Health Insurance Oversight System

Rate & Benefits Information System

User Manual

Version 06.00.00

May 2019

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RBIS User Manual Change History

May 2019 Revisions

The following sections in this document have been updated to support Release 16.00.00:

The sections below contain updated text information:

- Section 8 - Changed page title from “View Uploaded Files” to “Uploaded Files History”
- Section 8.2 - Updated all references to “View Uploaded Files” to display new page title “Uploaded Files History”
- Section 9.1.2.1 – updated text from “Primary subscriber” to “Person primarily seeking coverage” and “Secondary subscriber” to “Primary’s spouse or life partner seeking coverage”

The sections below contain updated screenshots:

- Section 2.4.1 – Updated Figure 1 of RBIS Submissions Tab on Landing Page
- Sections 4 – 6
    - Updated Figure 5 of RBIS Home Page
    - Updated Figure 6 of Submission Summary Page
    - Updated Figure 7 of Submission Summary Page Selection Examples
    - Updated Figure 8 of Submission Summary Page Search Results Table
    - Updated Figure 9 of Instructions and Reference Materials
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    - Updated Figure 17 of Data Upload Tab
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    - Updated Figure 33 of Attestation Available
    - Updated Figure 34 of Attestation Unavailable
    - Updated Figure 35 of Attestation Complete
    - Updated Figure 36 of Email Opt-Out Checkbox

August 2018 Revisions

The following sections in this document have been updated to support Release 15.00.00:

The following sections contain updated text information:

- Section 2.1 - Removed “Simple Choice Plan Add In – xlsm” from list of Minimum Requirements
- Section 2.2 - Changed all references from Exchange Operations Service Desk (XOSC) with Marketplace Service Desk (MSD)
- Section 3.2 - Added important information regarding the new RBIS Annual submission process
- Section 3.4 - Added text regarding Attestation process enhancements (Attestors will only need to attest once, throughout the entire submission year)
- Section 3.5 - Added text stating that reattestations are no longer necessary for data resubmission
- Section 6.2 - Added verbiage regarding IFP and SMG templates
- Section 7 - Added information regarding template version
- Section 8.3.1 - Added text explaining template validation to check for correct template version used
- Section 9.1.2.1 and 9.1.2.2 - Combined sections into 9.1.2.1 to display Search Criteria requried Fields - Individual and Small Group Markets
- Section 11.1 and 11.2 – Updated information regarding Resubmission requriements and Resubmssion Validation and Attestation requirements

The following sections contain updated screenshots:

- Section 4 - Updated Figure 5 screenshot of RBIS Home Page
- Section 6.2 - Updated Figure 10 screenshot of consolidated Submission Materials tab for IFP and SMG Markets
- Section 7.1 - Updated Figure 11 screenshot with 2019 Plan Benefits template
- Section 7.1 - Updated Figure 12 screenshot to display invalid data message on 2019 Plan Benefits template
- Section 7.2 - Updated Figure 14 screenshot with 2019 Service Area template
- Section 7.3 - Updated Figure 15 screenshot with 2019 Rates Template
- Section 7.4 - Updated Figure 16 screenshot with 2019 Business Rules Template
- Section 9.1.2.4 - Updated Figure 31 screenshot to show “required fields” populated with data
- Section 11.3 - Updated Figure 36 screenshot to show updated RBIS Home Page with email "Opt Out" option
- Section 12.3.4 - Updated Figure 37 screenshot to show Example Scenario 1 - Individual Rate Results on 2019 Rates template v.8.1
- Section 12.3.4 - Updated Figure 39 screenshot to show Example Scenario 2 - Individual Rate Results on on 2019 Rates template v.8.1
- Section 12.3.4 - Updated Figure 41 to show Example Scenario 3 - Individual and Group Rate Results on the 2019 Rates Template v8.1

August 2017 Revisions

The following sections in this document have been updated to support Release 14.00.00:

Multiple Sections:

- Updated screenshots throughout the document to capture the 2018 template changes.

July 2016 Revisions

The following sections in this document have been updated to support the Release 13.00 enhancements:

Multiple Sections:

- Updated screenshots throughout the document to reflect the addition of the Submission Summary tab and to capture the 2017 template changes.

Section 5: Submission Summary

- 5 Added new section to explain the Submission Summary page functionality.

April 2016 Revisions

The following sections in this document have been updated to support the Release 12.04 enhancements:

Section 8: Validate Data

- 8 Updated view all plan and search by scenario screenshots including Do Not Display functionality.
- 8.1.1.3 Added Yes, Do not Display definition
- 8.1.2.4 Added Yes, Do not Display definition

August 2015 Revisions

The following sections in this document have been updated to support the Release 12.0 enhancements:

Section 6: Templates

- 6 Updated template screenshots with 2016 templates

Section 11: Appendices

- 11.2 Added new email error messages for all templates

September 2014 Revisions

The following sections in this document have been updated to support the Release 11.0 enhancements:

Section 6: Templates

- 6 Updated template screenshots with 2015 templates

Section 11: Appendices

- 11.2 Added new email error messages for all templates

May 2014 Revisions

Significant updates have been made to support the Release 10.0 enhancements. Changes reflect the use of 2014 FFM Templates to collect new Plan Benefits, Rates, Service Area, and Business Rules data. The following is a list of changes made to this document:

Section 2: Getting Started

- 2.1.1 Updated references to submission materials available in RBIS.
- 2.1.3.3 Created a new section with screenshots to walk users through enabling Add-In support for the Plans and Benefits template.

Section 3: Process Overview

- 3.2 Minor changes to update references from .csv files to .xml.

Section 6: Templates

- 6 Added a list of the template names.
- 6.1 Updated this section to describe the Plan Benefits Template.
- 6.1.1 Created a new section for the Plans Benefits Template Add-In.
- 6.1.2 Created a new section for the AV calculator.
- 6.2 Updated this section to describe the Service Area Template.
- 6.3 Updated this section to describe the Rates Template.
- 6.4 Updated this section to describe the Business Rules Template.
- 6.5 Updated the description of the template validation and finalization process.

Section 7: Data Upload

- 7.3.1 Updated the list of template validations performed.
- 7.3.2 Updated the list of template cross-check validations performed.

Section 8: Validate Data

- 8.1.2.1 Updated description of search criteria and included a new screenshot of Search by Scenario for Small Group market.
- 8.1.2.2 Updated description of search criteria and included a new screenshot of Search by Scenario for Individual market.

Section 11: Appendices

- 11.2 Updated tables containing lists of email error messages for the Plan Benefits, Service Area, Business Rules, and Rates templates.
- 11.2.5 Updated the table with the list of cross check error messages.
- 11.3 Changed references from .csv to .xml and updated maximum file size to 50 MB.
- 11.4 Updated data dictionary definitions for fields in the Plan Benefits, Service Area, Rates, and Business Rules templates.
- 11.5.2 Updated the age rules listed based on the current template.
- 11.5.3 Updated tables of subscriber types and subscriber types/scenarios for both Individual and Group based rates. Included a new section on relationship types included in the Business Rules template.
- 11.5.4 Updated rate calculation scenarios based on the new templates.
- 11.6 Data elements listed have been updated to reflect the values stored in the database.

February 2014 Revisions

The following updates have been made to Section10 to explain the changes to the Attestation page:

- Section 10.1 – Updated Attestation agreement text.

1 Introduction

The Center for Consumer Information and Insurance Oversight (CCIIO), a division of the Department of Health and Human Services (HHS), is charged with helping implement many provisions of the Affordable Care Act. CCIIO oversees the implementation of the provisions related to private health insurance including providing oversight for the Issuer-based data exchanges that populate http://www.finder.healthcare.gov.

To facilitate this charge, the Health Insurance Oversight System (HIOS) allows the government to collect data from individual and small group market Issuers. The collected data is aggregated with other data sources and made public on a consumer-facing website. The Rate and Benefits Information System (RBIS) web site gathers detailed plan benefit and eligibility data. This user manual explains the features and other aspects related to the use of the RBIS module.

1.1 Instructional Layout

The term 'user' is used throughout this document to refer to a person who has acquired access to complete activities within the RBIS module. Each action that is required by the user is indicated via step-by-step bullets. If an action requires the user to select a specific button or link on the screen, the name of the item to look for will be in ***bold italics***. For example:

1. Select ***OK*.**

2 Getting Started

2.1 Minimum Requirements

Supported Applications

The templates and associated submission materials are provided in the following formats:

- Plans and Benefits Add-In – .xlam
- Plan Benefits Template – .xlsm (macro enabled xls worksheet)
- AV Calculator – .xlsm
- Service Area Template – .xls
- Rates Template – .xls
- Business Rules Template – .xls

The templates referenced above are the QHP templates also used for submission of plan and benefits information to the Federally Facilitated Marketplace (FFM). The templates may be downloaded through RBIS or directly from the QHP website under the Application Materials tab found at the address below: https://www.qhpcertification.cms.gov/s/Application%20Materials

The RBIS module supports Firefox versions 4.0 and above or Microsoft Internet Explorer versions 9.0 and above.

2.1.1 Macro Security Level Setting

The RBIS Templates use macros to perform the built-in functions including the Validation and Finalization processes. It is imperative that Excel's macro security level settings are set to allow macros. The following are the Excel macro security level settings:

- **Excel 2010 or later**: Macros should be set to "**Disable all macros with notification**." Instructions will be provided in *Section 2.1.2.1 : Set-up Considerations*.

2.1.2 Set-up Configurations

Configuration on the computer must be set to satisfy the following requirements for the data templates to work properly:

- Use Microsoft Excel version 2010 or later
- Enable the Excel standard toolbar

2.1.2.1 Excel Version 2010 or later

Set the Excel macro security settings as follows:

1. For Excel 2010/ latest version, set Excel macro security settings to "Disable all macros with notifications."
    a. Select the ***File*** button in the upper left corner of the window.
    b. Select the ***Options*** button at the bottom of the menu.
    c. Select ***Trust Center*** on the left navigation pane.
    d. Select ***Trust Center Settings***.
    e. Select ***Macro Settings*** on the left navigation pane.
    f. Select the radio button in front of ***Disable all macros with notification*s**.
    g. Select ***OK***.
    h. When the workbook is opened, select the ***Options*** button and select ***Enable Content*** and select ***OK***.

2.2 Marketplace Service Desk

If you need assistance with registering as a user, submitting data, reviewing and validating data, or other technical website functions, please contact the Marketplace Service Desk (MSD).

- Phone Number: 1-855-267-1515
- Email Address: CMS_FEPS@cms.hhs.gov

The MSD hours of operation are 9:00 AM to 6:00PM ET, Monday through Friday.

2.3 User Registration

Issuers must first be a registered user in HIOS in order to gain access into RBIS. A user can be registered in HIOS by being added as a contact for an Issuer. If you have questions, please refer to the HIOS user guide or call the MSD. Any access requests outside of the normal HIOS process must be submitted for CCIIO approval via the MSD at 1-855-267-1515 or via email at CCIIOPlanFinder@cms.hhs.gov.

2.4 Accessing the System

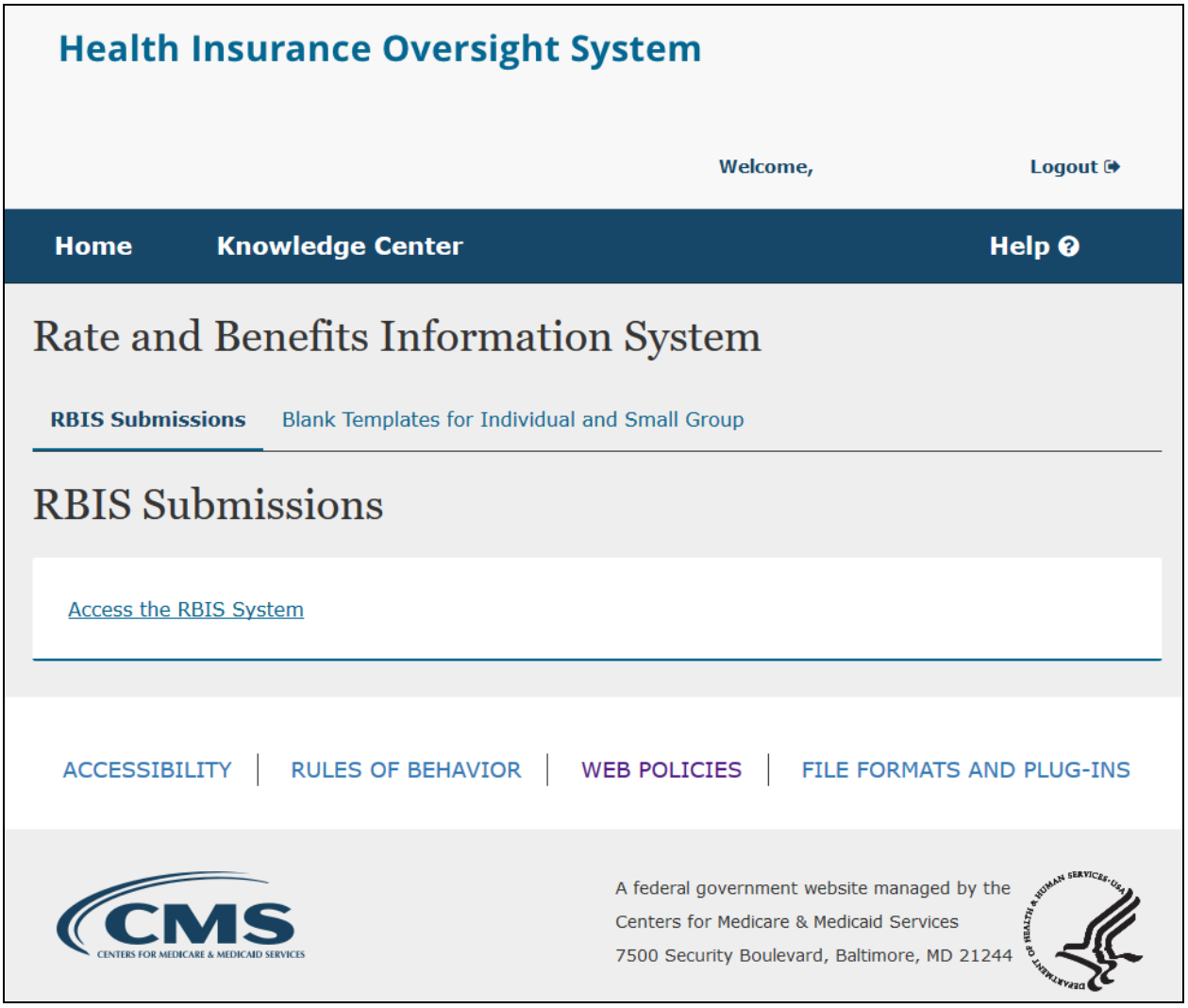
2.4.1 Log-In

Users who are registering with HIOS for the first time will receive a user name (their listed contact email address) and a randomly generated password. This information should be used to access the system. Users will be required to customize their password after the first login.

1. Login to the CMS Enterprise Portal. Select ***HIOS*** from the list of available applications in the upper left portion of the window. Next, select ***Access HIOS***.
2. On the HIOS Main Page, Select ***Rate & Benefits Information Systems (RBIS)***.
3. Select the ***Access the RBIS System*** link on the RBIS Submissions tab. See Figure 1 below.

4. You will be navigated to the RBIS Home Page.

Figure 1: Access the RBIS System Link on the RBIS Submissions Tab



3 Process Overview

The RBIS System is designed to automate the Data Submission, Validation, and Attestation processes. All tasks must be completed within the submission window for data to be displayed on the Finder.Healthcare.gov website.

At a very high level, the overall RBIS process can be summarized as follows:

1. An RBIS Submission window is opened for the collection of plan-related data
2. Users with the RBIS Submitter role prepare and submit templates to RBIS with plan-related data for their issuer(s), or indicate there is no data to submit. If the RBIS system finds data errors, the Submitter must correct and resubmit the plan data.
3. Once all data errors are resolved the data must be both issuer validated and attested:
    a. RBIS Validator users will review data for their issuer(s) and indicate whether the data is accurate and appropriate to publish
    b. RBIS Attestor users, a CEO or CFO, will provide their general approval of the data for the issuer(s) for whom they are associated
4. Once plan-related has completed steps 2 and 3 above, RBIS will publish the data, making available to consumers via the Finder.Healthcare.gov website.

3.1 Role Overview

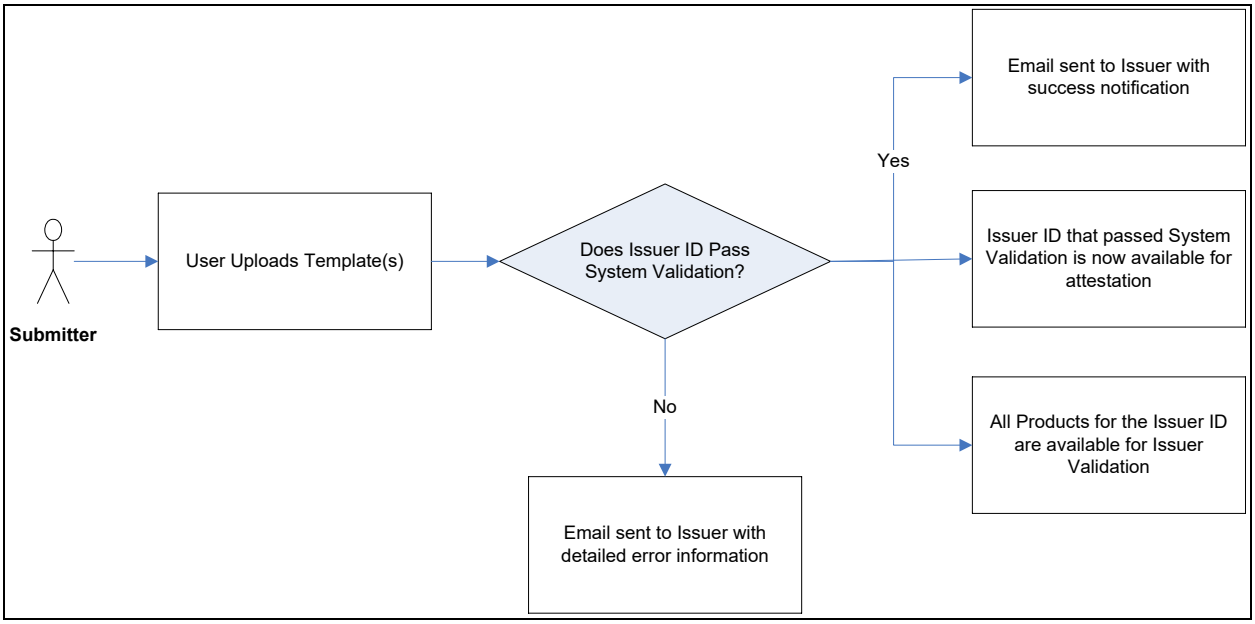
There are three different User roles that can be assigned in RBIS:

- **Submitter Role:** This user is both responsible for, and is allowed to submit data for, any Issuer for which they have submitter permissions. They will be notified via email of any errors during the submission process.
- **Validator Role:** This user is responsible for validating that the data submitted is correct. They are allowed to validate plans for any Issuer for which they have a Validator role.
- **Attester Role:** This user is responsible for attesting to data submitted by all Issuers for which they have permission. The Attester role is limited to the Issuer's Chief Executive Officer (CEO) or Chief Financial Officer (CFO).

3.2 Submitter Process

The Submission Process in RBIS is represented in Figure 2 below.

Figure 2: RBIS Submitter Role Flowchart



The Submission process starts with downloading the blank templates from the CMS website. Refer to the QHP Certification website at https://www.qhpcertification.cms.gov/s/Application%20Materials under the "Application Materials" heading . The templates used for data submission MUST be the proper versions for the current data collection year. The templates need to be downloaded and saved to the local machine. When the templates have all the required data populated, the data entered will need to be validated by selecting the ***Validate*** Button. When the template passes Validation, the ***Finalize*** Button will need to be selected to save a finalized .xml file that can be uploaded to RBIS. It is necessary for all four templates to be submitted as part of the first submission for a new plan year. It is further recommended that all four templates be submitted if there are additional submissions made during the year.

The Submission Contact's role in RBIS begins with the creation and upload of template(s) into the system. Once uploaded, the template(s) will go through a series of System Validations. The first stage of validations consists of checks to ensure file-level correctness. These first include checking the file size and file format. These validations occur automatically upon template upload. Next, data validations are performed to verify the template version is the most current and that values supplied within are valid. If a template passes these validations, it will progress to the second stage of validations.

The second stage of System Validations cross-checks the template(s) to ensure all the necessary data has been submitted for each Issuer ID. For example, the cross checks will verify all submitted plan IDs have corresponding rate information and vice versa. These validations run on a pre-set schedule daily and only occur if templates have successfully passed the first stage of validations.

If the templates fail either of these validations stages, the Submission Contact will receive an email notifying them that the template(s) failed System Validation. The Submitter will then be required to correct the errors listed in the email and resubmit the templates in RBIS. Alternatively, the Submitter will receive an email if the template(s) pass both stages of System Validation. Note that if a template

fails validation at either stage, all data within that template fails. Thus, a template must pass both validation stages for any of the data within to be recorded in RBIS.

