determined by whichever amount is greater or less, whether or not a certain set of criteria have been met, or some documents may not give any clues as to what causes either costshare to apply.
In these cases, the "greater" of the two costshares should be captured. There are three possible costshare

combinations:

- If two values are present with only “or” present and no distinction between the type of service, capture the larger value:
    - Example: DME would be **50%** (capture coinsurances over copays)
- If a copay range is presented, we can capture the copay range accordingly
    - Example - Specialist will be captured as **$35-$95**
- If a copay and a coinsurance value are present, capture the coinsurance value
    - Example 1: Prenatal/Postnatal
    - Example 2 - Prenatal/Postnatal
- If two coinsurances are present in the field with no distinction between applicable locations (i.e. office vs facility), capture the larger coinsurance value (***unless the brand page specifically says otherwise***).
- Per Occurrence Deductibles:
    - A copay value with an addition of “$0 after deductible”/“0% coinsurance” should be added on top of the copay value where applicable. See ER Example
    - A copay value with an addition of “no charge”/“$0” should be combined with the coinsurance. See PCP Example
    - (Example) ER would be captured as “$300 plus $0 after deductible.”
    - (Example) PCP would be captured as “$35”
- When there is a **copay** and **coinsurance** value listed for the same field without an “or” and not distinction between types of services, it should be captured as “**$x plus y%**”.
    - “Then” should only be used to link “first x day(s) value then coinsurance/copay per day”
- If OON drug values are all **copays** and the drug limit states that “out-of-network prescriptions are subject to an additional charge”, OON drugs should include the additional charge coinsurance value
    - (Example) OON Preferred Generic drugs should be captured as: **$10 per script plus 50%**
- If OON drug values are all **coinsurances** and the drug limit states that “out-of-network prescriptions are subject to an additional charge”, OON drugs should capture the coinsurance value in the field box rather than the additional charge value listed in the limits
    - (Example) OON Preferred Brand drugs should be captured as: **30% after deductible** with a **see carrier doc** in the limit

When there are **multiple coinsurance** box values listed in an SBC for a single field, capture the larger coinsurance value listed with a **see carrier doc** included in the limit.

- (Example) OON Non-Preferred Brand drugs would be captured as: **30% after deductible** with a **see carrier doc** in the limit

In 2021 we will not be adding a see carrier doc in the limit if there are 2 cost shares (outside of coinsurance plus coinsurance). It reduces clutter and our general policy is to always take the higher value in a field, so it can just be assumed in the future that’s why we took the greater value over the lesser one.

Not Covered vs. 100% vs. Not Applicable

“Not Covered” should be used when benefits appear as “Not Covered,” “100%,” “Unlimited”, or “Not Applicable” (with the exception of Not Applicable applying to full drug tiers). This language should also be used for Out-of-Network Deductibles and MOOPs when they do not apply or the value of the Deductibles or MOOPs are Unlimited .
“Not Applicable” and the limit “See Carrier Doc” should be used when there is coverage available outside of the

service area. Commonly seen in Urgent Care - Example

"100%" should be used when benefits appear as "100% after deductible," or a benefit is covered only via reimbursement.

"per procedure"

This language is used to indicate when the copay costshare applies per individual procedure rather than per a unit of time.
The formatting for this language is "[costshare] per procedure [after deductible]"

- Example (Imaging Center): $500 per procedure after deductible
- If both a copay and coinsurance apply, "per procedure" should be located after the copay.
    - Example (Imaging Center): $100 per procedure plus 30%

This language should be used when the following is present:

- "Per procedure" (Example: Imaging Center)
- "Per test" (Example: Diagnostic Test)
- "Per service" (Example: Imaging Center)
- "Per surgery" (Example: Outpatient Facility)
- "Per scan" (Example: Imaging Center)
- "Per each part of the body scanned" (Example: Imaging Center)
- "Per category of test/day" (Example: Imaging Center)
- "Per test type" (example tba)
- "Per image" (Example: Diagnostic)

This language is not necessary when the following is present:

- "Per exam" (Example: Child Eye Exam)
- "Per encounter" (Example: Diagnostic)

"Per occurrence" (Example: Outpatient Facility)

"Per date of service" (Example: Outpatient MH/Substance)

"per script"

This language is used in Prescription Drug fields to indicate when the cost share applies per overall prescription, rather than per individual fill.
The general formatting for this language is "[cost share] per script [after deductible]"

- Example (In-Network Preferred Brand Drugs): **$150 per script after deductible**
- If there is an "up to" maximum, "per script" should be moved to the end of the benefit string.
    - Example (In-Network Preferred Brand Drugs): "**30% after deductible, up to $500 per script**"
- When "**per prescription**", "**retail prescription**" or similar language is stated in the Limitations &

  Exceptions

    - This language should be applied for both in-network and out-of-network benefits, unless a network is specified (Example).
- This language may not apply to all drug tiers; only use "per script" where applicable per the source

  document.

- This language should only be used with dollar amounts (i.e. copays or up to limits) and should not be used with coinsurance values.
    - "**$0**" and "**$0 after deductible**" counts as a coinsurance for these purposes, and should not be accompanied by "per script" (Example).

- When “per script” can be used multiple times in a string, only use it once at the end.
    - Example: **$25, up to $250 per script**
- When per script is mentioned along with a copay plus a coinsurance value, place it after the copay value.
    - Example: **$25 per script plus 30%**

Use this language when:

- “/script” or “/prescription” is stated within the benefit box (Example).
- “Per script” or “per prescription” is present within the Limitations & Exceptions (Example).
- The cost share applies to a certain supply which is defined as a “retail prescription” in the Limitations & Exceptions (Example).

