Certification Process
Frequently Asked Questions

Certification Process Frequently Asked Questions (FAQ) #1

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Certification Process

Accreditation

Q1: The Accreditation instructions state that when entering the Product ID for each plan type, issuers must base the Plan ID on a plan with the largest number of enrollees. If an issuer is unable to determine a plan with the largest enrollment, may issuers enter any Product ID of that plan type?

A1: Yes, issuers may use any Product ID for a plan type if they are unable to determine which product has the largest enrollment.

Q2: May issuers provide multiple Product IDs with the Accreditation Module and upload several Accreditation Certifications as supporting documents?

A2: Yes, the Accreditation module will accept multiple documents.

Q3: Are Stand-alone Dental Plans (SADPs) required to have an Accreditation?

A3: No, SADPs are not required to have an Accreditation.

Q4: Are provisional Accreditations from URAC valid?

A4: The Centers for Medicare & Medicaid Services (CMS) encourages issuers to refer to the 2016 Letter to Issuers at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf for a list of allowable statuses for each of the different Accreditation entities. As noted in the letter, CMS will consider issuers accredited if they meet URAC "full," "provisional," and/or "conditional" status.

Actuarial Value

Q5: How are Stand-alone Dental Plans (SADPs) to use the Actuarial Value (AV) Calculator for coinsurance default percentages?

A5: As established under 45 CFR 156.150(b), SADPs may not use the AV Calculator. SADP issuers determine the level of coverage using an actuarial certification from a member of the American Academy of Actuaries using generally accepted actuarial principles.

Data Integrity Tool and Review Tools

Q6: Are off-Marketplace only submissions able to use the Data Integrity Tool (DIT)?

A6: DIT checks do not apply to plans that are offered only off the exchange. Any off-Marketplace plans imported into the DIT will be ignored.

Q7: Are issuers that solely offer Stand-alone Dental Plans (SADPs) off-Marketplace required to use the Data Integrity Tool (DIT)?

A7: Issuers offering only off-exchange SADPs should not use the DIT, as the tool validations are not designed to check for off-Marketplace plans.

Q8: Is the Meaningful Difference Tool applicable to Stand-alone Dental Plans (SADPs)?

A8: No, the Meaningful Difference Tool is not applicable to SADPs.

Q9: Is the new Summary of Benefits and Coverage (SBC) Examples Calculator available to calculate additional scenarios for 2016 SBC calculations?

A9: The SBC template that the Departments of Health and Human Services, Labor, and the Treasury issued in connection with the Dec. 30, 2014 proposed rule is proposed and not authorized for use. Issuers should use the SBC template that is currently authorized for use. This template contains two coverage examples, having a baby and managing type 2 diabetes, and is available in Word

format on the CCIIO web page at http://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Summary of Benefits and Coverage and Uniform Glossary.

In addition, because a third coverage example is not a part of the currently authorized template, issuers and group health plans are permitted to continue to use the calculator tool that has been created to complete the two existing coverage examples.

Drug Count

Q10: When must issuers have a live formulary Uniform Resource Locator (URL)?

A10: The formulary URL must be submitted during the Qualified Health Plan (QHP) Application process to validate the pharmacy template. The formulary URL must be functional at the time of QHP Agreement Signing.

Q11: Is the Rx Norm a resource for the RxNorm Concept Unique Identifiers (RxCUIs)?

A11: Yes, issuers may download the Rx Norm for a list of RxCUIs from either the National Library of Medicine website at: http://www.nlm.nih.gov/research/umls/rxnorm/ or on CCIIO's website in the drug count tool at: http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html.

Essential Community Provider

Q12: Must issuers use the Centers for Medicare & Medicaid Services (CMS) version of the Essential Community Provider (ECP) Supplemental Response Form? If issuers must use the CMS version and there is no header, should issuers create a header to include the State, Health Insurance Oversight System (HIOS) ID and Network ID?

A12: Issuers must use the CMS version of the ECP Supplemental Response Form available at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. CMS recommends issuers include the State, HIOS ID, and Network ID in the text portion of the response at the top of the form. This information does not appear as an entry field on the form, because the information appears on the Qualified Health Plan (QHP) Application. When uploading the form in the Issuer Module, the module will link the QHP Application to the Issuer ID.