Emails will be sent to the Submitter for the following reasons:

- The template(s) fail template validation(s) in stage 1.
- The template(s) fail cross-check validations in stage 2.
- The template(s) pass both stages of validations.

If there are any issues with data, Submitters must resubmit their template(s). Resubmissions will overwrite previous submissions, but will not remove any data that has gone through the publish process (AKA Interim Refresh), which will occur every two weeks. If there are any questions regarding a submitted Plan Benefit, Service Area, Rate or Business Rule template, please contact the MSD..

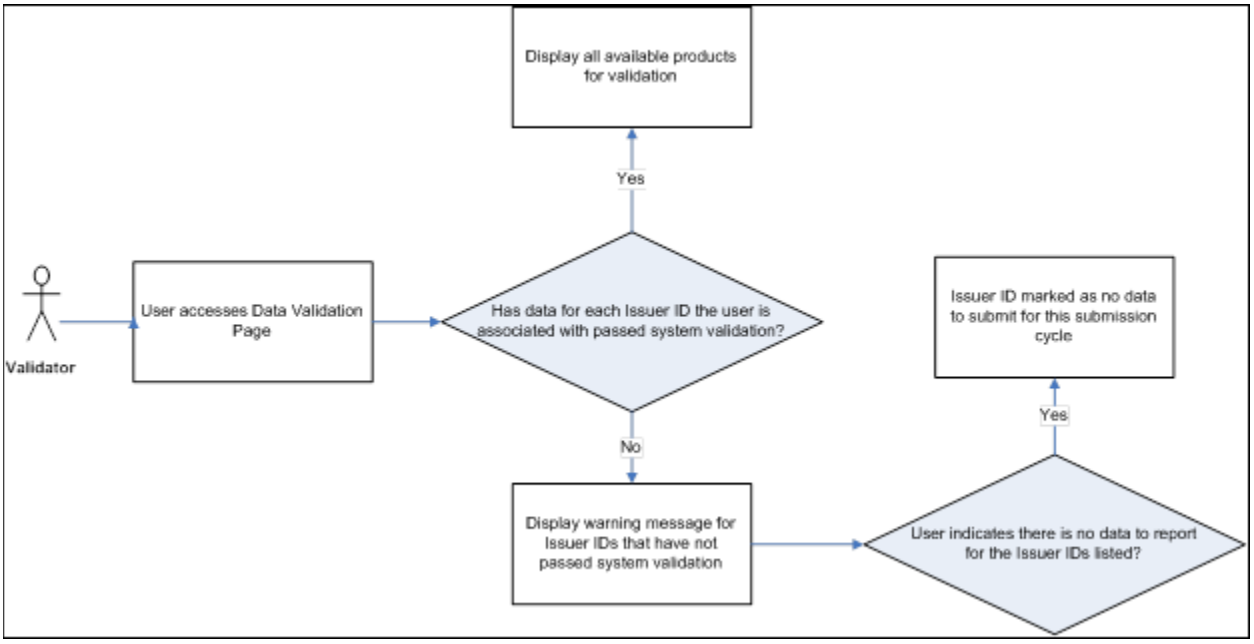
RBIS typcially controls the submission of template data through the use of four submission periods, or windows during a plan year. Each window is normally ten weeks in duration followed by a three week maintenance period where RBIS is closed for submissions. Therefore over the duration of an entire Plan Year data collection cycle, there will be 40 weeks for submissions and 12 weeks when the system is closed for maintenance purposes.

With RBIS operating on an Annual Submission schedule beginning with the 2019 Plan Year data collection, a single submission of plan data can be performed once during the plan year and will be active and valid for the entire year, assuming the Issuer Validation and Attestation steps are completed as detailed below. If updates are required, additional submissions can be performed, however any data that is resubmitted must be revalidated by a Validator user.

3.3 Validator Process

The Issuer Validation Process in RBIS is represented below in Figure 3.

Figure 3: RBIS Validator Role Flowchart



The Validation Contact's role in RBIS begins when Issuer Validation becomes available for the Issuer ID(s) associated with their User ID. In order for Validation to become available, data for the Issuer ID(s) that the Validator user is associated with must pass both stages of System Validation. Once data has passed System Validation, the data available for each Issuer ID will be displayed on the Validate Data screen and the Validator will receive an e-mail. Users will see data for all Issuer IDs for which they have permissions and can submit their Validation decisions for each Issuer's Plans.

If there is no data to be uploaded for the listed Issuer ID(s), the Validator may indicate this on the Validate Data tab. Once Issuer ID(s) have been marked as "no data to report," a new warning message is displayed stating that the user has indicated that there is no data to report for the listed Issuer IDs. Note that this choice is not binding; a Submitter can always provide a submission of data to RBIS later during the Plan Year if it is necessary.

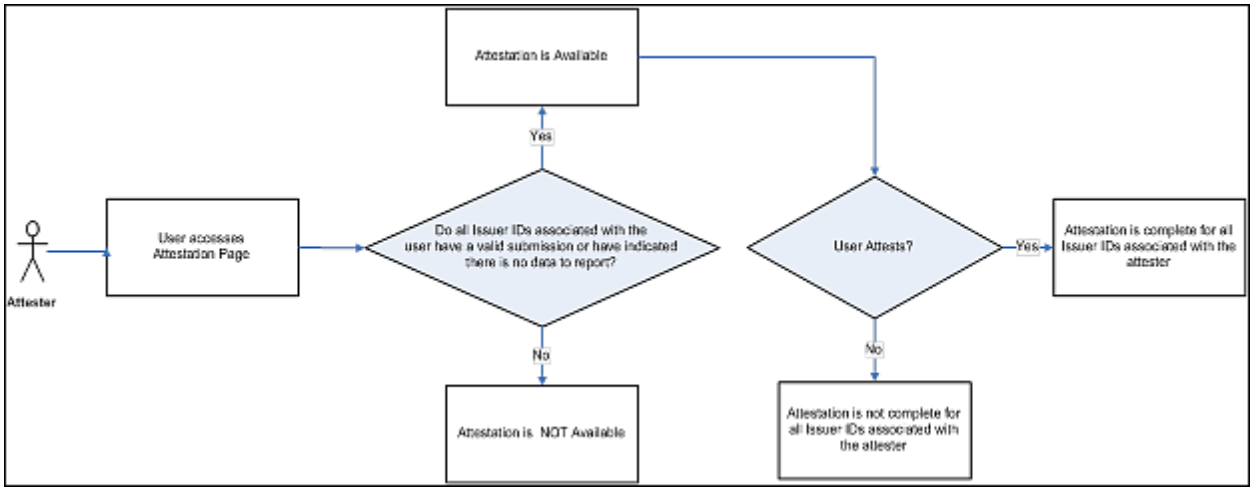
Plan data shown for an Issuer ID must be both validated and attested (refer to the following section) to appear on the Finder.Healthcare.gov website.

If there are any issues with data, Submitters can resubmit their templates. Each submission for an Issuer ID will completely overwrite the previous submission. If data is resubmitted, it must be revalidated by a Validator user.

3.4 Attester Process

The Attestation Process in RBIS is represented below in Figure 4.

Figure 4: RBIS Attester Role Flowchart



The Attestation Contact's role in RBIS begins when Attestation becomes available for all Issuer ID(s) for which the user is associated. Attestation will not be available until all Issuer IDs associated with the user have a valid submission or it is indicated that there is no data to report. Once Attestation is available, the Attester must read the Attestation agreement and provide an electronic signature confirming that they attest to the accuracy of the submitted data. The electronic signature entered must match the first name and last name on the Attestor Contact's HIOS account.

Users should use caution when completing Attestation, as it can only be completed one time per submission window. With RBIS operating under an Annual Submission schedule beginning with 2019 Plan Year data collection, this means an attestation performed once during the plan year will be active and valid for the entire year.

3.5 Resubmission Process

The resubmission process is similar to the submission process. After an Issuer has re-submitted data to RBIS, the templates will go through both template validations as well as overall cross-check validation. The resubmission process allows the Issuer to change or update any data currently in the RBIS system. The Issuer may also add new data or correct any previously failed data during this time. Any data that is resubmitted must be revalidated by a Validator user, but reattestation is not necessary.

Please refer to *Section 11* for further instructions on the Resubmission process.

3.6 Finder.Healthcare.gov Refresh

During an open submission window, there will be updates to the data displayed on the Finder.Healthcare.gov website. Both consumers seeking coverage and issuers are able to provide

specific search criteria on the Finder.Healthcare.gov website and review the results based upon data submitted to RBIS during the submission window. There are bi-weekly Interim Refreshes and a single Final Refresh performed during each submission window. The behavior of the refreshes is detailed below.

3.6.1 Interim Refresh

This is a scheduled process which occurs every two weeks during an open submission window. It publishes valid plan data so that it can be queried and viewed via the Finder.Healthcare.gov website.

- No plans currently on Finder.Healthcare.gov will be removed, instead this process only adds new plans or updates existing information
- Issuer and product data for plans that meet the following criteria will be visible on Finder.Healthcare.gov:
    - Issuer Validated
    - Attested
    - Open in HIOS
    - Not Suppressed in HIOS
    - Not CCIIO suppressed
    - Not Expired

3.6.2 Final Refresh

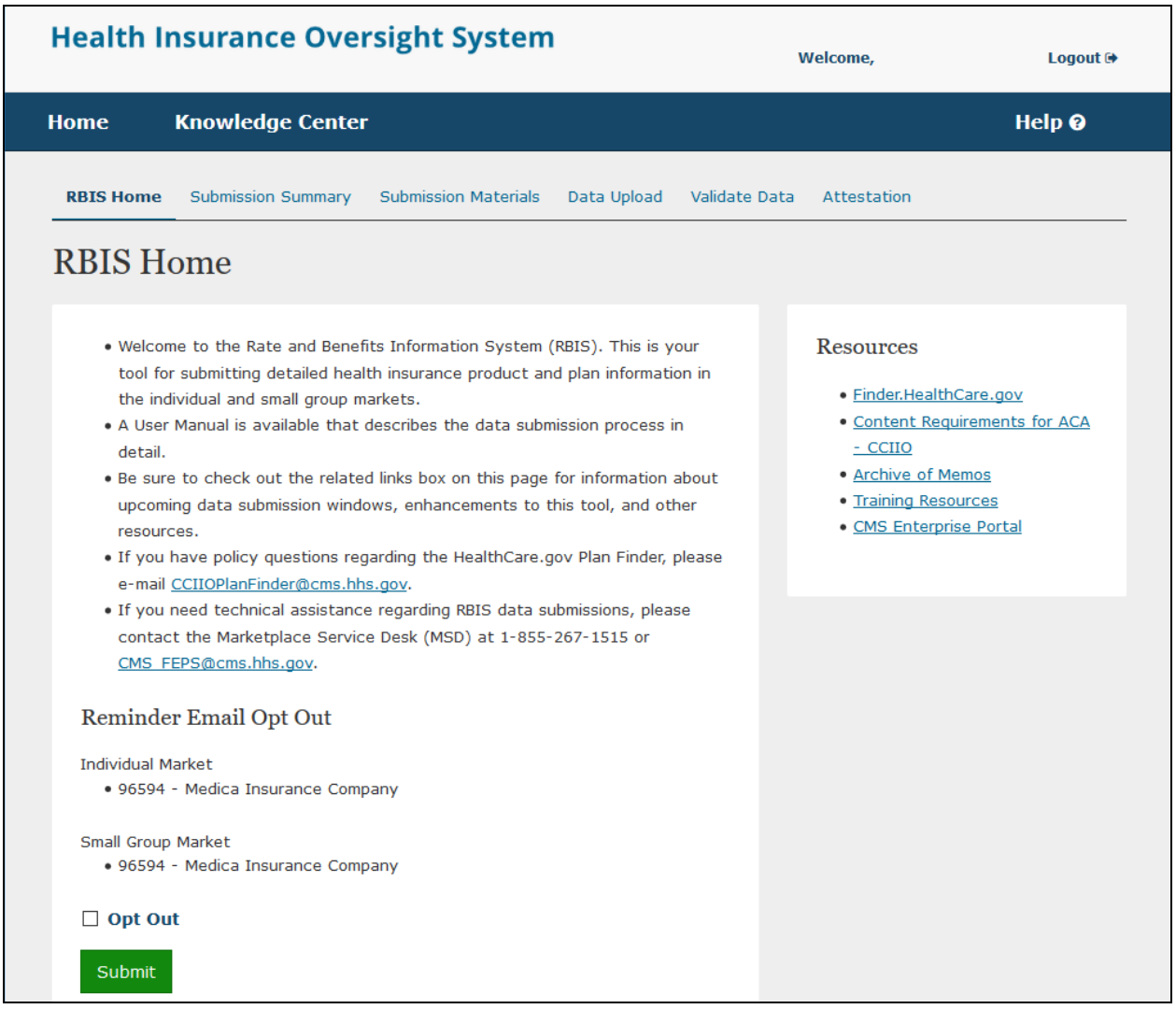
This is a scheduled process which occurs only once at the closure of each submission window. Plan data that is no longer valid (per the criteria below) is removed from display on the Finder.Healthcare.gov website.

- Issuer and product data for plans that do not meet the following criteria will be *removed* from Finder.Healthcare.gov:
    - Issuer Validated
    - Attested
    - Open in HIOS
    - Not Suppressed in HIOS
    - Not CCIIO suppressed
    - Not Expired

4 RBIS Home Page

Users will be navigated to the RBIS Home Page welcome screen when accessing RBIS via the link on the HIOS Portal webpage. The RBIS Home Page is displayed below in Figure 5.

Figure 5: RBIS Home Page



4.1 RBIS Announcements

The Home page of the RBIS website displays an Announcements section. This section includes helpful information, such as news, status updates, notable dates/events, and more. Additionally, it displays an informational list of all Issuer IDs and market types for which a user is associated.

4.2 RBIS Related Links

The Home page of the RBIS module contains a Related Links section. This section includes links that are useful to the users, such as Finder.Healthcare.gov, the CCIIO website, training materials, and more.

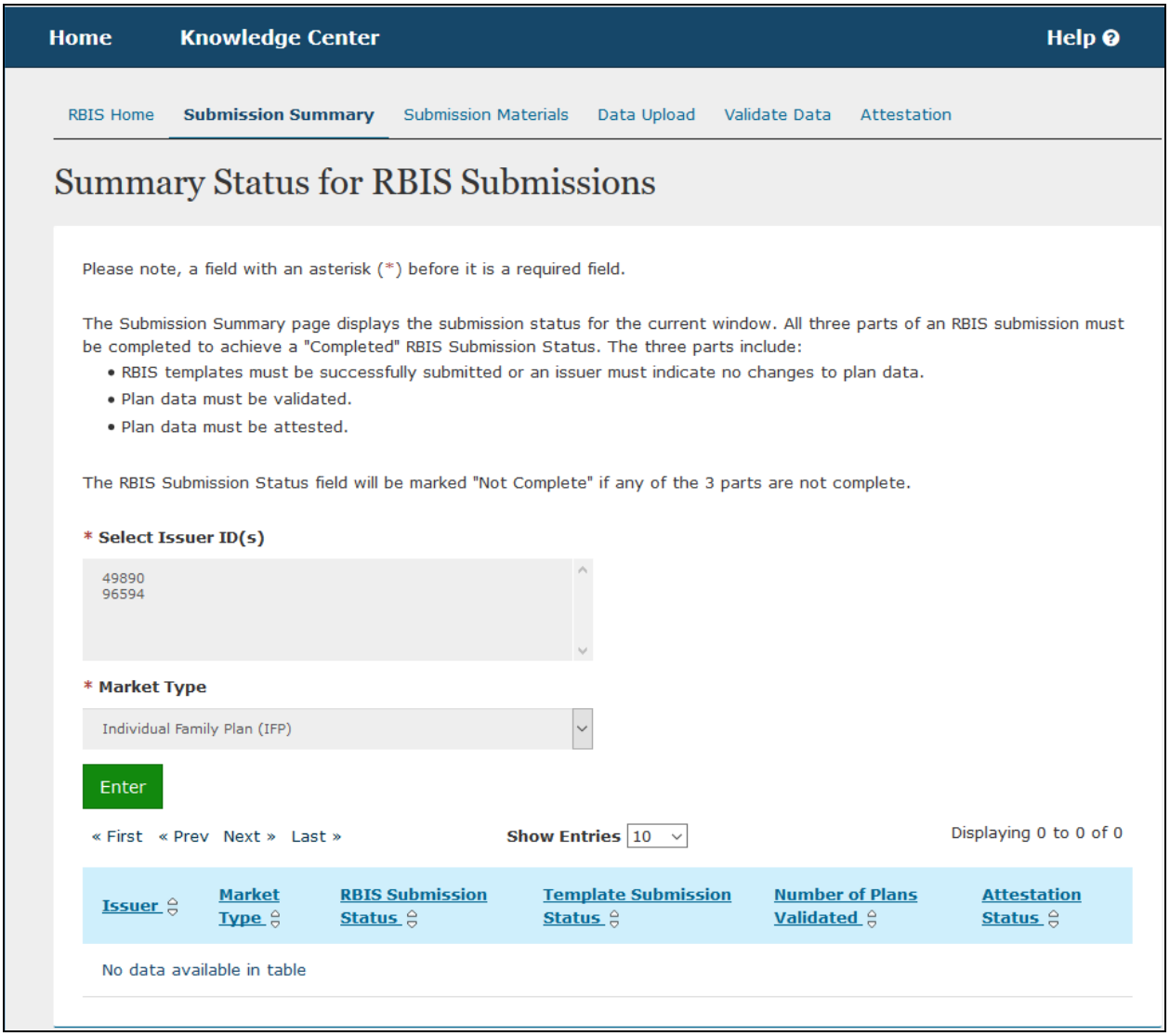
4.3 User Association Table

The Home page of the RBIS module contains a table at the bottom of the page. This provides a convenient opportunity to view and confirm all Issuers and roles for which the user is responsible.

5 Submission Summary

The Submission Summary page provides the submission status for each issuer ID associated with the user. The screen shown below in Figure 6 is displayed when the user selects the ***Submission Summary*** tab. A user with any valid RBIS role will be able to see a list of all the issuer IDs associated to them in Issuer ID dropdown.

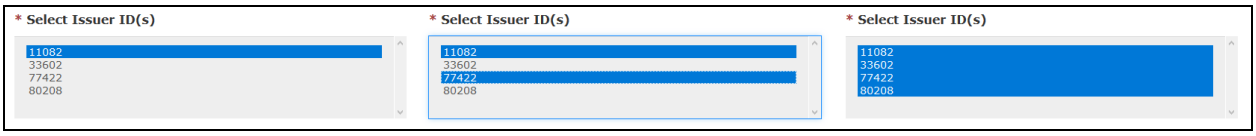
Figure 6: Submission Summary Page



5.1 Submission Summary Search Criteria

The Submission Summary page requires the user to select the Issuer ID(s) and Market Type for which they wish to see details. The user has the option to select one, multiple, or all of the displayed Issuer IDs along with a Market Type. See Figure 7 below for examples.