Do NOT use this language when:

- The cost share is stated to be “/fill” or “per fill”
- The cost share is a coinsurance value (i.e. “50% after deductible” does not require “per script”)
- The cost share is state to be “/per medication” or “/medication”

“up to” Limits

This language is used to capture a monetary maximum(s). It is embedded within the In-Network and/or Out- of-Network benefit strings, rather than the Limits field.
The formatting for this language is “[cost share], up to [dollar amount] per [unit].”

- If the cost share is a **coinsurance**:
    - Example (Skilled Nursing Facility, Out-of-Network): 50% after deductible, up to $150 per day

      “Up to” units (such as “per day” above) should be captured as specified in an SBC, unless it is the assumed base unit for that field (Example).

    - If no unit is specified, one does not need to be added.
- If the cost share is a **copay**:
    - Example (Imaging Center, In-Network): first 5 visit(s) $75 per procedure then $0
        - We asked for first 5 procedure(s) $75 per procedure then $0 language being accepted in 2022. It wasn’t able to be done.
    - If an “up to” unit is not specified in an SBC in this case, please share an example SBC with a member of the Grammar Steering Committee for evaluation.
- If the dollar maximum is equal to the Individual Medical MOOP, it should not be captured (Example: Inpatient Facility)

If a benefits maximum amount is cleanly divisible by its copay costshare, “first # visit(s)/day(s)...” grammar should be used.

Varying Cost Share per Visit/Day

Some benefits will have a different cost share depending on the number of visit or day one is seeking care.
When the cost share applies per visit, benefits should be built as “first # visit(s) [costshare] then [costshare]”

- Example (Primary Care Physician): first 3 visit(s) $75 then $75 after deductible

- If the deductible only applies to the first cost share, “after deductible” should be located following that cost share amount.
    - Example (Prenatal): **first 1 visit(s) 10% after deductible then $0**
    - Example (Prenatal): **first 1 visit(s) $0 after deductible then $0**
- If the deductible only applies to the second cost share, “after deductible” should be located at the end of the benefit string.
    - Example (Urgent Care): **first 3 visit(s) $40 then 20% after deductible**
- If the deductible applies to both cost share amounts, capture “after deductible” after both benefits strings.
    - Example (Skilled Nursing Facility): **first 90 day(s) 20% after deductible then 50% after deductible**

When the cost share applies per day, benefits should be built as “first # day(s) [costshare] per day then [copay] per day [after deductible]”

- Example (Inpatient Facility): first 5 day(s) $600 per day then $0
    - If the per day ending is $0 we do not need the per day unit
- If the deductible applies to only the second costshare, “after deductible” should be located at the end of the benefit string.
    - Example (Inpatient Facility): first 10 day(s) $500 per day then 30% after deductible
- There are potential carrier exceptions, inpatient hospital costshares with a deductible *applied only to the first costshare* should be written with “after deductible” at the end of the first benefit string.
    - Example (Inpatient Facility) first 5 day(s) $250 per day after deductible then $0
- This formatting should be used when a “per admission” limit can be evenly divided by the “per day” price.
    - Example (Inpatient Facility): first 3 day(s) $350 per day then $0

    Sometimes, the costshare applies both per day and per visit. In this case, capture both units.

- Example (Rehabilitation/Habilitation Services): first 3 visit(s) $25 per day then 5% after deductible
    - The logic follows: The deductible and coinsurance kick in after the third visit no matter what, but if all three visits happen on the same day, your hospital bill will be only $25.

If the second costshare is also a costshare that varies by day, capture the second costshare as the first value and add “see carrier doc.”

- Example (Postnatal): “first 1 visit(s) $0 then $95 | limit: see carrier documentation for more information”
- Example (Prenatal and Postnatal): “first 15 visit(s) $0 then $100 | limit: see carrier documentation for more information”

Sometimes there are varying costshares by prescription. Our grammar currently does not allow “first # script(s),” so we have to use different grammar. When the costshare applies per prescription, capture the more expensive costshare, and add “see carrier doc.”

Example (Specialty Drugs): “$100 per script after deductible | limit: see carrier documentation for more information”

This grammar structure should be used when a benefits maximum dollar amount can be cleanly divided by the per visit/day copay. If the maximum is not able to be cleanly divided, an up to limit should be used.

- Example: $75 per visit costshare with an annual maximum of $375 should be captured as “first 5 visit(s)

  $75 then $0”

- **However**, If the MOOP is lower than or equal to a benefit’s maximum dollar amount for a plan, then

  the maximum should be ignored.

    - Example (Inpatient Facility): “$1,000 per day”

HMO Plans with OON Coverage

When building SBCs sometimes HMO plans may have Out-of-Network coverage. In these cases we will capture the OON value and assume the deductible applies to the INN Deductibles.
Example: HMO Plan with OON Coverage
When to have OON Medical and Drug Deductible + MOOPs:

- In cases where there is a specific Medical Deductible and MOOP we can capture those for OON (Example): OON Medical Deductible: IND: $10,000 Fam: $20,000, etc.
- If there is not a specific OON value for the Deductibles and MOOPs we can capture as Not Covered (Example): OON Medical Deductible: IND: Not Covered Fam: Not Covered, etc.
- This field has not been populated since **2016** and is expected to remain blank in the ETL.