Q13: Must an issuer's provider contract with an essential community provider be exclusive to the Marketplace?

A13: While an issuer's contract with an essential community provider need not be exclusive to the Marketplace, the contract should include Marketplace requirements pertinent to the provider's contractual arrangement with the issuer.

Network Adequacy

Q14: Must an issuer apply Provider Directory tiering methodology across the issuer's network?

A14: Yes. Provider directory requirements are established in 45 CFR 156.230(b). Specifically, we require Qualified Health Plan (QHP) issuers to publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, and the Office of Personnel Management (OPM). As part of this requirement, the QHP issuer must update the directory information at least once a month, and that a provider directory will be considered easily accessible when the general public is able to view all of the current providers for a plan on the plan's public Web site through a clearly identifiable link or tab without having to create or access an account or enter a policy number. The general public should be able to easily discern which providers participate in which plan(s) and provider network(s) if the health plan issuer maintains multiple provider networks, and the plan(s) and provider network(s) associated with each provider, ***including the tier in which the provider is included***, should be clearly identified on the Web site and in the provider directory. The network adequacy template that is submitted during the certification process does not collect information about tiers and for that template issuers should include all providers they consider "in-network".

Q15: Where can issuers locate a precise explanation of the machine-readable standard for provider directories?

A15: CMS released a PRA package on March 30, 2015, for a 60-day comment period, which can be found at http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10558.html?DLPage=1&DLSort=1&DLSortDir=descending. The Centers for Medicare & Medicaid Services (CMS) intends to seek feedback from issuers, States and other stakeholders prior to finalizing the requirements.

Q16: Must issuers provide consumers with an electronic copy or hardcopy provider directory? Must issuers print new provider directories monthly or only update the website?

A16: Issuers must provide consumers with a copy of the provider directory on the website. Issuers must also provide a hard copy upon request.

The provider directory must be current and updated at least once a month. This requirement applies to both print and electronic directories.

Q17: May issuers provide customers with a Uniform Resource Locator (URL) to a provider list search tool and another link within the search tool for the Provider Directory?

A17: The Centers for Medicare & Medicare Services (CMS) prefers issuers to provide customers with direct links to Provider Directories and in general to provide access with as few links as possible.

Stand-Alone Dental Plans and Pediatric Dental

Q18: Do 2015 Stand-alone Dental Plans (SADPs) sold outside the Federally-facilitated Marketplace seeking recertification for 2016 need to resubmit all application materials?

A18: Issuers seeking recertification, including SADPs sold outside of the Marketplace, should submit all information required under the 2016 QHP Application.

Q19: Can the Centers for Medicare & Medicaid Services (CMS) provide guidance whether off-Marketplace Stand-alone Dental Plans (SADPs) can use the same Plan and Product IDs that were used in 2015, and recertify the same IDs, or create new plans?

A19: Issuers should use the same HIOS Plan ID if the same plan was offered in the previous plan year and remains available for the upcoming 2016 plan year.

In the 2015 Letter to Issuers in the Federally-facilitated Marketplaces (2015 Letter to Issuers), we indicated that we will apply the guaranteed renewability standards to determine whether a plan offered in 2014 is the same plan for purposes of recertifying the plan for sale in 2015 through the Federally-facilitated Exchange, and that this standard would also apply to the determination of whether SADPs are being renewed for purposes of recertification.

This is merely using the uniform modification standard for the purpose of identifying SADPs that can be recertified and renewed, rather than certified as different plans from those that were Exchange-certified in 2014.

Q20: How can off-Marketplace Stand-alone Dental issuers offer products on the Marketplace?

A20: Stand-alone Dental Plans (SADPs) must complete a Qualified Health Plan (QHP) Application and have that application approved to participate on-Marketplace.

Q21: How should Stand-alone Dental Plan (SADP) issuers report the Essential Health Benefit (EHB) allocation amounts?