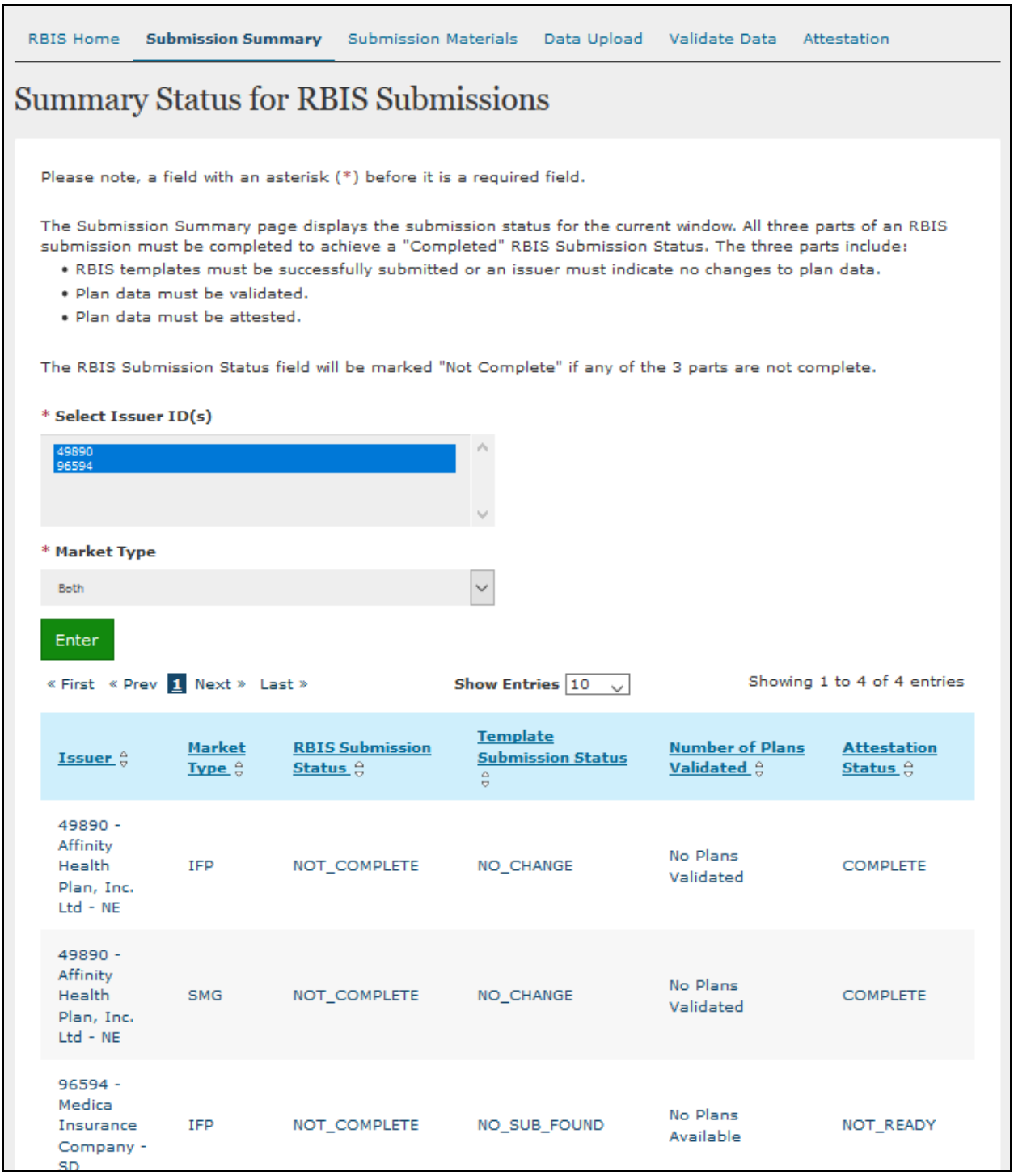
Figure 7: Submission Summary Page Selection Examples



5.2 Submission Summary Search Results

The Submission Summary page search results will display after the user selects the ***Enter*** button after selecting the Issuer ID(s) and Market Type. The search results table will display the following data elements: Issuer (including the Issuer ID, Issuer Name and State Code), Market Type, RBIS Submission Status, Template Submission Status, Number of Plans Validated and Attestation Status. See Figure 8.

Figure 8: Submission Summary Page Search Results Table



5.2.1 Submission Summary Results - Possible Values and their Meanings

Table 1 below displays the possible results for each data element and a brief description of each.

Table 1: Submission Summary Detailed Result Values

Data Element Name	Result Value	Description
RBIS Submission Status	Complete	An overall summary of the issuer's actions for the Plan Year collection cycle: • The issuer has submitted without data errors or indicated no data to submit, manually validated their plan data and the plan data has been attested by the CEO/CFO. • The plan data will appear on the Finder.Healthcare.gov website.
RBIS Submission Status	Not Complete	An overall summary of the issuer's actions for the Plan Year collection cycle: • The issuer has one or more tasks (submit without errors, issuer validate or attest) to perform to enable their plan data to display on the Finder.Healthcare.gov website.
Template Submission Status	Complete	The status of template submission for the Plan Year collection cycle: • A complete set of templates has been submitted to RBIS and has passed system validations.
Template Submission Status	Indicated No Changes to Plans	The status of template submission for the Plan Year collection cycle: • The issuer has indicated they have no new data to submit to RBIS during the window.
Template Submission Status	Failed Template Validation	The status of template submission for the Plan Year collection cycle: • Template submissions were received by RBIS, but System Validation errors were found. These templates must be corrected and resubmitted.
Number of Plans Validated	[Numeric Value]	Provides a status of the plans in RBIS that have been validated or await validation by the issuer for the Plan Year collection cycle: • A count of the plans in RBIS that have been Issuer Validated as either Yes, Display or Yes, Do Not Display.
Number of Plans Validated	No Plans Available	Provides a status of the plans in RBIS that have been validated or await validation by the issuer for the Plan Year collection cycle: • No plans were found in RBIS that have passed System Validation and are awaiting issuer validation.
Number of Plans Validated	No Plans Validated	Provides a status of the plans in RBIS that have been validated or await validation by the issuer for the Plan Year collection cycle: • System validated plans exist in RBIS and are awaiting validation by the issuer.
Attestation Status	Complete	Provides a status of the plans in RBIS that have been attested or await attestation by the CEO/CFO for the Plan Year collection cycle: • Attestation of the RBIS plan data by the CEO/CFO has been completed.

Data Element Name	Result Value	Description
Attestation Status	Ready	Provides a status of the plans in RBIS that have been attested or await attestation by the CEO/CFO for the Plan Year collection cycle • Plans were found in RBIS that have passed System Validation and are awaiting attestation by the CEO/CFO attester.
Attestation Status	Not Ready	Provides a status of the plans in RBIS that have been attested or await attestation by the CEO/CFO for the Plan Year collection cycle • No plans were found in RBIS that have passed System Validation and are awaiting attestation.

6 Submission Materials

The Submission Materials tab has download links to the following items:

- Instructions and reference materials
- Templates for submitting plan data

6.1 Instructions and Reference Materials

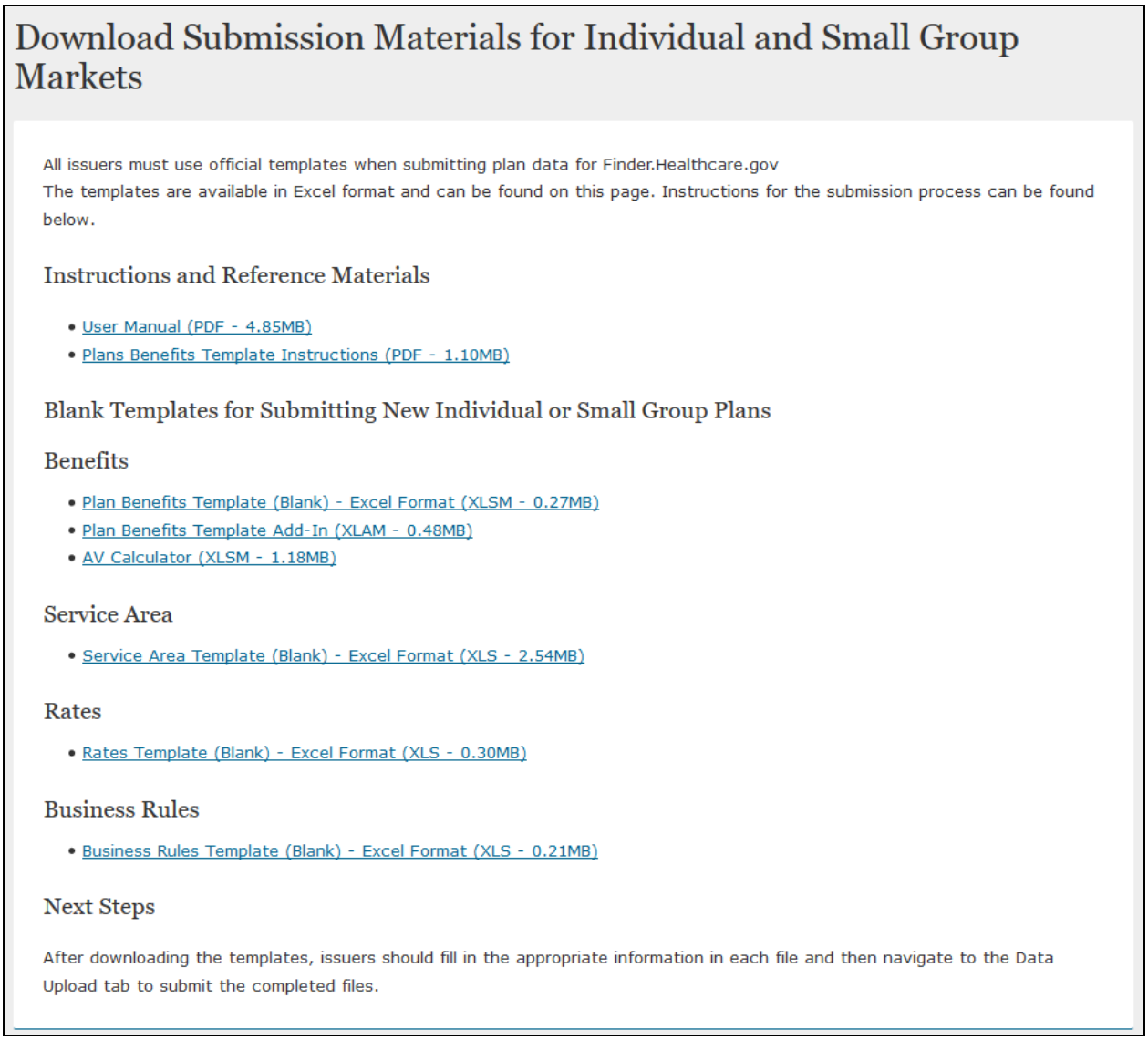
The links below in Figure 9 allow users to view and access the latest version of the User Manual and Plans and Benefits Template instructions.

Figure 9: Instructions and Reference Materials

6.2 Download Submission Materials

The user can access and download blank templates and add-ins under the Submission Materials tab. Simply select which template to download from the list by selecting the template hyperlinks. The Submission Materials Links are displayed below in Figure 10. Note that the Excel templates for both the Small Group and Individual market submission are the same. As a result there is a single webpage from which to download the template files for both market types.

Figure 10: Download Data Submission Materials



Download Submission Materials for Individual and Small Group Markets

All issuers must use official templates when submitting plan data for Finder.Healthcare.gov
The templates are available in Excel format and can be found on this page. Instructions for the submission process can be found below.

Instructions and Reference Materials

- User Manual (PDF - 4.85MB)
- Plans Benefits Template Instructions (PDF - 1.10MB)

Blank Templates for Submitting New Individual or Small Group Plans

Benefits

- Plan Benefits Template (Blank) - Excel Format (XLSM - 0.27MB)
- Plan Benefits Template Add-In (XLAM - 0.48MB)
- AV Calculator (XLSM - 1.18MB)

Service Area

- Service Area Template (Blank) - Excel Format (XLS - 2.54MB)

Rates

- Rates Template (Blank) - Excel Format (XLS - 0.30MB)

Business Rules

- Business Rules Template (Blank) - Excel Format (XLS - 0.21MB)

Next Steps

After downloading the templates, issuers should fill in the appropriate information in each file and then navigate to the Data Upload tab to submit the completed files.

7 Templates

All Issuers must use the official QHP templates when submitting plan data to RBIS, and must use the template versions that are active for the Plan Year data being submitted. Both Individual and Small Group markets utilize the same set of excel templates. There are four templates available for download that must be completed in order to submit new or updated plan data into RBIS. If an issuer is reporting plan data in both markets, RBIS requires that all four templates be submitted for each market type, even if the values within do not necessarily vary based upon market (e.g., Service Area data). The four templates used by RBIS are shown below:

- Plans and Benefits Template (along with the Add-In file that supports this template)
- Service Area Template
- Rates Template
- Business Rules Template

The current versions of each of the templates and add-in above can be downloaded either from the Submission Materials tab in the previous section or from the QHP website (at https://www.qhpcertification.cms.gov/s/Application%20Materials). Note that the QHP website also provides additional instructions to aid in completing the templates.

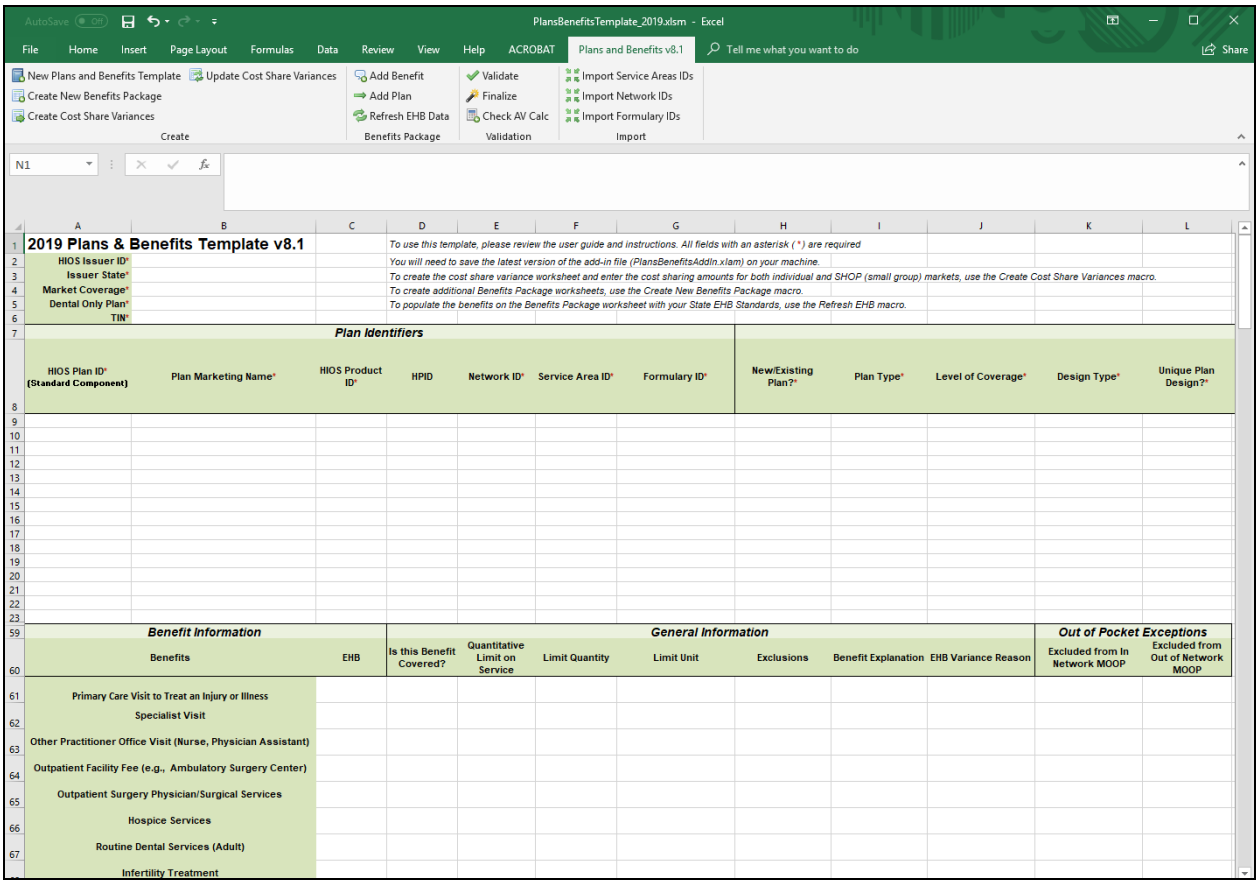
The specifics of each template are detailed in the following sections.

7.1 Plans and Benefits Template

The Plans and Benefits Template provides the capability for users to submit plan benefits and cost share data to RBIS. The template includes instructions on how users should utilize the Plans and Benefits Add-In to complete the template.

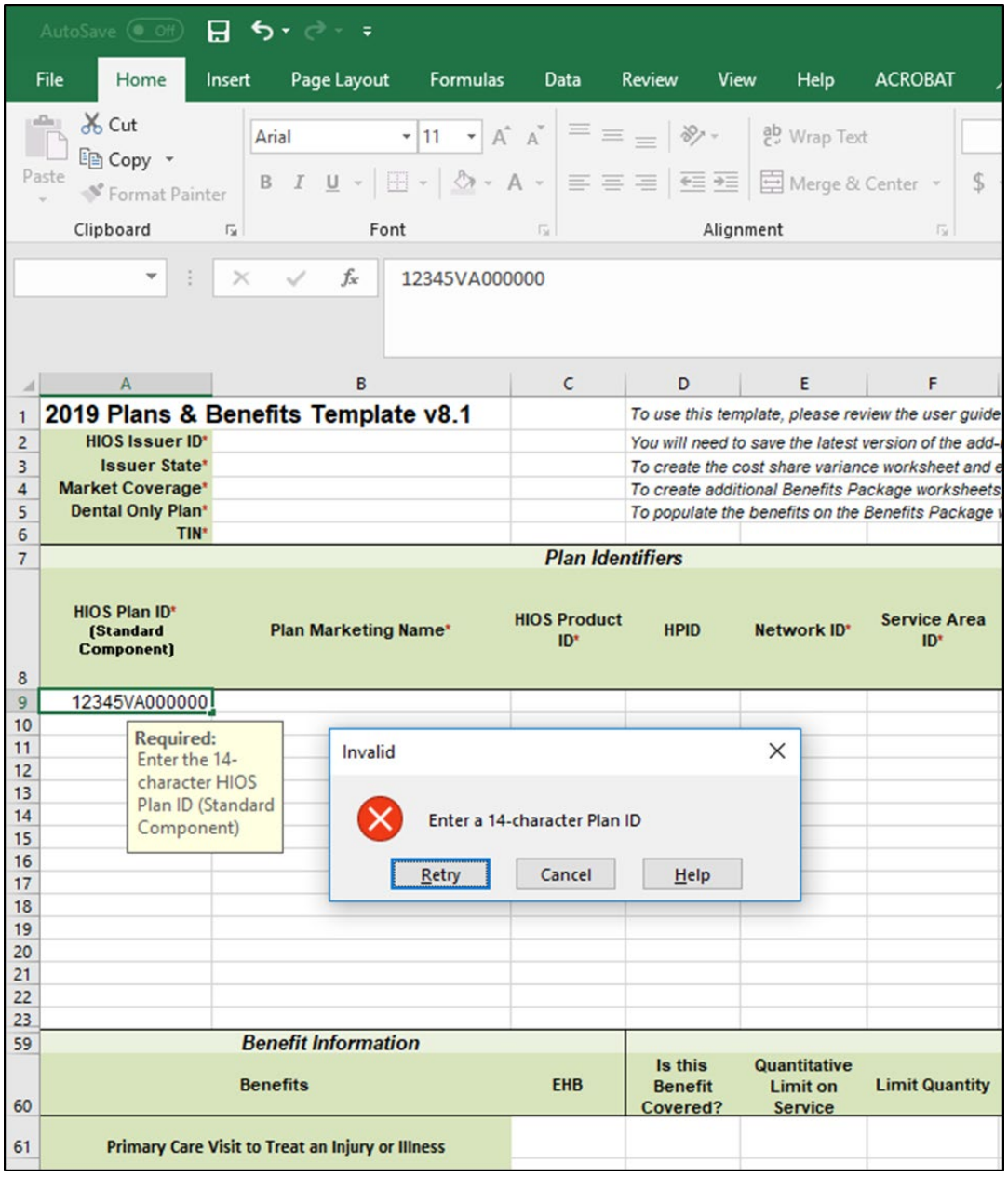
The Plans Benefits template is displayed below in Figure 11.

Figure 11: Plans and Benefits Template for Individual and Small Group Plans



If the user enters an invalid character or value, the template will produce an error similar to that displayed in Figure 12. Selecting “Retry” will redirect the user back to the cell with the invalid entry and allow the user to re-enter the correct value. Selecting “Cancel” will redirect the user back to the cell with the invalid entry and clear the data. Selecting “Help” will open the Microsoft Office Excel Help screen.

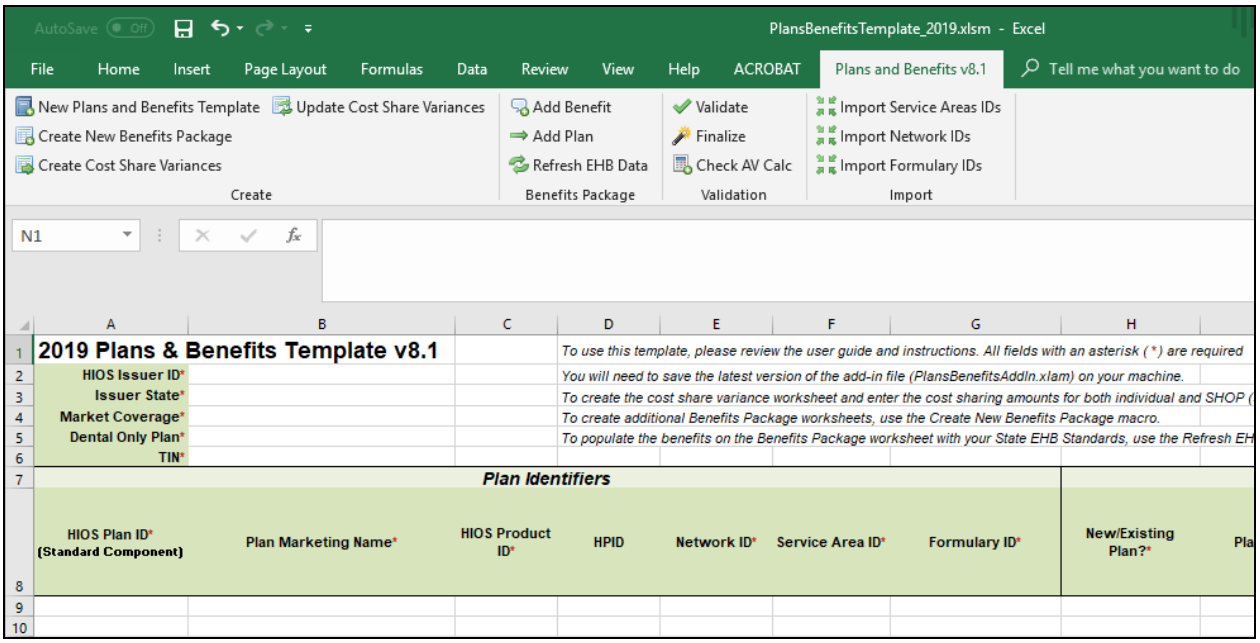
Figure 12: Invalid Data – Format is Invalid



7.1.1 Plans and Benefits Template Add-In

In addition to the Plans and Benefits Template, a link is available on the Submission Materials tab to download the Plans and Benefits Template Add-In, which provides additional functionality for the template. Using this Add-In, a user is able to validate and finalize data in the template in preparation for uploading the file to RBIS. Additional functions that are available via the Plans and Benefits Add-In are shown below in Figure 13.