A21: Issuers must refer to Chapter 15 instructions for guidance on allocation amounts, online at: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter15StandAloneDentalPlan-Ver2-033015.pdf

Q22: Does the Centers for Medicare & Medicaid Services (CMS) require embedded Pediatric Dental benefits for off-Marketplace plans?

A22: The Affordable Care Act does not provide for the exclusion of the pediatric dental essential health benefit (EHB) outside of the Marketplace, as it does in section 1302(b)(4)(F) of the Affordable Care Act for qualified health plans (QHPs). Therefore, individuals enrolling in off-Marketplace coverage must be offered the full ten EHB categories, including the pediatric dental benefit. However, in cases in which an individual has purchased stand-alone pediatric dental coverage offered by an Exchange-certified stand-alone dental plan, that individual would not have to purchase a plan with the pediatric dental benefit embedded. This alternate method of compliance is at the option of the medical plan issuer, and would only apply with respect to individuals for whom the medical plan issuer is reasonably assured have obtained pediatric dental coverage through an Exchange-certified stand- alone dental plan. If the issuer does not have this reasonable assurance, it must embed the benefit.

Service Area/Network

Q23: Does the Centers for Medicare & Medicaid Services (CMS) allow issuers to have counties in more than one Service Area?

A23: Yes, CMS permits issuers to include the same county in more than one Service Area ID.

The Service Area of a QHP or SADP is the geographic area in which an enrollee could access services and be covered under that particular plan. Issuers identify their Service Areas by state or by one or more counties within a state. Counties may be included in more than one Service Area.

QHPs and SADPs may not use the same service areas. Dual product issuers offering QHPs and dental plans must create two different Service Area IDs for use with the two plan types regardless of whether the Service Area is intended to serve both QHPs and dental plans. However, within the

coverage type (QHP or SADP) multiple plans and products may be included in the same service area. A different Service Area ID is not required for each product within a county.

Note that a plan may only be associated with a single service area.

Other

Q24: May Multi-State Plans (MSPs) appear under the same Product ID as a Qualified Health Plan (QHP)?

A24: Yes, as long as the products share the same benefits. Issuers participating in the Multi-State Plan (MSP) Program are required to complete a separate template for their MSP options and follow a different submission process. The Centers for Medicare and Medicaid Services (CMS) recommends that issuers contact the Office of Personnel Management (OPM) for guidance.

Q25: Are plan design modifications allowable during the third quarter or only rate changes?

A25: Issuers cannot make plan design modifications during the middle of a plan year. Small Business Health Options (SHOP) issuers can make quarterly rate changes for any prospective quarter, during quarterly data change windows.

Q26: Does Chapter 16 regarding the supporting documentation naming convention requirement apply to State Partnership Marketplaces in which the State requires a different naming convention for supporting documentation?

A26: Issuers are not required to adhere to the naming convention. However, the Centers for Medicare & Medicaid Services (CMS) highly recommends that issuer use the naming conventions in Chapter 16 to ensure CMS properly receives justification forms. Chapter 16 instructions can be found at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Chapter16Justification-Ver1-021315.pdf.

System

Health Insurance Oversight System (HIOS)

Q27: Where can issuers locate instructions and guidance for creating Health Insurance Oversight System (HIOS) Plan and Product IDs?

A27: Issuers may locate the HIOS Portal User Guide on the Center for Consumer Information and Insurance Oversight (CCIIO) website at http://www.cms.gov/CCIIO/Resources/Files/faq_plan_finder_data_entry.html.

Q28: Where can issuers locate the billing address filed in the Health Insurance Oversight System (HIOS)?

A28: Issuers will use HIOS to provide insurance company and product information, such as issuer names, addresses, contact information, and product level data.

Template

Accreditation Template

Q29: For the Product IDs on the National Committee for Quality Assurance (NCQA) Revision Template, must issuers include Product IDs that issuers will offer in 2016?

A29: Yes, issuers must include the 2016 Product IDs. However, issuers are only required to include a single Product ID per Market type.

Q30: Must issuers that offer two separate products types include the product types on separate rows within the National Committee for Quality Assurance (NCQA) Template?