Figure 13: Plans and Benefits Add-In Module Available Functions



For further instructions on how to download the Add-In module, please refer to Section 6.2. Instructions for enabling the Add-In module are found in Section 2.1.2.1.

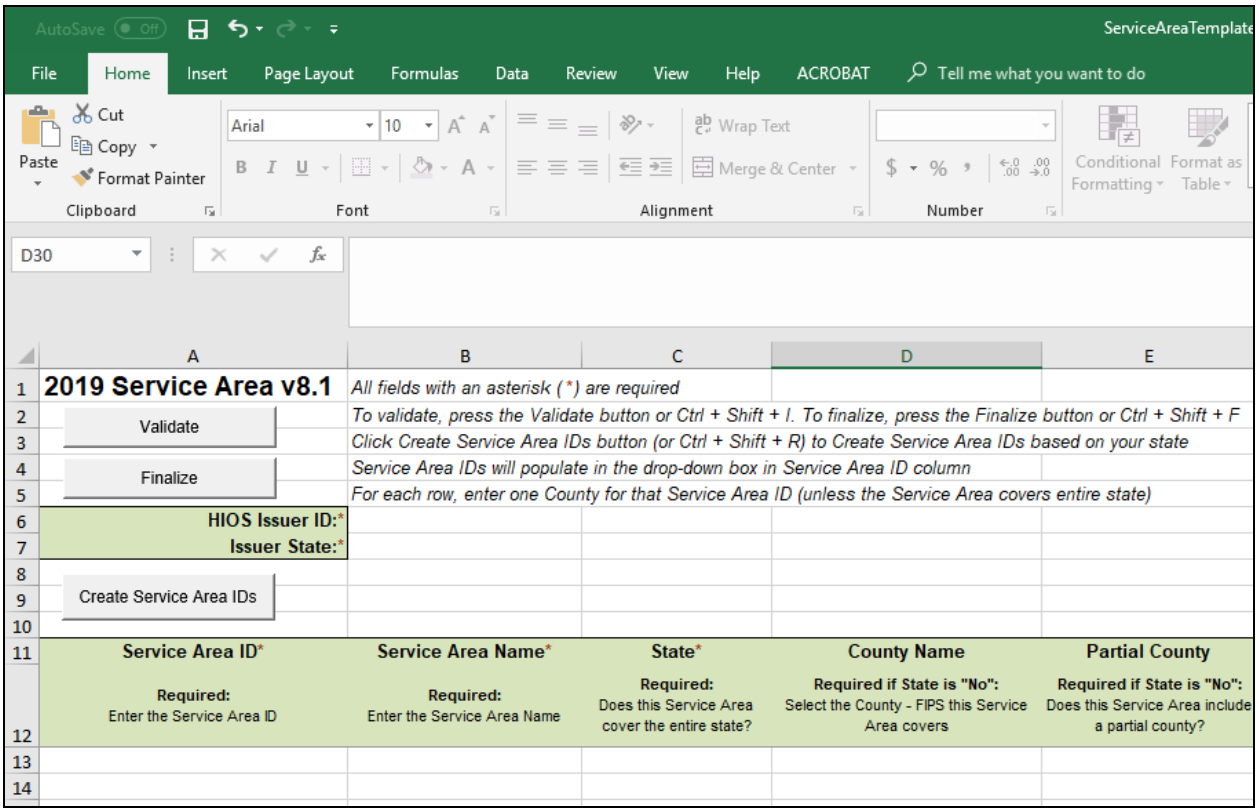
7.1.2 AV Calculator

A link is available on the Submission Materials tab to download an Actuarial Value (AV) Calculator which can be used in conjunction with the Plans and Benefits Template to determine an estimate of network liability for a given plan based upon commercial data. For further instructions on how to download the AV Calculator, please refer to Section 6.2.

7.2 Service Area Template

The Service Area Template provides the capability for users to submit data that defines the Service Areas in which the Issuers operate. The Service Area Template requires that the Service Area ID, Service Area Name, and State fields be completed for each Service Area. Users can define a Service Area using FIPS codes and county names if the Service Area does not comprise the entire state. Federal Information Processing Standards (FIPS) County codes are a five digit Federal standard for identifying United States Counties. Figure 14 below depicts the Service Area Template.

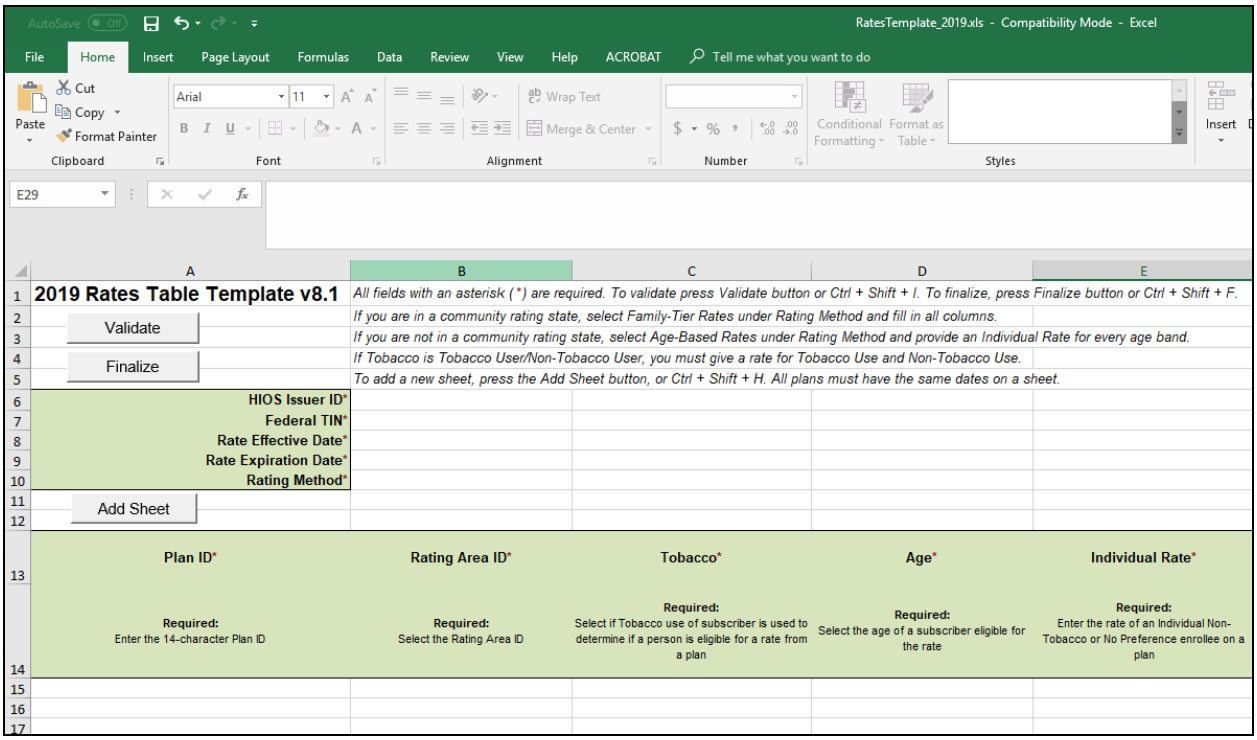
Figure 14: Service Area Template for Individual and Small Group Plans



7.3 Rates Template

The Rates Template provides the ability to enter plan-specific rate values for combinations of Rating Areas, effective dates, tobacco usage, and age. These rates are used to calculate the estimated total monthly premium for plans. The template includes instructions on how users should fill out the fields. The Rates Template is displayed below in Figure 15.

Figure 15: Rates Template for Individual and Small Group Plans

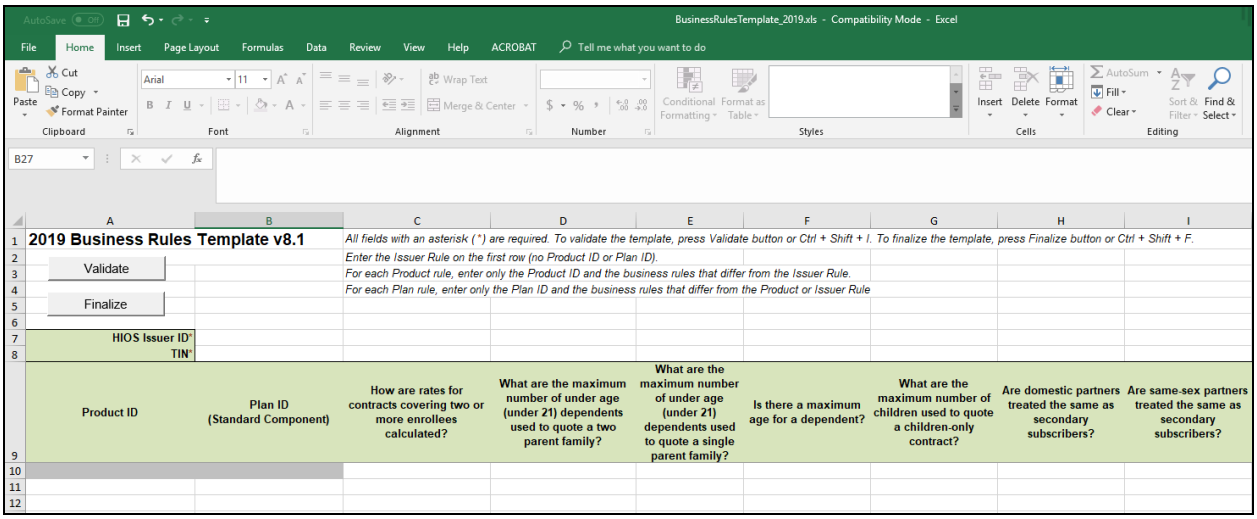


There may be a significant number of rate combinations for an Issuer's plans and therefore many rows required in the template. As such, the template has the ability to create additional sheets to include more rates. Select the ***Add Sheet*** button to create an additional sheet in the workbook.

7.4 Business Rules Template

The Business Rules template provides a collection of parameters that control how RBIS determines factors such as plan eligibility and the computation of estimated monthly premium totals when it provides results to the Finder.Healthcare.gov website. The Business Rules Template is displayed below in Figure 16.

Figure 16: Business Rules Template for Individual and Small Group Plans



7.5 Template Validation & Finalization Processes

Each template contains two buttons: ***Validate*** and ***Finalize.*** Note that for the Plans and Benefits template, these buttons are available via the Plans and Benefits Add-In.

Selecting the ***Validate*** button runs a Validation check against the data entered within the templates. When Validation has successfully completed, selecting the ***Finalize*** button will generate an .xml file suitable for the user to upload into the RBIS system. The .xml files generated by the templates will replace some of the data on the spreadsheet with corresponding codes to make the upload process more efficient.

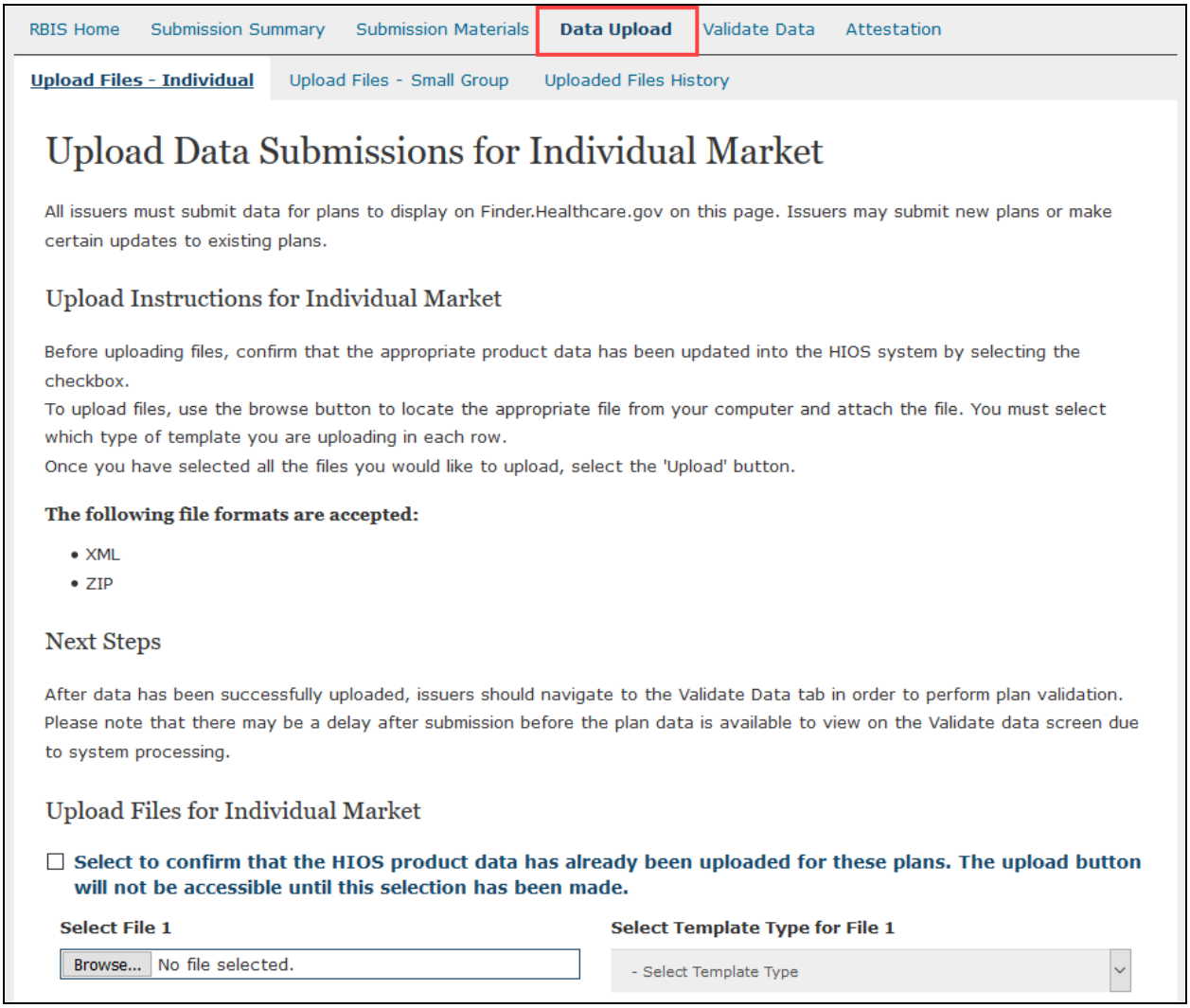
8 Data Upload

The Data Upload tab allows a Submitter user to upload the finalized .xml version of their template files(s) into RBIS. Through this tab the user will select the appropriate market type for which they are uploading and then specify the filenames and template types they wish to upload.

The Data Upload tab is broken up into three subsections:

- Upload Files – Individual
- Upload Files – Small Group
- Uploaded Files History

Figure 17: Data Upload Tab



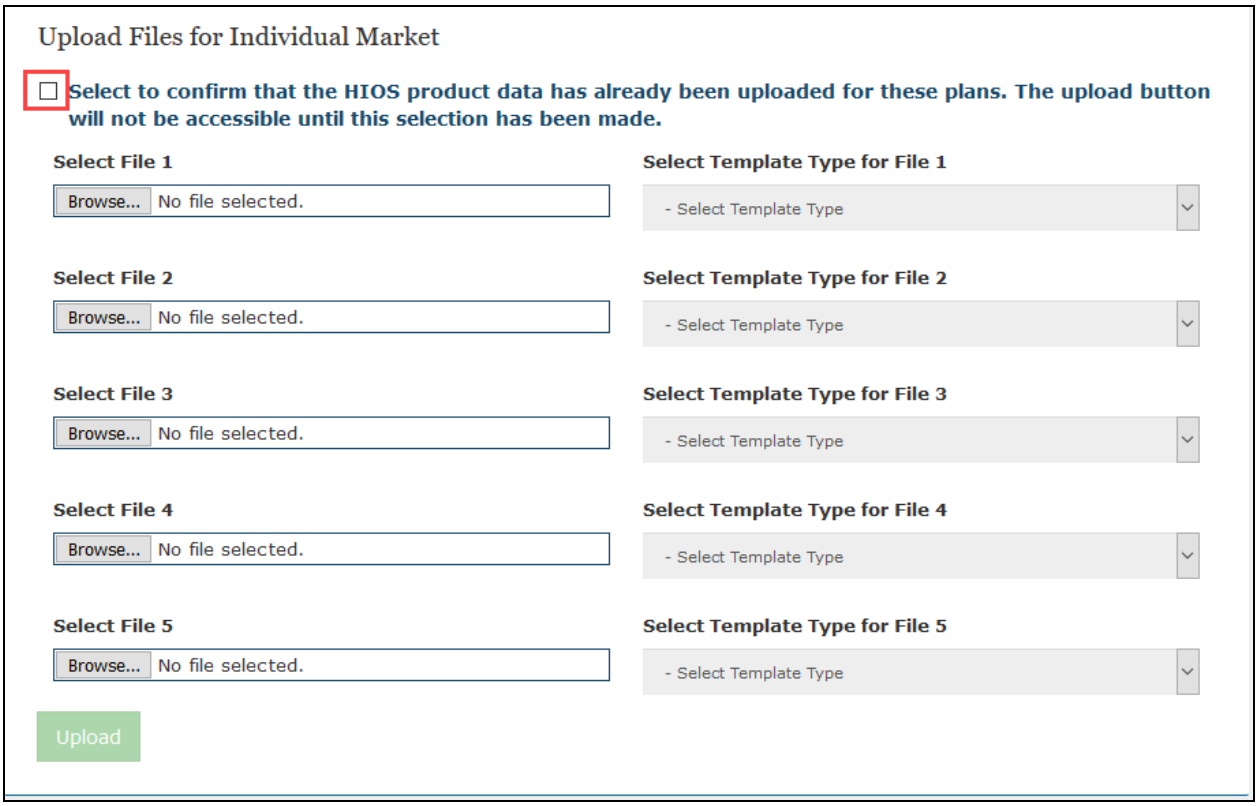
8.1 Data Upload – Small Group and Individual Market

Submitter users can upload submission materials for the Small Group and Individual Markets via their respective Upload Files page links under the Data Upload tab. All Issuers must submit data for plans to display on the Finder.Healthcare.gov website. Please refer to Figure 17 above.

8.1.1 Upload Files

Before uploading files, users must first confirm that the appropriate Product data has been uploaded into the HIOS system by selecting the checkbox displayed below in Figure 18.

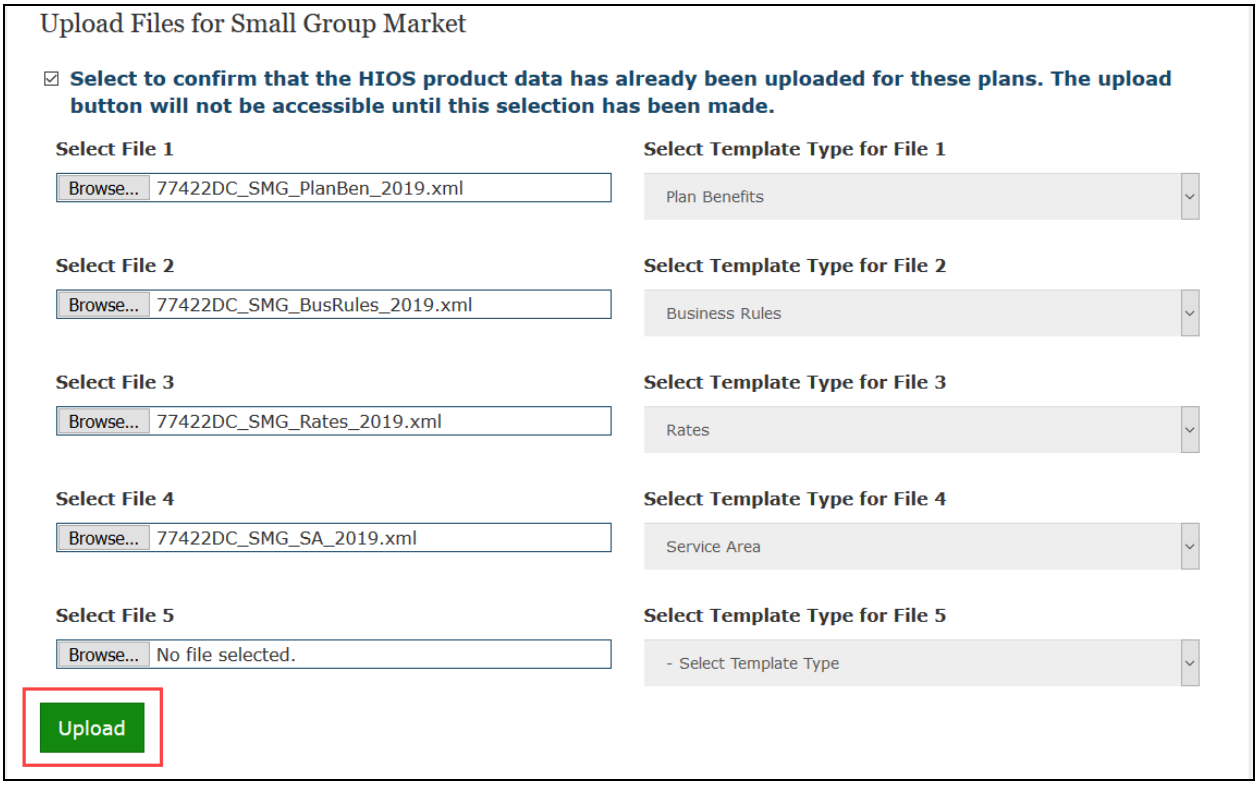
Figure 18: HIOS Product Data Upload Confirmation – Individual Market Example



To upload files, the Submitter user will need to select the ***Browse*** button to locate and attach the appropriate .xml or .zip file saved to the computer. Please refer to Figure 19 for an example. After selecting the file to upload, the correct template type must be selected for the corresponding template that is being uploaded. Users should remember to select only completed, finalized files (.xml format) for submission. All files must be 50 MB or smaller.

Submitter users may upload a .zip file as one of the filename selections shown above. However, this zip file must contain templates of the same type (e.g., all Plans and Benefits, or all Rates) and that type must match the value in the Template Type field shown below in Figure 19.

Figure 19: Files Selected to Upload – Small Group Market Example

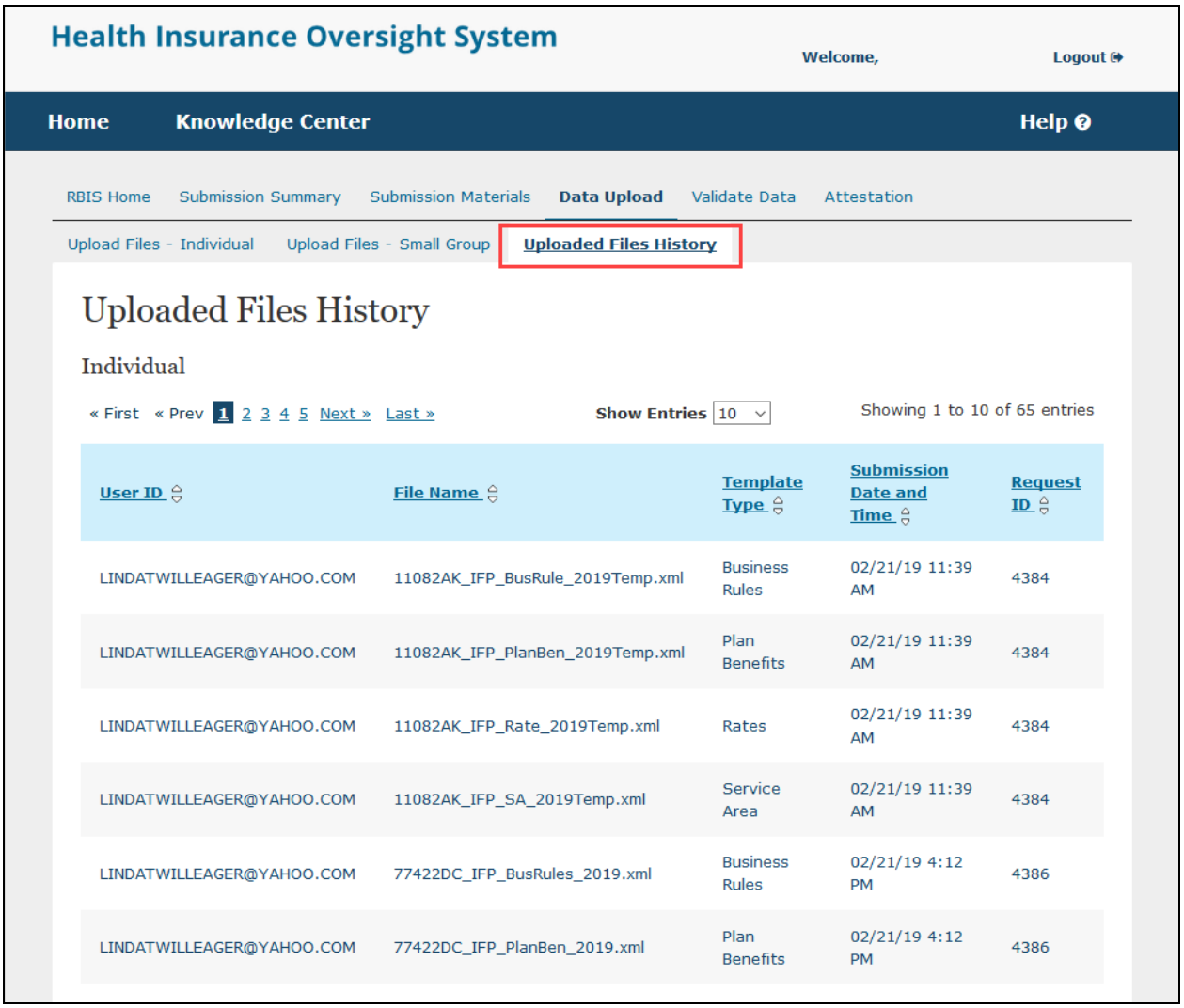


Once all of the files to be uploaded have been selected, the user may select the Template Type from the dropdown and select ***Upload*** to begin the file upload process.

8.2 Uploaded Files History for Small Group and Individual Markets

Once files have been successfully uploaded, the user may view their upload file history for both Small Group and Individual markets on the Uploaded Files History page. All files that have been uploaded during the current submission window will be displayed on this page. Please refer to Figure 20.

Figure 20: Uploaded Files History



Details displayed in the Uploaded Files History table include:

- User ID of the submitting user
- File Name
- Template Type
- Submission Date and Time
- Request ID

8.3 Submission Complete

After an Issuer has uploaded their data, the templates will go through both template validation as well as an overall cross-check validation. Template-specific system validations will be performed, and must

pass before the cross-check validations are run. These are referred to as stages 1 and 2 of the System Validtion process.

8.3.1 Template Validations – Stage 1

Before any plans for an Issuer ID are available for cross-check validation, all plans for that Issuer ID must pass template validation. The template validations will ensure data within each individual template file is appropriate and correct. The template validations include, but are not limited to the following:

- Validating the Issuer ID exists in HIOS
- Validating the correct template version number was submitted
- Validating the data entered in each field matches the appropriate data type
- Validating that the template matches the template type
- Validating the User ID submitting the file is associated with all Issuer IDs for which they are submitting data
- Validating each Product ID listed exists in HIOS
- Validating each Plan ID listed exists in HIOS
- Validating all required fields are complete for each Template
- Validating all FIPS Codes are valid and exist within the Issuer ID's associated state

As soon as the template validation has been completed, the Submitter user will receive notification via email with the results of template validation for each Issuer ID associated with the uploaded template(s). The e-mail will include the following information:

- List of error codes and descriptions (if applicable) for first 1000 errors
- List of files submitted
- Issuer ID
- Issuer Name
- Market Type
- Outcome of System Validations
- Template type of each file
- Time of submission

In the event that one or more plans fail template validations, the Submitter user will receive an email with the total number of errors, but will not receive more than 1000 errors due to size constraints. The Submitter user must correct the errors listed in the e-mail and re-upload the templates to RBIS. If all plans submtted for an Issuer ID pass template validations (Stage 1), they must then pass cross-check validations (Stage 2) before they are eligible for Issuer Validation in RBIS.

8.3.2 Cross-Check Validations – Stage 2

After plan data in the templates has successfully completed template validations, it must also pass cross-check validations. The cross-check validations include, but are not limited to:

- Validating that all Individual and Small Group Plans cited in the Rates Template have benefits information in the Plans and Benefits Template
- Validating that all Individual and Small Group Plans cited in the Plans and Benefits Template have Rate information in the Rates Template
- Validating that Service Areas cited in the Plans and Benefits Template have Service Area information in the Service Areas Template
- Validating that Business Rule information from the Business Rules Template exists for the Issuer ID(s)

Cross-check validations are run daily on a pre-set schedule. Once cross-check validations have been completed, Submitter users will receive an email for each Issuer ID associated with the uploaded template(s). The email will include the following information:

- List of error codes and descriptions (if applicable) for first 1000 errors)
- List of files submitted
- Issuer ID
- Issuer Name
- Market type
- Outcome of System Validations
- Template type of each file

In the event that one or more plans for an Issuer ID fail cross-check validations, the Submitter user will receive an email with the total number of errors, but will not receive more than 1000 errors due to size constraints. The plans for the Issuer ID will not be re-checked until another template submission for the Issuer ID is uploaded. Submitter users must correct the errors listed in the email, resubmit the templates and pass both validation stages before submitted plan data for the Issuer is eligible for Issuer Validation. (Correcting errors might only require uploading a template that had not been uploaded at the time of the Cross-check Validation.) If all plans pass cross-check validations, the Submitter user will receive an email indicating the cross-check validations have completed successfully.

9 Validate Data

Validator users will access the Validate Data tab to review the submitted data that has passed both stages of system validation. The Validator user will review the data and then indicate whether they believe the data shown in RBIS is accurate and suitable for publishing to the Finder.Healthcare.gov website.

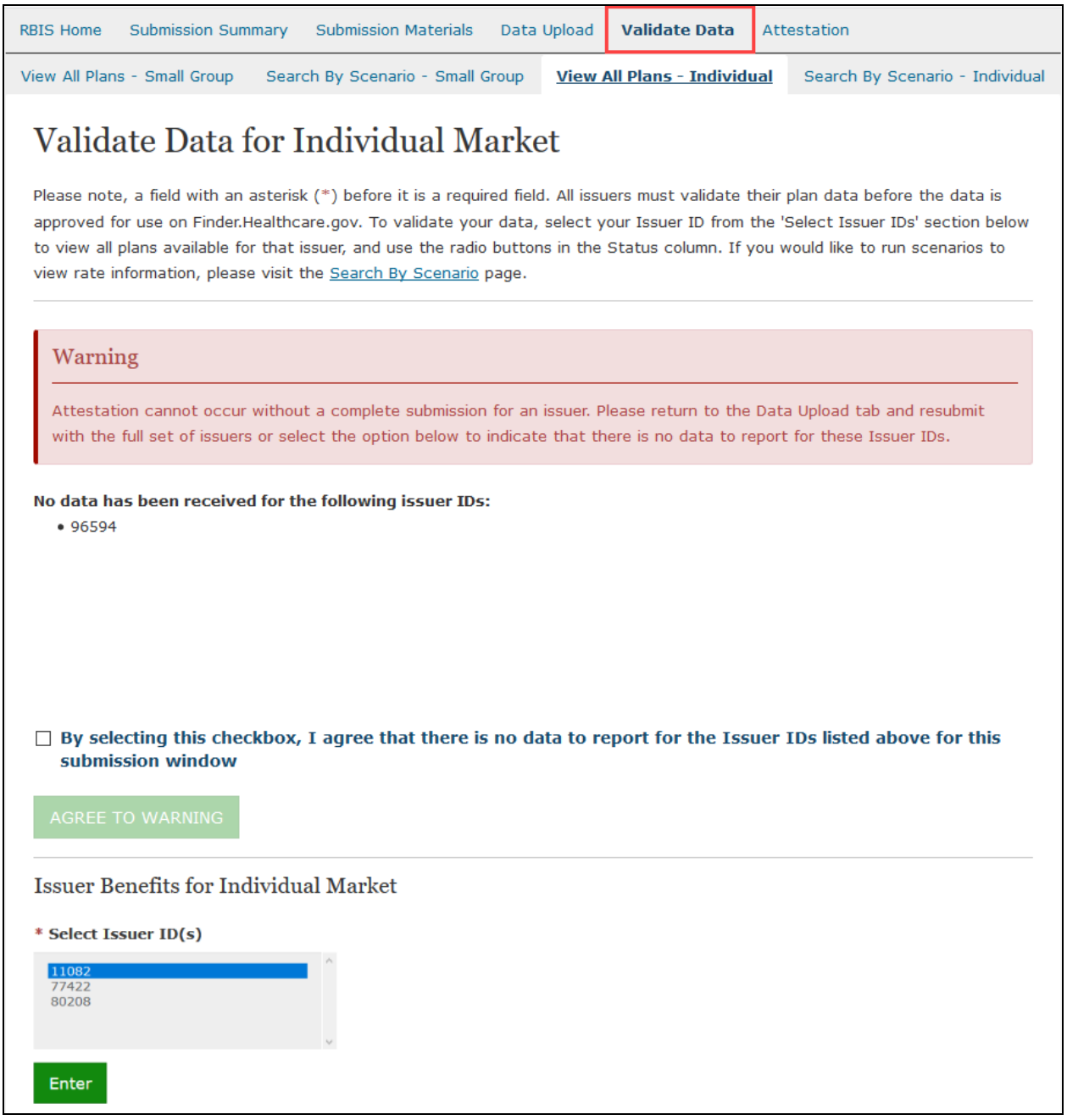
There are two display options for the data within each market type, with each option displayed on its own tab. On the “View All” pages, RBIS displays all the plan data for a specified Issuer ID. On the “Search by Scenario” pages, a Validator user provides a specific coverage scenario to verify the results returned match what is expected. The Search by Scenario pages closely resemble how the plan data will be accessed by consumers on the Finder.Healthcare.gov website.

The Validate Data tab is broken up into four subsections. Based upon the Validator user’s role and the market(s) in which their Issuer(s) offer coverage, they will see tabs for the Small Group and/or Individual market type as shown below.

- View All Plans - Small Group
- Search by Scenario - Small Group
- View All Plans - Individual
- Search by Scenario - Individual

The layout of the Validate Data tab is shown in Figure 21 below.

Figure 21: Validate Data tab – Individual Market Example



All Issuers must complete issuer validation for their plans before the data is eligible for display on the Finder.Healthcare.gov website.

9.1 Validate Data

Issuers with a Validator role can validate data from two different views: View All Plans and Search by Scenario.

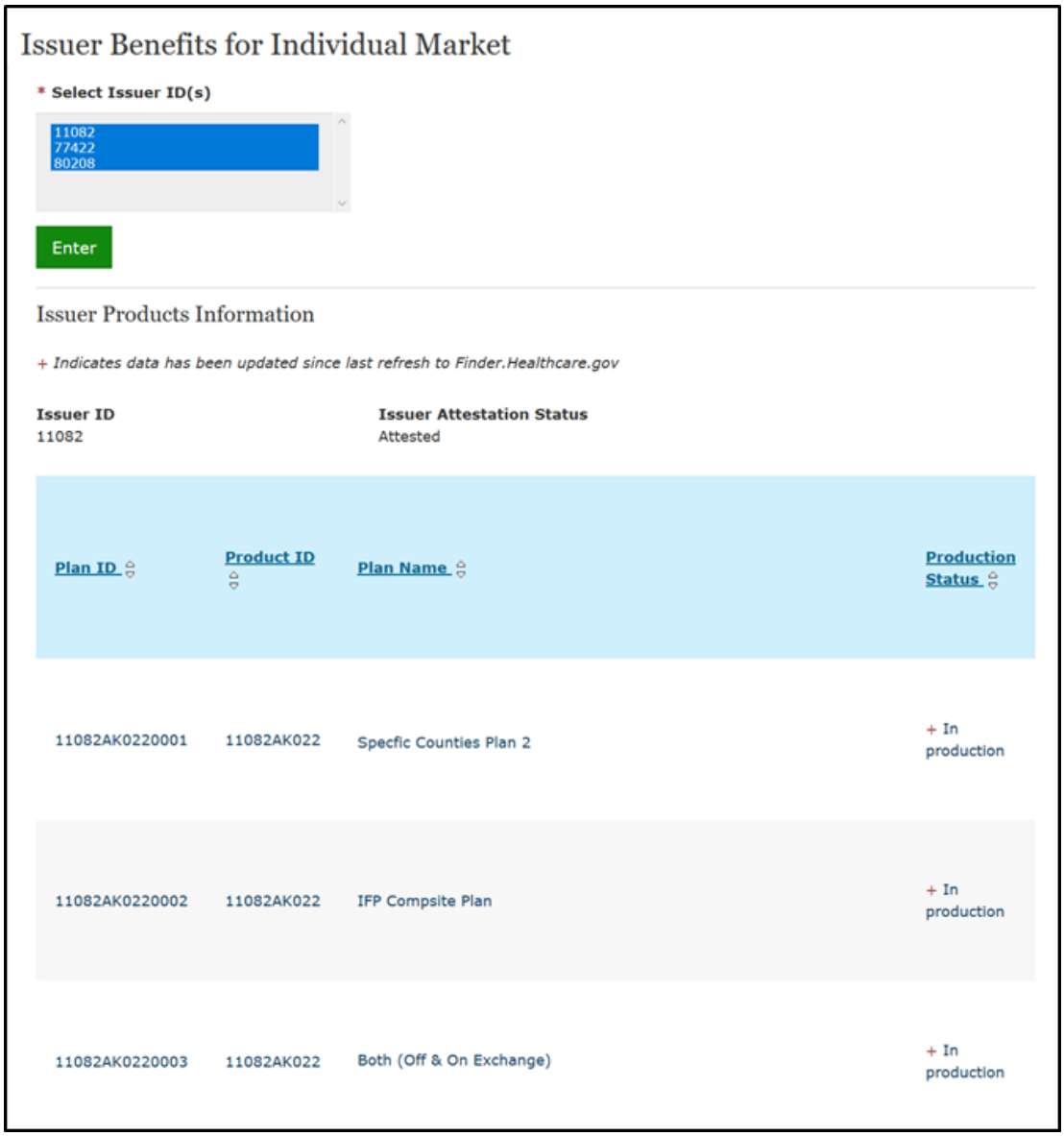
9.1.1 View All Plans Views

The View All Plans page allows Validator users to validate data by viewing all plans available for a given Issuer ID. If a Validator user would prefer to validate using specific coverage scenarios, please see the instructions in *9.1.2 Search by Scenario* for additional information.

9.1.1.1 View Issuer ID

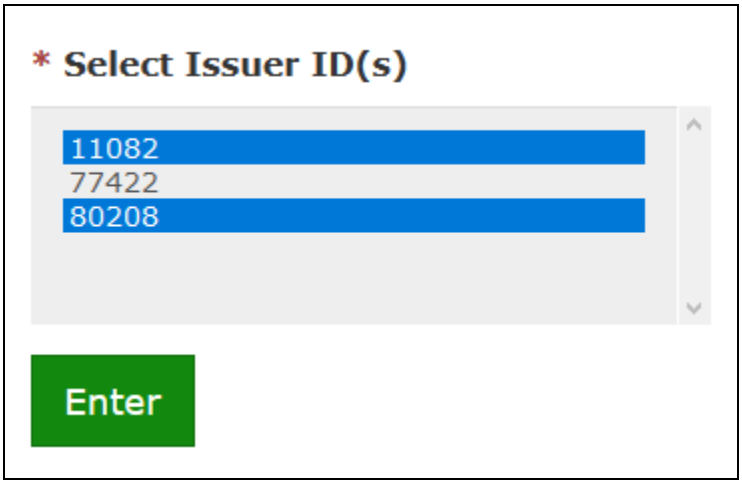
To validate data on the View All Plans page, Validator users must first select the Issuer ID(s) for the plans they would like to view and validate and then select the ***Enter*** button. Please refer to Figure 22 below.

Figure 22: Select Issuer ID(s) – Individual Market Example



To validate data for multiple Issuer IDs at once, Validators can hold down Ctrl key + select each Issuer ID they wish to view. Please refer to Figure 23.