A30: Yes, issuers that offer two separate products types must include the product types on separate rows within the NCQA Template.

Q31: Must issuers wait until the receipt of a new National Committee for Quality Assurance (NCQA) certification expiration date prior to uploading templates?

A31: No, issuers should complete the Qualified Health Plan (QHP) application process using current NCQA expiration dates.

Administrative Template

Q32: Is the Administrative Template a requirement for issuers that file with System for Electronic Rate and Form Filing (SERFF)?

A32: In SERFF, issuers must include an Administrative Template. Issuers must include the same template for all binders if there are Individual and Small Group plans. In addition, issuers must complete two customer service fields in the Health Insurance Oversight System (HIOS). The Administrative Instructions found at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html provide additional information on completing the HIOS fields.

Benefits Template

Q33: On the Plans and Benefits Template on the Cost Variance tab, there is an in-network, out of network, and a combined in and out of network deductible. Is the combined in and out of network deductible not applicable if the two fields are genuinely separate fields and the Maximum out-of-pocket (MOOP)?

A33: Yes, if the in-network and out of network deductibles are not combined, issuers should enter 'Not Applicable' for the combined in and out of network deductible field. This entry indicates that the in network and out of network values are separate fields. Please refer to section 4.15 of "Chapter 10: Instructions for the Plans and Benefits Application Section" for guidance on entering MOOP and deductible information (located here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html).

Q34: On the Plan and Benefits Template, how are issuers to enter a plan with a deductible equal to the out-of-pocket maximum, with the plan paying 100% once the deductible is met?

A34: The Centers for Medicare & Medicaid Services (CMS) recommends that issuers enter that the plan has a deductible equal to the maximum out-of-pocket amount.

Q35: Does the guidance for Summary of Benefits and Coverage (SBC) Uniform Resource Locators (URLs) apply to Small Business Health Options Program (SHOP) plans?

A35: Issuers should link directly to plan-specific SBCs for plans they intend to offer in a Federally-facilitated Marketplace (FFM) for the individual market and those in a Federally-facilitated Small Business Health Options Program (FF-SHOP) for the small group market.

Q36: Is it permissible for issuers to have some indicator of Actuarial Value (AV) level within the Plan Brochure URL?

A36: Issuers should link URLs directly to all plans and plan variations. The link for each plan may include information for that plans AV level. Please refer to section 4.24 of the "Chapter 10: Instructions for the Plans and Benefits Application Section" for guidance on linking URLs to plans (located here: http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html)

Q37: May issuers provide customers with one Summary and Benefits and Coverage (SBC) Uniform Resource Locator (URL) to all available SBCs rather than linking directly to one specific SBC?

A37: Issuers should link directly to plan-specific SBCs. The Centers for Medicare & Medicaid Services (CMS) also expects that issuers will provide links directly to SBCs for cost sharing reduction (CSR) plan variations as defined in the 2016 HHS Notice of Benefit and Payment Parameters. Issuers should also ensure that prospective enrollees can view the relevant information without logging on to a website, clicking through several web pages, or creating user accounts, memberships, or registrations.

Q38: Is the Plan Brochure Uniform Resource Locator (URL) a required field on the Cost-Share Variance tab of the template or may issuers not input a URL in that field?

A38: The Plan Brochure Uniform Resource Locator (URL) is an optional field on the Cost-Share Variance tab of the template. This field may be used by issuers to clearly communicate any cost sharing and other information not displayed by Plan Compare that consumers need to understand when shopping for insurance coverage.

Business Rules Template

Q39: Why is there a requirement for QHPs to enter age "25" and not "26" under field "F" of the Business Rules Template?

A39: In the Business Rules Template, the age entered in the field for maximum age of a dependent is inclusive *through* that age (25), rather than up to that age. Market rules require Qualified Health Plan (QHP) issuers that make available dependent coverage of children to make such coverage available for children until attainment of age 26 (e.g., through the age of 25).

Q40: Must issuers in State-based Marketplaces (SBMs) submit Service Area, Formulary, Business Rules, Administrative and Network Adequacy templates through the Health Insurance Oversight System (HIOS) for on and off-Marketplace products?