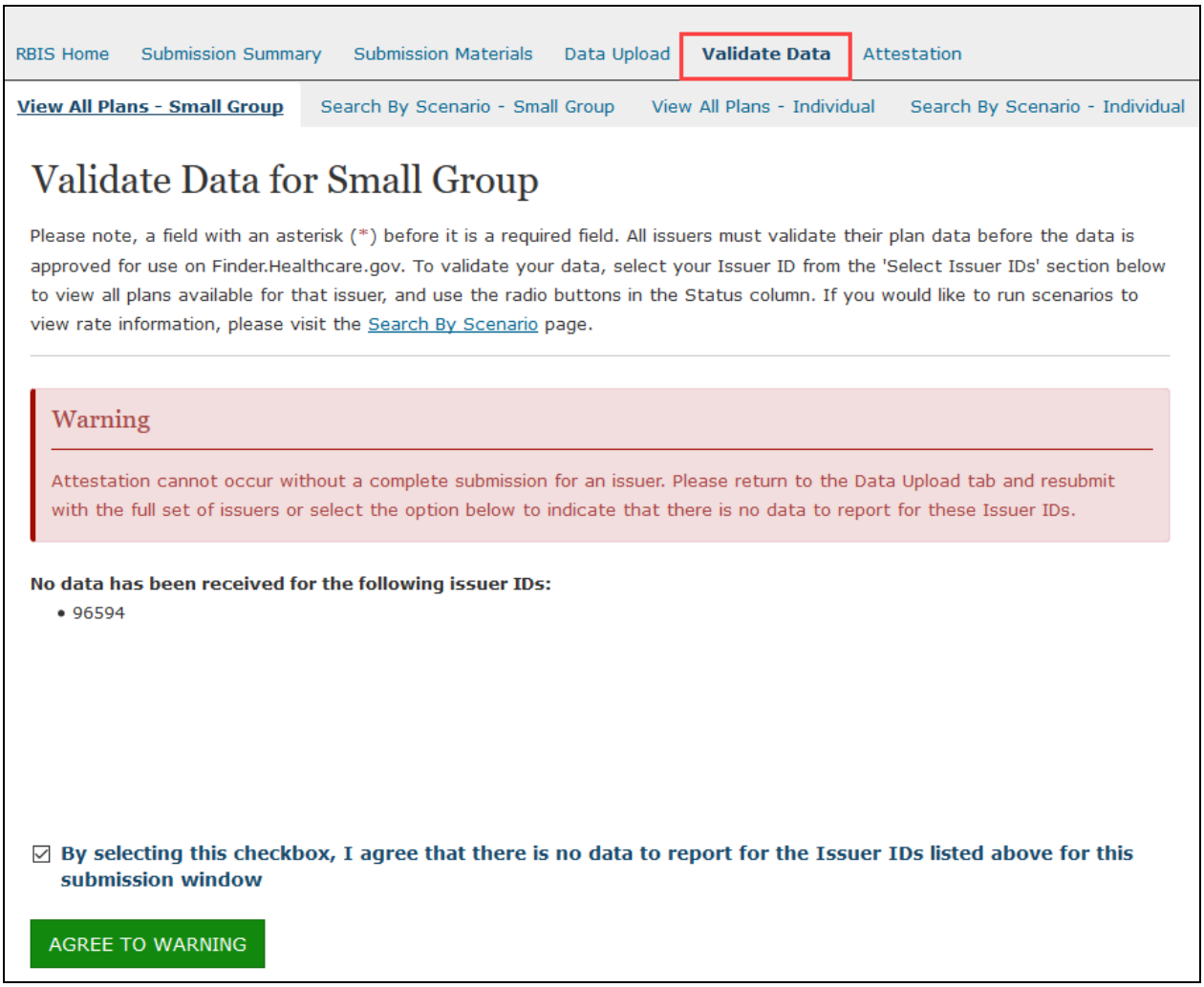
Figure 23: Issuer ID Multi-Select Example



9.1.1.2 No Data Received for Issuer ID(s)

If a Submitter user has not submitted data for an Issuer, a warning message will be displayed when plan details for that Issuer ID are displayed to the Validator user. The message will list the Issuer ID(s) for which no data has been received and explain that Attestation cannot occur without a complete submission. In the event that there is no data to report for the Issuer IDs listed for the current submission window, Validators may select the checkbox indicating that no data will be submitted and select “Agree to Warning”. Please refer to Figure 24.

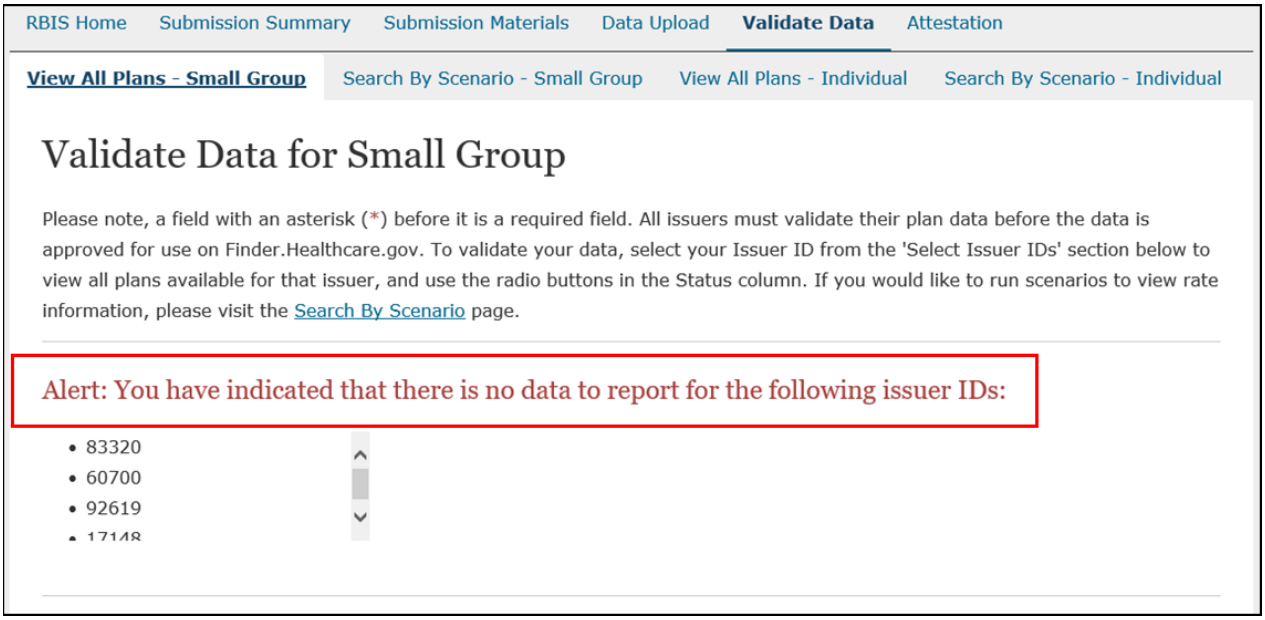
Figure 24: No Data Received for Issuer ID(s) – Small Group Market Example



9.1.1.2.1 No Data to Report for Issuer ID(s)

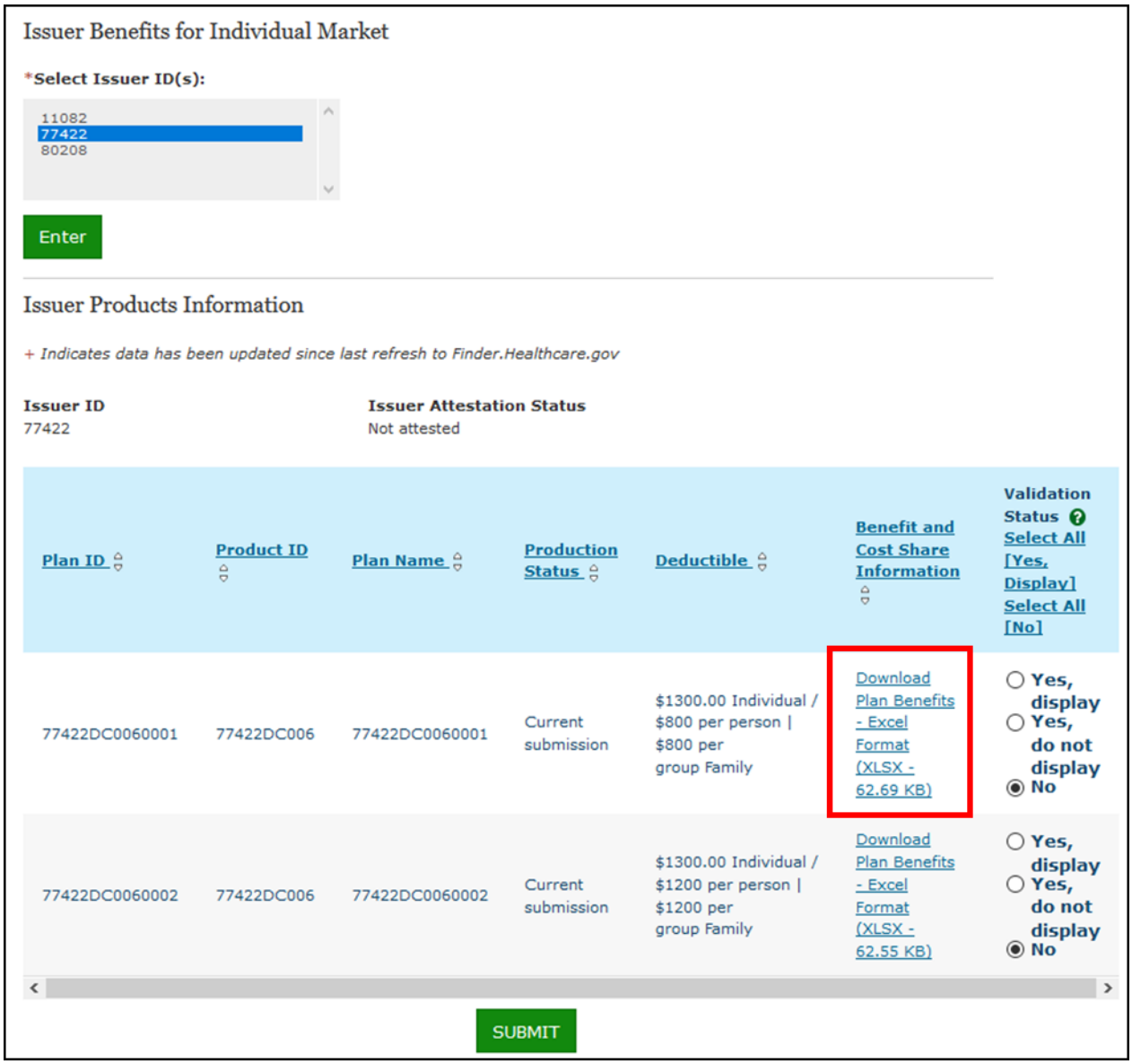
If a Submitter has not submitted data for an Issuer ID and has agreed that there is no data to report for the current submission window, the warning message in Figure 25 will be displayed.

Figure 25: No Data to Report for Issuer ID(s) (Example from Small Group Market)



When plan information is available and is displayed in the results table, the Validator user may select the ***Download Plan Benefits*** hyperlink next to the applicable Plan ID in the Benefit and Cost Share Information column of the table shown in Figure 26.

Figure 26: View Benefit Details for Individual Plans – Individual Market Example



Selecting the ***Download Plan Benefits*** hyperlink will download an Excel file containing benefits and cost share data submitted for the selected Plan ID as shown in Figure 27. The format of the downloaded file closely resembles the Plans and Benefits template.

Figure 27: Benefit Details for Individual Plans – Individual Market

	A	B	C	D	E	F	G
1	**Plan Benefits and Cost Share Information**						
2	**HIOS Issuer ID**	10000					
3	**Issuer State**	NE					
4	**Market Coverage**	Individual					
5	**Dental Only Plan**	No					
6	**TIN**						
7	***Plan Identifiers***						
8	**HIOS Plan ID (Standard Component)**	**Plan Marketing Name**	**HIOS Product ID**	**HPID**	**Network ID**	**Service Area ID**	**Formulary ID**
9	10000NE0580003	Sample Plan ABC	10000NE058	0	NEN001	NES001	NEF001
45							
46	***Benefit Information***						
47	**Benefits**		**EHB**	**State-Required Benefit**	**Is this Benefit Covered?**	**Quantitative Limit on Service**	**Limit Quantity**
48	**Primary Care Visit to Treat an Injury or Illness**		Yes	No	Covered	No	
49	**Specialist Visit**		Yes	No	Covered	No	

9.1.1.3 Validation Status

Using the radio buttons in the Validation Status column, Validator users must decide between the three Validation Status options, ***Yes, Display***, ***Yes, Do not Display*** or ***No***, for each plan.

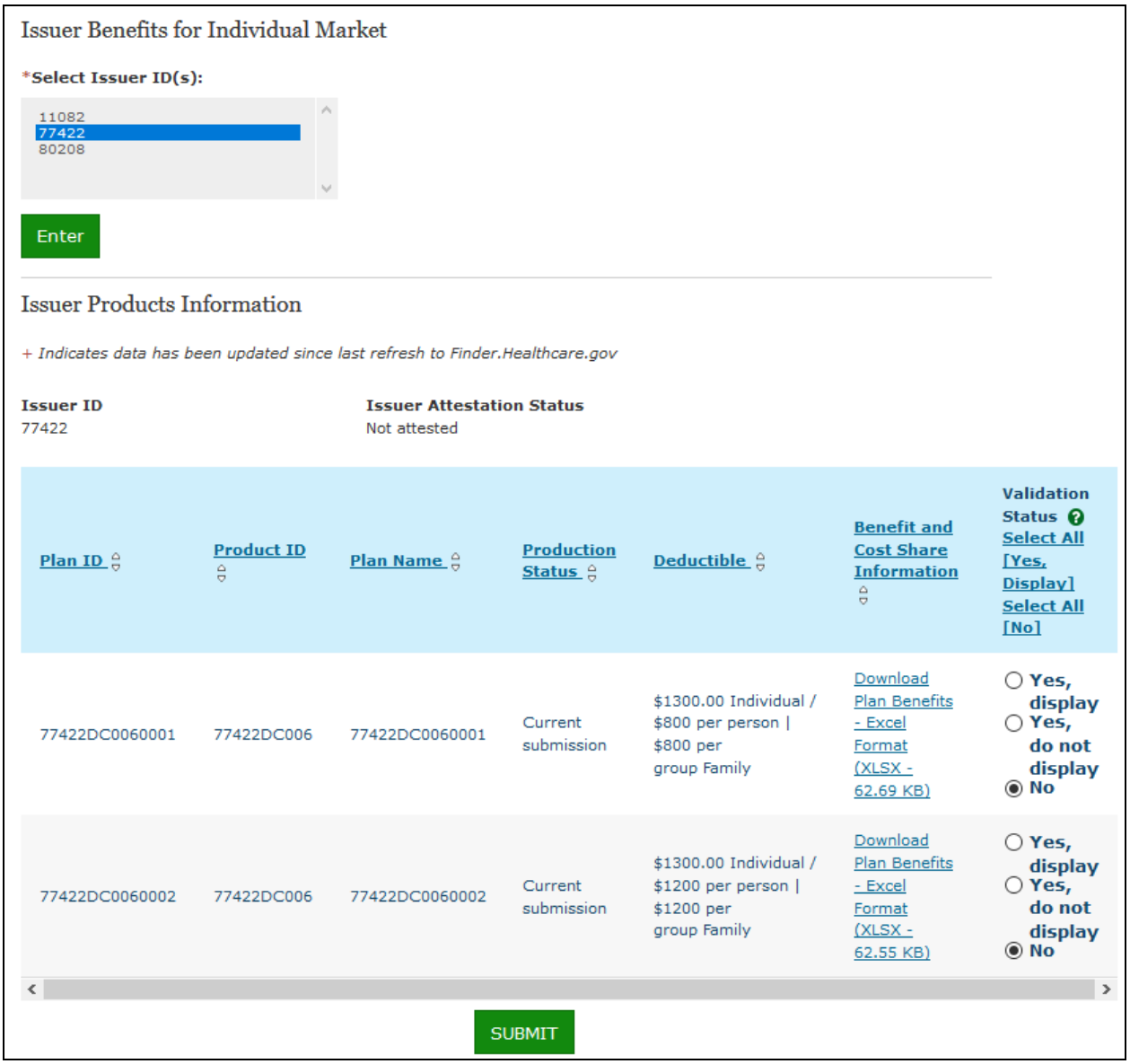
- By selecting ***Yes, Display***, the Validator user indicates that data for the given plan is valid and correct. In doing so, the plan passes Issuer Validation and will be visible to consumers on the Finder.Healthcare.gov website.

- By selecting ***Yes, Do not Display*** the Validator user indicates that data for the given plan is valid and therefore passes Issuer Validation, but they do not want the plan to be visible to consumers on the Finder.Healthcare.gov website.

- By selecting ***No***, the Validator indicates that data for the given plan is ***not*** valid. In doing so, the plan fails Issuer Validation.

Validators may change the Validation Status for all plans for an Issuer ID at one time by selecting either the ***Select All [Yes, Display]*** or ***Select All [No]*** link. Validator users must select the ***Submit*** button for the Validation Status to be saved in RBIS. By default the Validation Status is ***No***. Please refer to Figure 28.

Figure 28: Validation Status – Individual Market Example



9.1.2 Search by Scenario Views

The Search by Scenario function allows Validator users to view and validate data by running various enrollment scenarios to confirm the appropriate plans and computed premium amounts are returned.

9.1.2.1 Search Criteria Required Fields – Individual and Small Group Markets

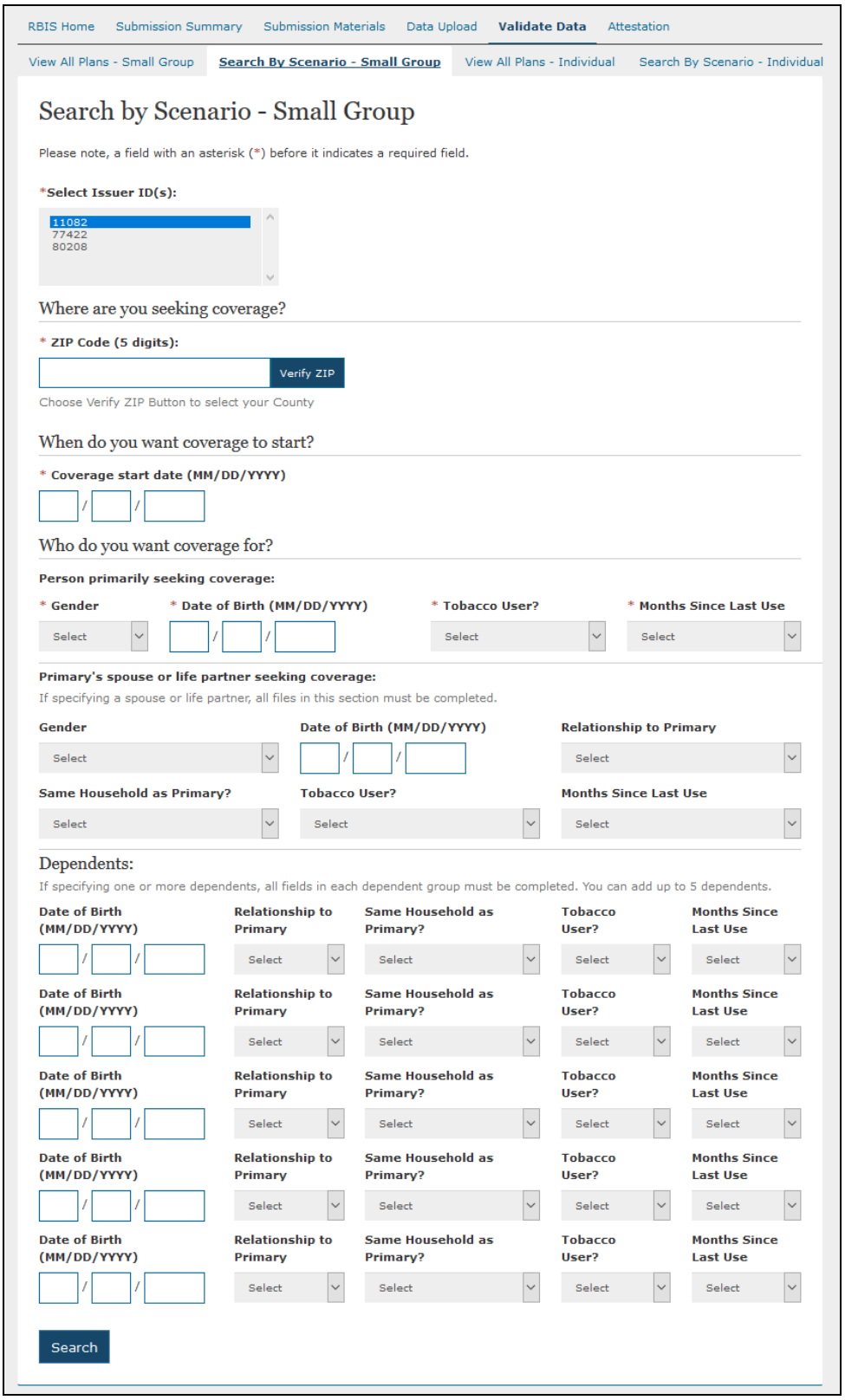
To execute a search scenario and view plan information, values for the following fields must be provided:

- Issuer ID

- ZIP Code
- County (if prompted)
- Coverage start date
- Person primarily seeking coverage
    - Gender
    - Date of Birth
    - Tobacco User?
    - Months Since Last Use (if tobacco user status is Y)
- Primary's spouse or life partner seeking coverage (as applicable)
    - Gender
    - Date of Birth
    - Relationship to Primary Subscriber
    - Same Household as Primary?
    - Tobacco User?
    - Months Since Last Use (if tobacco user status is Y)
- Dependents Information (as applicable)
    - Date of Birth
    - Relationship to Primary Subscriber
    - Same Household as Primary?
    - Tobacco User?
    - Months Since Last Use (if tobacco user status is Y)

Please note: The search criteria fields are the same for both the Individual and Small Group markets. The User Manual displays screenshots of the search criteria and results pages for the Small Group market for example purposes.

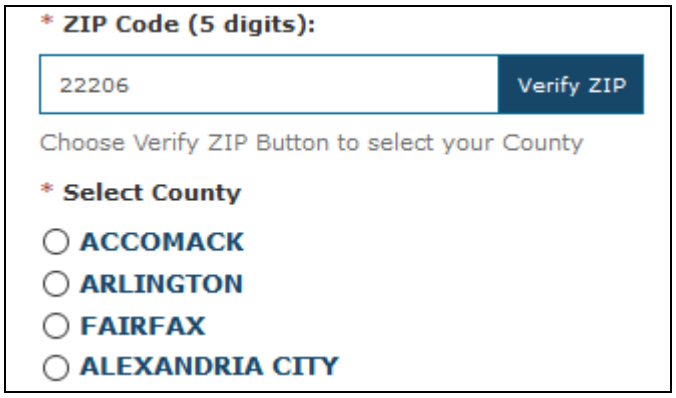
Figure 29: Search Criteria – Small Group Market



9.1.2.2 ZIP Code

After a ZIP code has been entered, Validator users must select the ***Verify ZIP*** button. If a ZIP code spans multiple counties, those county names will appear and Validator users must select the appropriate county before selecting the ***Search*** button. Please refer to Figure 30.

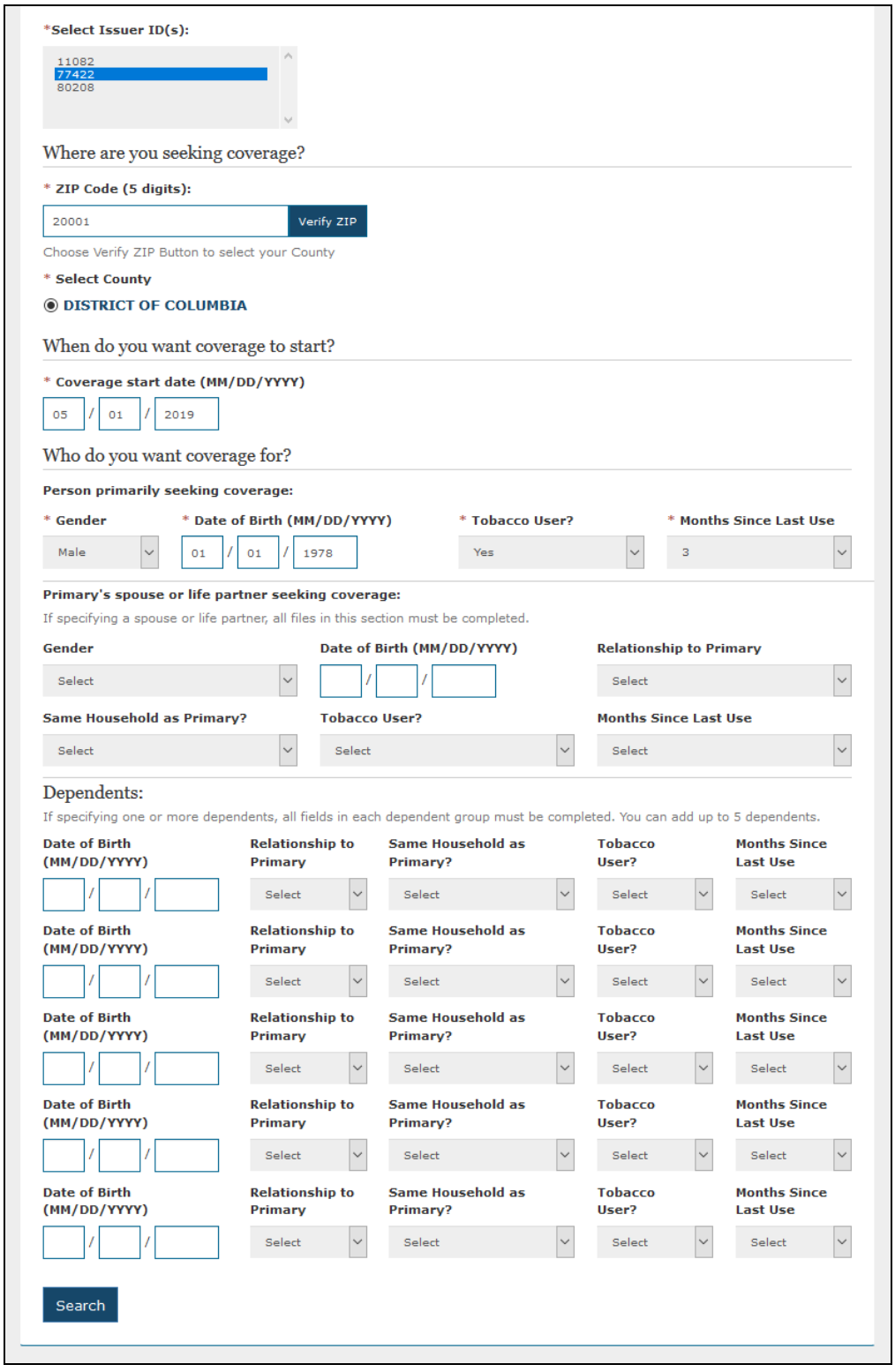
Figure 30: ZIP Code Field



9.1.2.3 Search Results

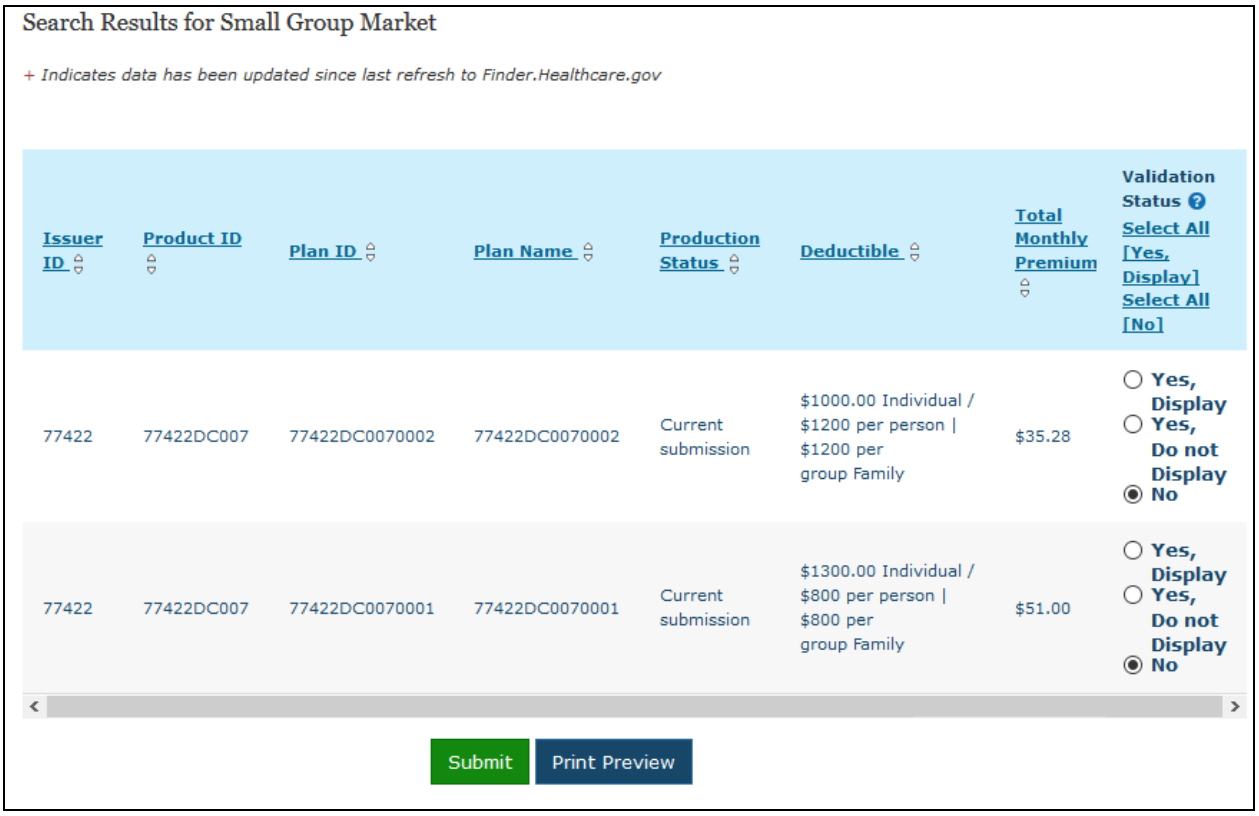
Once all required fields have been populated on the Search by Scenario page, Validator users can select the ***Search*** button to review their results. Please refer to Figure 31 and Figure 32.

Figure 31: Search by Scenario Screen – Small Group Market Example



Using the sample search critiera above, a Validator user would next select the ***Search*** button and results would be displayed as shown in Figure 32 below.

Figure 32: Search by Scenario Results Table – Small Group Market Example



Validator users may assign the Validation Status from the Search Results table.

- By selecting ***Yes, Display***, the Validator user indicates that all data for the given plan is valid and suitable for display to consumers on the Finder.HealthCare.gov website.
- By selecting ***Yes, Do Not Display***, the Validator user indicates that all data for the plan is valid, but they do not want the plan to be visible to the consumer on the Finder.HealthCare.gov website.
- By selecting ***No***, the Validator user indicates that all data for the plan is ***not*** valid.

Validator users must select the ***Submit*** button to save their Validation Status selections.

10 Attestation

Each Issuer must attest to the accuracy of their plan data before the data will be made available to consumers via the Finder.Healthcare.gov website. When attesting within RBIS, a single attestation action performed by an Attester user will attest to data for all Issuer IDs linked to that attester. In situations where an Attester user will be attesting for multiple Issuer IDs, if even one Issuer ID has not completed their submission process and resolved all system validation errors or has not selected "No Data to Submit", then attestation all for Issuer IDs linked to the Attester will be unavailable.

Since RBIS operates under an annual submission model, if an attestation is performed once during the data collection process, it will remain valid for the entire plan year's data collection cycle, regardless of whether additional submissions are made after the initial attestation.

10.1 Attestation Available

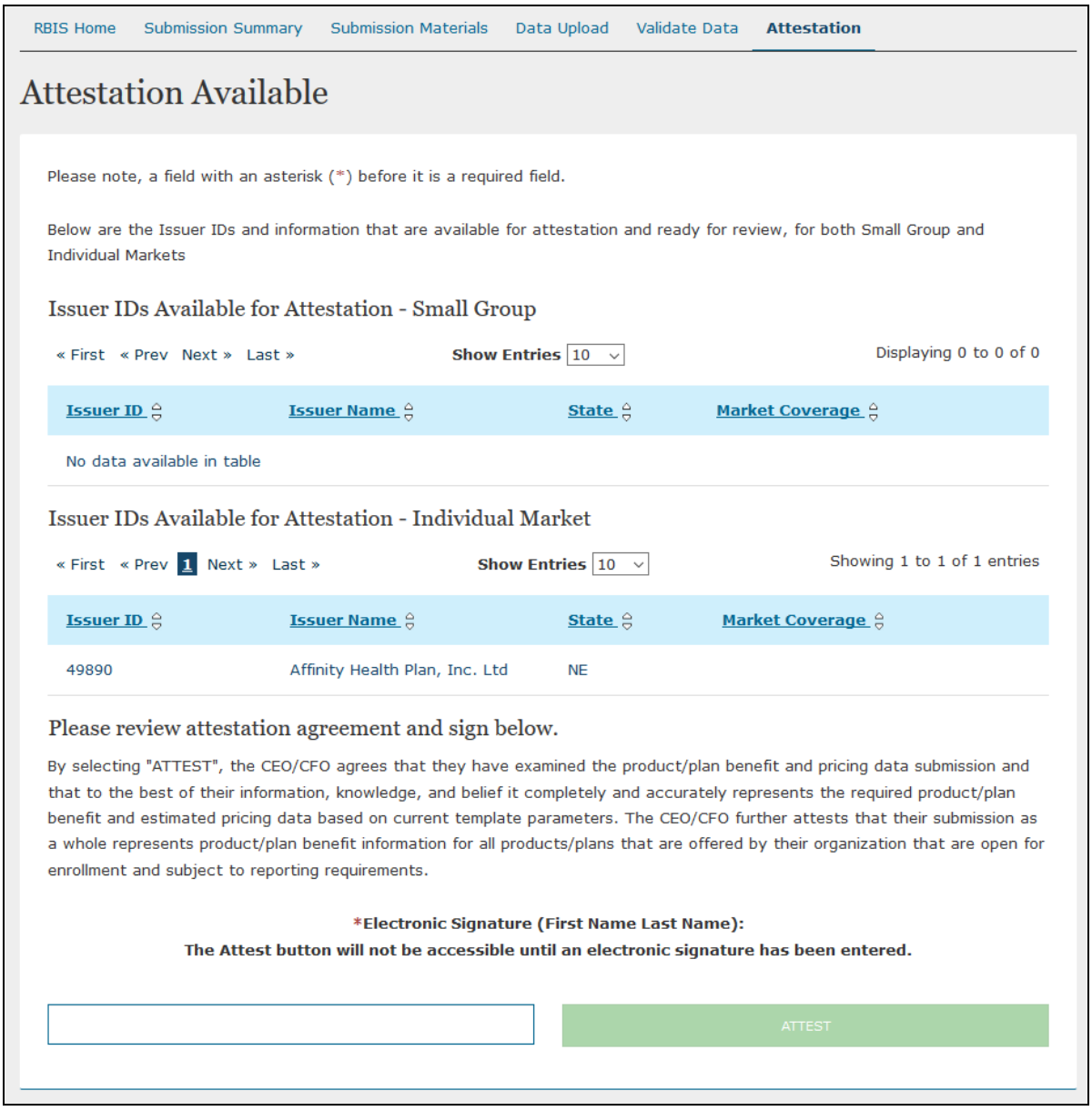
Attestation becomes available when all Issuers associated to a CEO/CFO from both markets (if the issuers offer coverage in both markets) have been submitted successfully or have indicated they have no data to submit. In order to attest to the accuracy of plan data, the Attester must fill in the ***Electronic Signature*** box and select the ***Attest*** button. Please note that first name and last name entered as the electronic signature must match the first and last name of the Attester user as stored in HIOS, otherwise an error message will displayed and the attestation will not be accepted.

There is a single Attestation page and a single Attestation button for the Attester user. The Attester must attest to all plans for all associated Issuer IDs for all applicable markets (Individual and/or Small Group) concurrently as information for each Issuer associated to the Attester user is displayed on the Attestation page grouped by market type. Information provided includes status information if the Issuer is not available for Attestation or a list of the Issuer IDs for which the Attester user is attesting when Attestation is available.

There are manual attestation forms available upon request for special circumstances, such as if the Attester is not able to access RBIS or when an Attester wishes to only attest to a single market. The request for the manual attestation form will need to be sent to insuranceoversight@hhs.gov for CCIIO approval and should contain an explanation of the circumstances and a description of what Issuer ID(s) and market type(s) need to be attested.

By selecting ***Attest***, the CEO/CFO agrees that they have examined the product/plan benefit and pricing data submission and that to the best of their information, knowledge, and belief it completely and accurately represents the required product/plan benefit and estimated pricing data based on current template parameters. The CEO/CFO further attests that their submission as a whole represents product/plan benefit information for all products/plans that are offered by their organization that are open for enrollment and subject to reporting requirements. Please refer to Figure 33.

Figure 33: Attestation Available

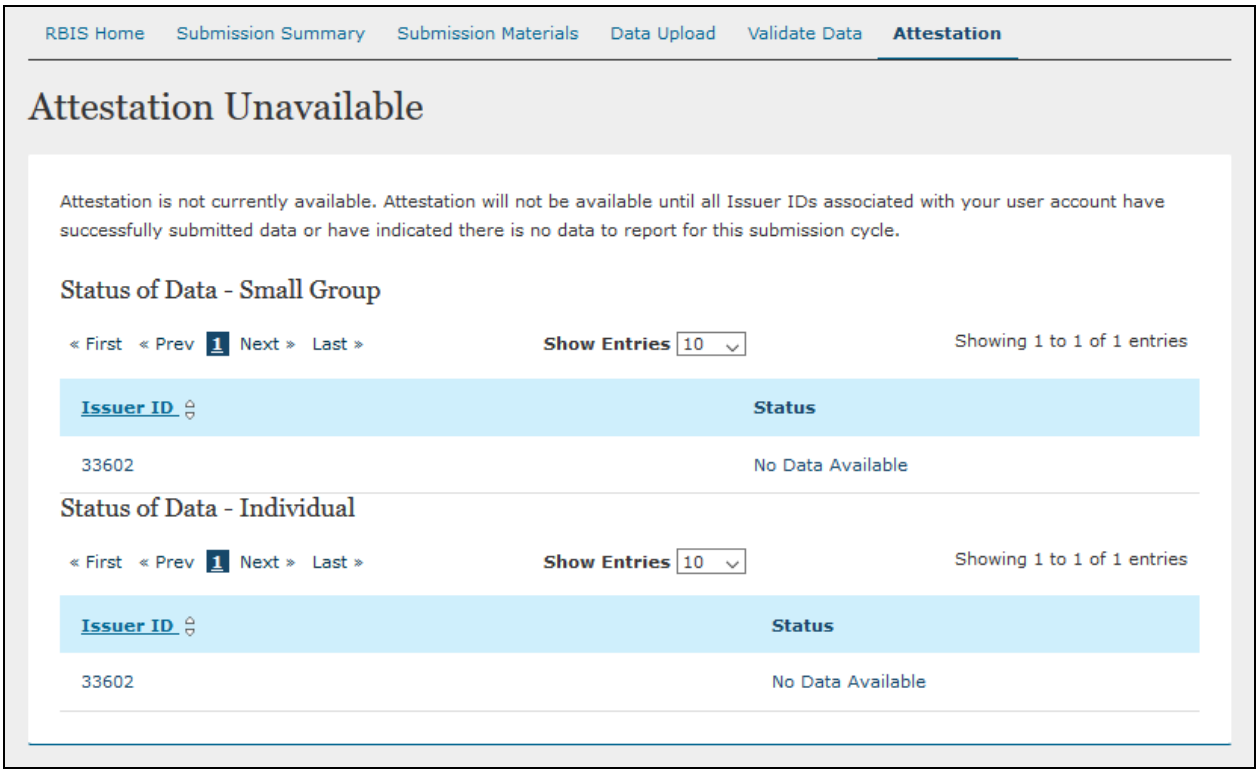


+]

10.2 Attestation Unavailable

Data Attestation is unavailable when a complete submission has not been received for all Issuer IDs associated to the Attester's User ID. Please refer to Figure 34. To upload data, Submitter users should refer to Section 8 of this document. In the event that there is no data to report for the current submission window for one or more Issuer IDs associated with the Attester ID, Validator users may indicate under the Validate Data tab that no data will be submitted. Please see Section 9.1.1.2.1. for further instructions on indicating no data to submit.

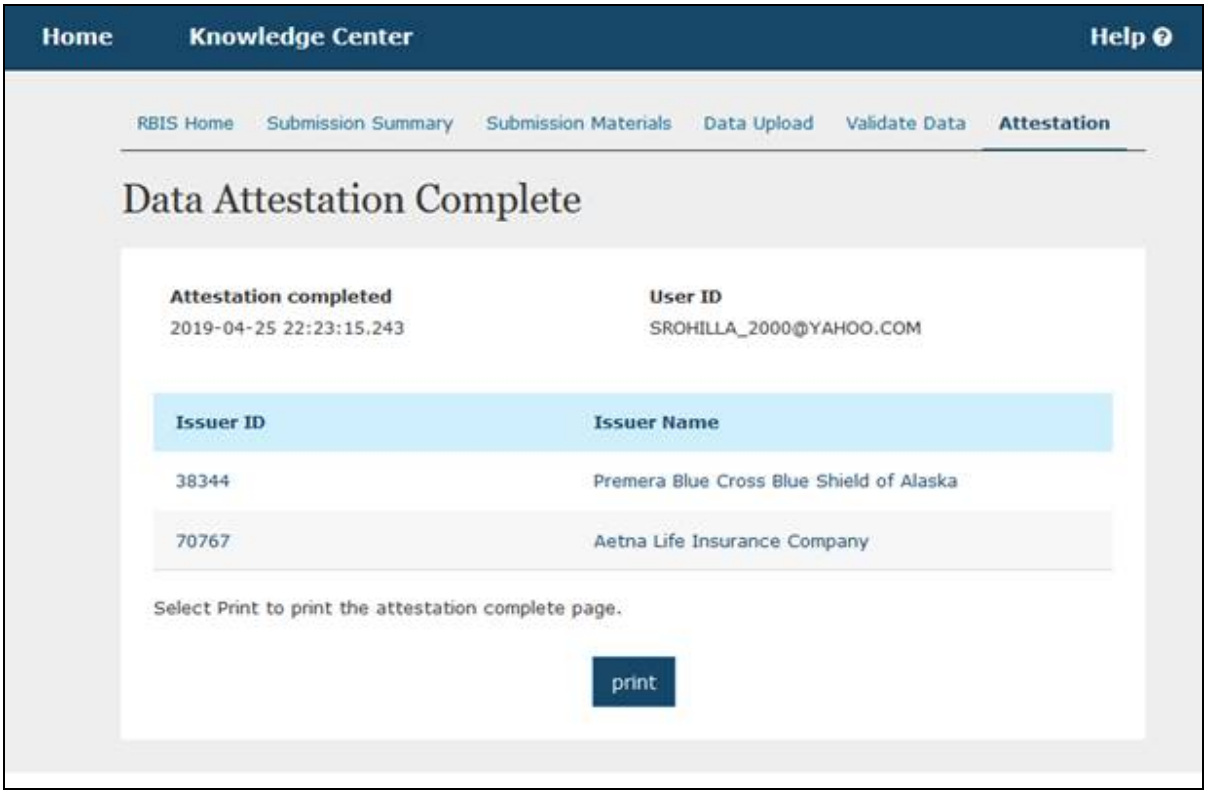
Figure 34: Attestation Unavailable



10.3 Attestation Complete

Once Attestation has been completed, the Attester user see the Attestation Complete message displayed in Figure 35.