A40: Issuers in State-based Marketplaces (SBMs) should confer with their State Departments of Insurance (DOI) regarding certification data submission requirements.

Q41: Are issuers to list both the copayment and the coinsurance for the greater of or the lesser of the copayment and the coinsurance on the Plans and Benefits Template?

A41: The 2016 Business Rules Template does not allow issuers to capture the greater of or the lesser of the copayment and coinsurance data. Issuers may capture the cost-share design on the Plans and Benefits Template in the explanation field or on the Plan Brochure and Formulary Uniform Resource Locator (URL).

ECP Template

Q42: May issuers select more than one Essential Community Provider (ECP) category on the ECP Template for a single provider if that provider has indicated that it provides both categories of services, even if only one type of service is reflected for that provider on the HHS ECP list?

A42: Yes, if the provider indicates to the issuer that it provides two different types of services that are options within the ECP template dropdown menu, issuers may select both ECP categories even if the HHS ECP list reflects that the provider provides only one type of service.

Q43: Can issuers satisfy the Essential Community Provider (ECP) category requirements by offering a contract in good faith to at least one ECP per ECP category per county in the plan's service area?

A43: Yes, to satisfy the ECP category requirement, issuers must offer a contract in good faith to at least one ECP per ECP category per county in the plan's service area. However, for purposes of issuer satisfaction of the ECP 30 percent threshold requirement, only fully executed contracts count toward satisfying the 30 percent threshold.

Q44: How can issuers identify the type(s) of services provided by Essential Community Providers (ECPs) listed in the "other" category on the ECP list?

A44: As outlined in Table 11 of the 2016 Payment Notice, the "Other ECP Providers" category includes STD Clinics, TB Clinics, Hemophilia Treatment Centers, Black Lung Clinics, Community Mental Health Centers, Rural Health Clinics, and other entities that serve predominantly low-income, medically underserved individuals. As CMS strengthens the ECP list, we anticipate collecting

additional information from providers that results in fewer ECPs falling in this "Other ECP Providers" category in future years.

Q45: How must issuers with embedded dental products enter the dental provider type on the Essential Community Provider (ECP) Template?

A45: Issuers, including both Stand-alone Dental Plans (SADPs) and plans with embedded dental products, must select "Other ECP Provider" from the ECP category column on the ECP Template to reflect providers that provide dental services.

Q46: On the Essential Community Provider (ECP) Template, are multiple suite numbers for a single billing address considered different billing addresses?

A46: No, if two providers share the same street address with different suite numbers, the two providers count only once toward satisfaction of the ECP 30 percent threshold requirement.

Q47: May issuers use underscores instead of dashes to indicate a provider with multiple practice locations on the Essential Community Provider (ECP) Template?

A47: If the ECP has multiple locations using the same provider name, issuers must add a three-digit number to the provider name to distinguish each location (e.g., Provider Name-001). Issuers must use dashes and not underscores. Using a dash will ensure that the ECP tool correctly identifies each ECP as unique.

Network Adequacy Template

Q48: For the purposes of the Network Adequacy Template, how does the Centers for Medicare & Medicaid Services (CMS) define physician and non-physician?

A48: CMS defines a physician as an individual who holds a license(s) to practice medicine such as Medical Doctor (M.D.), Doctor of Osteopathic Medicine (D.O.) or Doctor of Dental Surgery (D.D.S.).

Q49: Does the Network Adequacy Template require issuers to complete Tier Levels?

A49: At this time, the Network Adequacy Template does not require issuers to complete Tier Levels.

Prescription Drug Template

Q50: How should a benefit appear on the Prescription Drug Template that has a percentage with minimum copay and maximum copay?

A50: The Prescription Drug Template does not allow for minimum or maximum copays and coinsurances. Issuers should complete all fields in the Prescription Drug Template for the most typical or most utilized method. Issuers can describe any nuances to their plan design and cost sharing features that do not directly fit into the Prescription Drug Template in the Explanations field of the Plans & Benefits Template or in plan brochure and formulary URL, and include the information on the Summary of Benefits and Coverage (SBC) which are linked to Healthcare.gov.