Figure 35: Attestation Complete



The Attester users, Submission users, and Validation users associated to the Issuer ID(s) successfully attested will all receive a copy of the Attestation Complete email notification. The email will provide the following information:

- Issuer ID(s)
- Issuer Name(s)
- Market Type(s)
- Message confirming that Attestation is complete for the Issuer(s)
- Date Attestation is complete
- Time Attestation is complete

10.4 Manual Attestation

If an electronic attestation cannot be completed, issuers may request a paper attestation form for the Small Group and/or Individual market. This manual attestation request must be approved by CCIIO before Issuers will be granted access to the form. If Issuers are granted approval to manually attest, they will be provided with a form for the CEO/CFO to sign. This form must be scanned and emailed back to insuranceoversight@hhs.gov.

11 Resubmission

The resubmission process is an opportunity for the Issuer to change or update any data currently in the RBIS system. The Issuer can also add new data or correct any previously failed data during the submission process. After a Submitter user has re-submitted their data, the templates will go through both template validations and overall cross-check validations to verify the data.

Plans that are displayed for issuer validation in RBIS during the resubmission process include:

- Plans currently in production (i.e., plans previously published to Finder.Healthcare.gov)
- Previously submitted plans that were validated successfully but not attested
- Plans newly submitted to RBIS

11.1 Resubmission Requirements

Issuers may submit any updates or changes, or correct failed submissions via the resubmission process. Plans currently in production can only be updated and cannot be removed from the Validate Data tab through submission. However, a Validator user can validate a plan as “Yes, Do Not Display” which would remove that plan from display on the Finder.Healthcare.gov website. Alternatively, validating a plan as “No” would also remove a plan from the website, but would require a Final Refresh process to be run; please refer to Section 3.6.2 for more information on this process.

If no changes or updates need to be made, then resubmission is not necessary. In the ideal scenario, an issuer submits, validates and attests their data once during a plan year data collection cycle. If no further updates are needed to the data, they need not perform any additional actions in RBIS for the remainder of the year.

11.2 Resubmission Validation and Attestation Requirements

All plans will require Issuer Re-Validation if data is resubmitted to RBIS. If the issuer has previously recorded an attestation from their Attester (Issuer CEO/CFO) there is no need to attest again during the same Plan Year, even if multiple resubmissions are made after the initial Attestation.

12 Appendices

12.1 Appendix A – Template Data Validations

To trigger the validation process:

1. When the Submitter user has completed the data entry or updates, it is recommended to save the document before starting the validation process.
    - For Excel 2010 and later, Select ***File***, ***Save As*** and save the file as an Excel Macro-Enabled Workbook.There is no need to rename the document at this point.
2. Select the ***Validate*** button.

Upon triggering the validation process, a message box will pop up indicating which cells did not pass validation along with a brief description of why the cell did not pass validation. Once the validation errors are corrected, the validate process will display a message indicating the validation was successful.

Once the template has passed validation, the Excel file must be finalized. In order to finalize the Excel file, select the ***Finalize*** button. This will create an .xml file that is suitable for submission to the RBIS system.

12.2 Appendix B - File Type Instructions

The following file formats are accepted for data upload into the Rate and Benefits Information System:

- XML
- ZIP

12.2.1 XML

All files must be 50 MB or smaller. Before saving the finalized document, users should ensure that all required fields have been filled in correctly by running the validate process described above.

12.2.2 ZIP

All files must be 50 MB or smaller. If users have difficulty with the file size, zipped or compressed files take up less storage space and may be utilized instead. User can combine several files into a single compressed folder, making it easier to upload into RBIS. It is important to note that **users may only submit one Template type per ZIP file**.

For example, users may upload multiple Plans and Benefits templates in one ZIP file, but they cannot upload a Plans and Benefits template with a Rates template in the same ZIP file.

12.2.3 Saving Documents in .ZIP Format

Before saving the finalized document as a ZIP file, users should ensure that all required fields have been filled in correctly by running the validate process described above.

To compress a file or folder using Windows:

1. Locate the file(s) or folder(s) that you want to compress.
2. Select the file(s) or folder(s) and right-select, point to ***Send To***, and then select ***Compressed (zipped) Folder***.
    a. A new compressed folder is created. To rename it, right-click the folder, select ***Rename***, and then enter the new name.

To compress files and folders using Mac OS:

1. Select the item or items you want to compress.
2. Choose ***File*** and select ***Compress***.
    a. If compressing a single item, the compressed file has the name of the original item with a .zip extension. If compressing multiple items at once, the compressed file is called Archive.zip.
    b. When opening a compressed file, it is replaced by a folder containing uncompressed copies of the original items. As the item is being uncompressed, the Archive Utility appears in the Dock. To change where the uncompressed files appear or automatically delete the .zip files, select ***Archive Utility***, and select ***Archive Utility > Preferences***.

12.3 Appendix C - Business Rules and Rates Template Integration

The Finder.HealthCare.gov website is used to assist consumers in identifying affordable and comprehensive health insurance coverage options that are available in their state. The information displayed on Finder.HealthCare.gov should include, but is not limited to, information on eligibility, availability, premium rates, and benefit descriptions by plan and within an appropriate geographic context.

The purpose of this section is to illustrate how the search parameter data input from consumers on the Finder.HealthCare.gov website combined with Issuer plan data submissions in the Rate and Benefits Information System generate the estimated premium rates that are output and displayed to a consumer on Finder.HealthCare.gov. The following three components are involved:

- **Consumer Input on the Finder.Healthcare.gov website** – The scenario data that a consumer inputs on Finder.Healthcare.gov helps determine the benefit plans for which the consumer is eligible.
- **Business Rules Template** – This template allows Issuers to submit the answers to questions that will determine how the estimated premium amounts for their plans are calculated.
- **Rates Template** - The Rates Template allows Issuers to submit plan rate data as well as other determining factors such as subscriber type and smoking habits.

The combination of all three components outlined above determines the benefit plans and associated premium amounts that are displayed to a consumer when they perform a search on Finder.Healthcare.gov for available healthcare plans for which they are eligible.

12.3.1 Business Rules Template Guidelines

1. Download the Business Rules Template
    a. For further instructions on how to download the Business Rules Template for submission, see Section 6.2.
2. The Business Rules Template should be completed with values appropriate for the issuer. It should be validated and finalized into an .xml file for submission.
3. The finalized template should be submitted along with the other three templates as part of an RBIS submission as defined in Section 7.

12.3.2 Age Calculation for Eligibility and Quote Determination

The subscriber's age is used for determining:

- Eligibility for a specific plan
- Rate value lookup for a specific plan

There are three factors that influence the age calculation:

1. The subscribers date of birth (DOB)
2. The insurance effective date (IED)
3. One of the following issuer specified rules to determine the age on a specific date:
    a. Age on effective date
    b. Age on January 1st of the effective date year
    c. Age on insurance date (age on birthday nearest the effective date)
    d. Age on January 1st or July 1st

Age related eligibility rules are provided in months, while rates are specified for age bands in years. Therefore, the age will first be calculated in months and then converted into years.

For a specific subscriber born on date “DOB” the following algorithm is used to determine the age in months on a specific date “IED”:

1. Determine “age in years” as DOB.year – IED.year
2. If the birthday did not yet come up as of the IED, then subtract one year from the “age in years” and determine the “months that have passed since the last birthday” as 12 - DOB.month + IED.month
3. Else determine the “months that have passed since the last birthday” as IED.month – DOB.month
4. If the day of the month of IED is before the day of the month of the DOB, then subtract one month from the “months that have passed since the last birthday”
5. The resulting age in months is then determined as 12 * “age in years” + “months that have passed since the last birthday”

The age in years is then calculated from the age in months by dividing the age in months by 12, ignoring the fractional portion of the result (which is the same as “age in years” from the above calculation).

12.3.3 Rates Template Guidelines

1. Download the Rates Template
    a. For further instructions on how to download the Rates Template for submission, see Section 6.2.
2. The Rates Template should be completed with values appropriate for the issuer. It should be validated and finalized into an .xml file for submission.
3. The finalized template should be submitted along with the other three templates as part of an RBIS submission as defined in Section 7.

The information below in Table 2 and Table 3 provides subscriber type mappings for users based on the method in which they calculate plan rates.

Individual Rates - The following table displays subscriber type mappings for when rates are calculated individually by adding up individual rates.

Table 2: Subscriber Type Mapping for Individual Rate Calculations

Scenario	Template Subscriber Type
Single Person	Primary Subscriber
Child	Dependent
One Child Only	Primary Subscriber
Two Children Only	Primary Subscriber + Primary Subscriber
Three Children Only	Primary Subscriber + Primary Subscriber + Primary Subscriber
Husband + Wife	Primary Subscriber + Secondary Subscriber

Scenario	Template Subscriber Type
Husband + Wife + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Husband + Wife + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Husband + Wife + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent
Single Parent + One Child	Primary Subscriber + Dependent
Single Parent + Two Children	Primary Subscriber + Dependent + Dependent
Single Parent + Three or more Children	Primary Subscriber + Dependent + Dependent + Dependent
Domestic Partner + Domestic Partner	Primary Subscriber + Secondary Subscriber
Domestic Partner + Domestic Partner + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Domestic Partner + Domestic Partner + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Domestic Partner + Domestic Partner + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent
Same Sex Partner + Same Sex Partner	Primary Subscriber + Secondary Subscriber
Same Sex Partner + Same Sex Partner + One Child	Primary Subscriber + Secondary Subscriber + Dependent
Same Sex Partner + Same Sex Partner + Two Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent
Same Sex Partner + Same Sex Partner + Three or more Children	Primary Subscriber + Secondary Subscriber + Dependent + Dependent + Dependent

Group Rates – When determining group rates, the relationships between the primary subscriber and dependent(s) specified on Business Rules template must be considered. Issuers can define permissible relationship types and whether the dependent must live with the primary subscriber.

The following information in Table 3 displays subscriber type mappings for when group rates are applied to a family of two or more enrollees.

Table 3: Subscriber Type Mapping for Group Rate Calculations

Scenario	Template Subscriber Type	Limitations/Exceptions
Single Person	Primary Subscriber	N/A
Child	Dependent	N/A
One Child Only	Primary Subscriber	N/A

Scenario	Template Subscriber Type	Limitations/Exceptions
Two Children Only	Primary Subscriber + Primary Subscriber	N/A
Three Children Only	Primary Subscriber + Primary Subscriber + Primary Subscriber	N/A
Husband + Wife	Couple	N/A
Husband + Wife + One Child	Couple and One Dependent	N/A
Husband + Wife + Two Children	Couple and Two Dependents	N/A
Husband + Wife + Three (or more) Children	Couple and Three or More Dependents	N/A
Single Parent + One Child	Primary Subscriber and One Dependent	N/A
Single Parent + Two Children	Primary Subscriber and Two Dependents	N/A
Single Parent + Three (or more) Children	Primary Subscriber and Three or More Dependents	N/A
Domestic Partner + Domestic Partner	Couple	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + One Child	Couple and One Dependent	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + Two Children	Couple and Two Dependents	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Domestic Partner + Domestic Partner + Three (or more) Children	Couple and Three or More Dependents	Rate applies only if Domestic Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner	Couple	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner + One Child	Couple and One Dependent	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.

Scenario	Template Subscriber Type	Limitations/Exceptions
Same Sex Partner + Same Sex Partner + Two Children	Couple and Two Dependents	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.
Same Sex Partner + Same Sex Partner + Three (or more) Children	Couple and Three or more Dependents	Rate applies only if Same-Sex Partners are treated the same as Secondary Subscribers.

12.3.4 Sample Rate Calculations

Please note: the Scenarios below display a simple breakdown of sample rate calculations. There are additional variances within the Business Rules template that will affect which rates will return for each indivudal subscriber.

Example Scenario 1 – Husband, Wife and 2 Children

*For this example, assume the business rules classify a person using tobacco within the last six months as a tobacco user subject to tobacco user rates.

Table 4: Example Scenario 1 - Individual Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Husband	38	Tobacco use within 3 months*	Primary Subscriber	54
Wife	36	Non-tobacco	Secondary Subscriber	42
Child	12	Non-tobacco	Dependent	23
Child	14	Non-tobacco	Dependent	20

Figure 36: Example Scenario 1 – Group Rate Results

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	Individual Tobacco Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of an Individual tobacco enrollee on a plan
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	0-14	20.00	20.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	15	21.00	21.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	16	22.00	22.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	17	23.00	23.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	18	24.00	34.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	19	25.00	35.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	20	26.00	36.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	21	27.00	37.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	22	28.00	38.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	23	29.00	39.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	24	30.00	40.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	25	31.00	41.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	26	32.00	42.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	27	33.00	43.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	28	34.00	44.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	29	35.00	45.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	30	36.00	46.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	31	37.00	47.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	32	38.00	48.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	33	39.00	49.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	34	40.00	50.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	35	41.00	51.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	36	42.00	52.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	37	43.00	53.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	38	44.00	54.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	39	45.00	55.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	40	46.00	56.00

The template rows are populated by age starting from 0-14: The first row outlined displays the child, who is under 14 years of age and has an individual rate of $20.00. The second row outlined displays the other dependent, 17 years old, with an individual rate with a rate of $23.00. The third row outlined displays the rate for the wife, 36 years of age (non-tobacco user), with an individual rate of $42.00. the Last row outlined shows the husband, 38 years of age (tobacco user), with an Individual Tobacco Rate of $54.00. The total rate would be the sum of $20 + $23 +$42 + $54 = $139.

Table 5: Example Scenario 1 – Group Rate Calculation

Enrollees	Template Subscriber Type	Sample Output Rate
Husband, Wife, and two Children	Primary Subscriber, Secondary Subscriber and Two Dependents	130

Figure 37: Example Scenario 1 – Group Rate Results

					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1			40	70	60	80	100	110	130	150

One row is populated. The rate listed is $130.00 covering the field primary subscriber, secondary subscriber and two dependents.

Example Scenario 2 – Husband, Wife, two Children and Grandmother

* For this example, assume the business rules classify a person using tobacco within the last six months as a tobacco user subject to tobacco user rates.

Table 6: Example Scenario 2 - Individual Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Husband	38	Non-tobacco	Primary Subscriber	80
Wife	36	Tobacco use within 2 months*	Secondary Subscriber	50
Child	12	Non-tobacco	Dependent	25
Child	14	Non-tobacco	Dependent	25
Grandmother	65	Non-tobacco	Dependent	65

Figure 38: Example Scenario 2 – Individual Rate Results

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	Individual Tobacco Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of an individual tobacco enrollee on a plan
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	0-14	20.00	20.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	15	21.00	21.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	16	22.00	22.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	17	23.00	23.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	18	24.00	34.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	19	25.00	35.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	20	26.00	36.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	21	27.00	37.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	22	28.00	38.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	23	29.00	39.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	24	30.00	40.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	25	31.00	41.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	26	32.00	42.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	27	33.00	43.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	28	34.00	44.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	29	35.00	45.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	30	36.00	46.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	31	37.00	47.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	32	38.00	48.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	33	39.00	49.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	34	40.00	50.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	35	41.00	51.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	36	42.00	52.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	37	43.00	53.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	38	44.00	54.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	39	45.00	55.00
[illegible]					
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	59	65.00	75.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	60	66.00	76.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	61	67.00	77.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	62	68.00	78.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	63	69.00	79.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	64 and over	70.00	80.00

Four rows are outlined: The first row outlined displays the rate for the two children (both under 14 years of age) at $20.00 per person. The next row outlined displays the wife, 36 years old, who is a tobacco user with a rate of $42.00. The third row outlined displays the husband, 38 years old, who is a non-tobacco user with a rate of $44.00. The fourth row outlined displays the grandmother, 65 years old, who is a non-smoker with a rate of $70.00 per person. The total rate would be the sum of $20 + $20 +$42 + $44 + $70 = $196.

Table 7: Example Scenario 2 - Group Rate Calculation No Plans Returned

Enrollees	Template Subscriber Type	Sample Output Rates
Husband, Wife, 2 Children, and grandmother	N/A because grandmother is older than 21 and does not qualify as a dependent.	No plans will be returned for this family configuration

Instead, the family configuration will be returned as follows for group rate calculations:

Table 8: Example Scenario 2 - Group Rate Calculation Plans Returned

Enrollees	Template Subscriber Type	Sample Output Rates
Husband, Wife, and 2 Children	Primary Subscriber, Secondary Subscriber, and two dependents	130
Grandmother	Individual	65

Figure 39: Example Scenario 2 – Group Rate Results

					Family Tier						
Plan ID*	Rating Area ID*	Age*	Tobacco*	Individual*	Primary Subscriber and Secondary Subscriber	Primary Subscriber and One Dependent	Primary Subscriber and Two Dependents	Primary Subscriber and Three or More Dependents	Primary Subscriber, Secondary Subscriber and One Dependent	Primary Subscriber, Secondary Subscriber and Two Dependents	Primary Subscriber, Secondary Subscriber and Three or More Dependents
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select the age of a subscriber eligible for the rate	Require: Select if Tobacco use of subscriber is used to determine if a person is elible for a rate from a plan	Required: Enter the rate of an individual enrollee on a plan	Optional: Enter the rate of a couple based on the pairing of a primary enrollee and a secondary subscriber (e.g. husband and spouse)	Optional: Enter the rate of a family based on a single parent with one dependent	Optional: Enter the rate of a family based on a single parent with two dependents	Optional: Enter the rate of a family based on a single parent with three or more dependents	Optional: Enter the rate of a family based on a couple with one dependent	Optional: Enter the rate of a family based on a couple with two dependents	Optional: Enter the rate of a family based on a couple with three or more dependents
12345678912345	Rating Area 1			65	70	75	80	85	125	130	135

One row is populated. The rate listed is $130.00 covering the field primary subscriber, secondary subscriber and two dependents, plus the grandmother is listed as an individual (on a separate plan) with a rate of $65.00.

Example Scenario 3 – Four Children Only

For this scenario, the rate calculation would be the same for both individual and group rates. This is because there are no group rates for child only plans. For both cases, the overall rate is the sum of the individual rates for the children, using the three oldest for rate determination.

Table 9: Example Scenario 3 – Individual and Group Rate Calculation

Enrollees	Age	Tobacco/Non-Tobacco	Template Subscriber Type	Sample Output Rates
Child 1	20	Tobacco use within 4 months*	Individual	36
Child 2	18	Tobacco use within 1 month*	Individual	34
Child 3	16	Non-tobacco	Individual	22
Child 4	14	Non-tobacco	Individual	20

Figure 40: Example Scenario 3 – Individual and Group Rate Results

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*	Individual Tobacco Rate*
Required: Enter the 14-character Plan ID	Required: Select the Rating Area ID	Required: Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	Required: Select the age of a subscriber eligible for the rate	Required: Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan	Required: Enter the rate of an Individual tobacco enrollee on a plan
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	0-14	20.00	20.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	15	21.00	21.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	16	22.00	22.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	17	23.00	23.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	18	24.00	34.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	19	25.00	35.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	20	26.00	36.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	21	27.00	37.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	22	28.00	38.00
12345XX1234567	Rating Area 1	Tobacco User/Non-Tobacco User	23	29.00	39.00

There are four rows outlined. The first row displays Child 4, 14 years old, who is a non-tobacco user with a rate of $20.00. The second row displays the rate for Child 3, 14 years old, who is a non-tobacco user with a rate of $22.00. The next row outlined shows Child 2, 18 years old, who is a tobacco user with a rate of $34.00. The last row outlined shows Child 1, 20 years old, also a tobacco user, with a rate of $36.00. The total rate would be the sum of $20 + $22 + $34 + $36 = $112.