Q51: On the Prescription Drug Template, will the co-pay display differently to the consumer depending on which option issuers choose, "'no charge" co-pay or $0.00 copay?

A51: The Prescription Drug Template will validate regardless if the copay is $0.00 or "No charge." Cost sharing data from the Prescription Drug Template will not be visible to consumers on HealthCare.gov. The cost sharing data will be pulled from the Plans and Benefits Template. HealthCare.gov only displays the formulary URL and the Yes/No option of the three-month mail order benefits offered from the Prescription Drug Template.

Q52: Should issuers create formulary IDs within the Prescription Drug Template for variant plans, although the IDs are not incorporated into the Plans and Benefits Template?

A52: Only one formulary ID may be associated with a Plan ID. The cost sharing differences for the variants should be reported in the Plans and Benefits template and the Plan Brochure.

Q53: For the Prescription Drug Template, must issuers provide a balanced billing explanation for out-of- network retail pharmacy benefits?

A53: No, the Prescription Drug Template does not have an explanations field. Please describe any cost-sharing features that do not directly fit into the Prescription Drug Template in the Explanation field of the Plans & Benefits Template or in a plan brochure and Formulary URL.

Q54: Must an issuer use the Prescription Drug Template for both Individual and Small Group plans?

A54: Yes, for plans with a prescription drug benefit, issuers must include both Small Group and individual plans in the same Prescription Drug Template when submitting to HIOS. In states that

collect templates in SERFF, issuers may submit separate sets of templates for Individual and SHOP plans.

Q55: May issuers continue to enter the copay amounts and then refer to the Plans and Benefits Template to identify whether or not the copays are subject to deductibles?

A55: No, issuers should use the updated copayment and coinsurance options, which include subject to deductible options, in the 2016 Prescription Drug Template. If copays and coinsurances are subject to deductible, please use the options in the copayment and coinsurance fields that contain deductible considerations. Please describe the cost sharing details that are not captured in the Prescription Dug Template in the Explanations field of the Plans and Benefits Template and in the Plan Brochure and Formulary URL.

Q56: How are issuers to proceed with Formulary IDs that are entered into the Prescription Drug Templates that are not used for Qualified Health Plans (QHPs)?

A56: It is recommended that issuers delete any Formulary IDs not associated with a Drug List. The Prescription Drug Template will validate with Formulary IDs that are not used for QHPs. Issuers should also delete any unused drug lists from the Prescription Drug Template.

Q57: What are some possible causes for Formulary Tier errors on the Drug List tab?

A57: If the Tier Level column in the Drug List worksheet contains text rather than numbers the issuer will receive an error when the template tries to validate. One fix is to copy the Tier Level column into a blank workbook, convert the text to numbers, and then paste (not paste values) those numbers back into the template.

If there is a Formulary ID in the Formulary Tiers worksheet linked to a Drug List as defined in the Drug List worksheet, and the Formulary ID and Drug List have a different number of tiers, then the issuer will receive an error when the template tries to validate.

Unified Rate Review Template

Q58: Have the Centers for Medicare & Medicaid Services (CMS) released the final Unified Rate Review Template (URRT)?

A58: Yes, the final URRT and instructions are on the Center for Consumer Information and Insurance Oversight (CCIIO) website at: http://www.cms.gov/cciio/Resources/forms-reports-and-other-resources/index.html#Review of Insurance Rates.

Other

Q59: May issuers submit incomplete templates if final guidance and tools are not available prior to the submission deadline?

A59: Issuers should submit templates using the most recent guidance and tools that are available. Current tools and instructions can be found at http://www.cms.gov/cciio/programs-and-initiatives/health-insurance-marketplaces/qhp.html. Issuers should not submit templates with blank fields per the data element requirement for submissions.

Other

Q60: Where can issuers locate Payment Notice Frequently Asked Questions (FAQs) and product definitions?

A60: Frequently Asked Questions (FAQs) regarding the HHS Notice of Benefit and Payment Parameters for 2016 are located at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/2016-PN-Fact-Sheet-final.pdf. The "Payment Notice" itself is available at http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.