CGI TECHNOLOGIES AND SOLUTIONS, INC.

Moderator: Andrew Adrian-Karlin
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Operator: Good afternoon, my name is (Angel) and I will be your conference operator today. At this time, I would like to welcome everyone to the RBIS individual and family plan training call. All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

I would now like to turn the call over to our host, Mr. (Joe Mercer). Sir, you may begin your conference.

(Joe Mercer):   Thank you. How are you folks? Good afternoon. Welcome to our first individual and family technical training. Just a few announcements before we get started. Obviously, we have this training today. There will be a repeat of this training on Wednesday morning at 10 am. The details are in your memo and we will still have our scheduled issuer call next Wednesday at two pm. I would like to also announce the user manual will actually go up at the end of the call, so it should be available for you as soon as we get finished up here. And with no further ado, I would like to turn things over to Andrew Adrian-Karlin who will be doing the training. (Andrew)?

Andrew Adrian-Karlin: Thanks, (Joe). Well, here's the training that we've all been looking forward to. So starting off on the agenda, introducing the call, we'll go through a brief process summary on the individual and family process in RBIS, discuss this mission materials page, the templates, go into a bit of detail

on the business rules, then cover upload and system validations, user validations and attestations and finally, information about the help desk and any questions that you may have.

So what is RBIS individual and family plan edition? RBIS is collecting plan level, not product level, this time it's plan level, individual market rates and benefits for display on healthcare.gov. So we're collecting both rates and benefits as opposed to just benefits in small group. Access to RBIS is going to be through the (inaudible) home screen with your (inaudible) user account. For those of you who have different individual and small group users, please be aware that RBIS does differentiate. So if you have a different set of small group submitters or validators, then your individual validators, you're going to need to use your individual validators and submitters this time. And finally, RBIS is collecting individual data in a very similar manner to how small group was collected. It's roughly the same process; you'll see screens that are very familiar if you've worked on small group before.

Pre-populated templates will be provided as of Monday, the 5th for download from RBIS with plan IDs. The templates should be completed and submitted RBIS for process through system validation and submission starts on the 12th of December. The templates that were provided to you earlier, Version 1.0, have been superceded by Version – the most recent version, 1.3 and there have been a couple of issues that have been resolved. So we strongly recommend that on Monday you go ahead and download the pre-populated templates and you transfer any data from the current templates that you're working off of into the most recent templates. Obviously, if you prefer to use blank templates, we'd recommend that you download the blank templates on Monday and move your data over there.

The process, the post submission process is very similar. There is both validation stages one and two. An attestation will be available when all issuers for an attester have uploaded and completed system validation and only system validation. It is not dependent on user validation and user validation will be available when an issuer assigned to that user – assigned to the validation user gets uploaded. So once that issuer is uploaded and past the system validations, they will available for user validations.

The submission materials screen is very similar to the submission materials screen that you saw for the small group. And we use the same tab structure that was in small group. The difference being that now you can see is there under the tab; there are options for the individual versus small group versions of these tabs. So in this case where it – (inaudible) the individual submission materials screen and it has user manual available for download. There are links available for pre-populated and blank benefits templates and we strongly recommend that you download and save the templates locally. If the templates are not saved locally to your machine, your desktop, my documents, C, wherever, if they aren't saved locally, then the validate and finalize process will not work successfully. So when you click on that link and it says, you know would you like to save? Please save it somewhere on your machine.

So once you've downloaded your templates, the first template I'd like to discuss is the benefits template and it's very similar to the small group benefits template. Most of the fields are required with a few exceptions. The plan effective date field is not required and the brochure URL field is not required as well. The brochure URL field is an optional field if you want to specify a plan level URL. So if you put one in, it will supercede you (inaudible) product level brochure URL and so it will be shown in place of that. If you do not put one in, then the brochure URL that you submitted for the product in (inaudible) will be displayed. As with all the other – as with the templates for small group, they'll be uploaded on an issuer basis. So on these you'll need to fill in all plans for your issuer before you submit it. They can accept multiple issuers, but you cannot bring a single issuer across multiple templates.

When you download a pre-populated benefits template, it will have your list of issuer IDs, a list of product smart IDs and then a pre-populated set of plan IDs. If you need more plan IDs than are provided, please contact the help desk, we can issue you new plan IDs relatively quickly – additional plan IDs. If you need less than are listed for a product, please go ahead and delete the row. Please don't hide it, the validate and finalize process does not recognize hidden rows, so it thinks that those rows are there and if blank rows are left in, the system might not realize that there is data continuing below. So if you are

not using a set of plan IDs, please go ahead and delete those plan IDs from the template. Just go ahead, delete the row.

Additionally, copy and paste values – copy and paste, we're recommending that you use copy and paste value. Similar to the (inaudible) templates and the small group templates, these templates have a number of macros inside them and if you use the standard copy and paste functionality, the Excel carries the macro over. So the example we ran into when we were playing around with these was if we copy product smart ID into plan ID and then we try and enter a plan ID at the end of it, what Excel thinks is that the – is that it's looking at the product's smart ID field. So it can cause errors, it can cause Excel to reject valid data, it can cause Excel accept it if its invalid. So again, we're recommending that when you go ahead and you copy and paste inside these documents, you use copy and then you paste value, which is one of the paste options in Excel.

Additionally, we'd ask that when you use the fill handle, which is – it's an option if you use it. It's at the bottom right of a selected Excel cell. It allows you to drag down values. Be careful in how you're using that. It tends to increment up so if you have the number one in the first cell, it will turn that into the number two and the next cell to number three and the cell after that. Please watch that closely.

With those warnings aside, it's very similar to how you filled out the small group benefits – or the small group benefits template. Each of those different columns has drop down options or has the option for you to enter data. And speaking about one of the cells specifically, for annual max benefit, there is not an option to enter none only number values and so if you need to enter a none, please enter 999 999 999, basically $1 billion minus one. That will indicate to us that you don't have an annual max benefit and we'll go ahead and ignore that.

And I think that wraps up all of the items that I had to discuss on the benefits template. There are a significant number of columns, as you've seen, but it should be relatively straightforward to use. Once you complete filling it out, please go ahead and validate it to ensure that you don't have any issues.

Validate and finalize and the finalized file will be created. The individual templates are finalizing in a different format than the small group template, so the icon might look a slight bit different, but it will go ahead and finalize in the same manner.

The next template I'd like to discuss is the regions template and it's the same as small group in format. So you have your issuer ID, your region, your zip code, (inaudible) or county and the state abbreviation. And you can go ahead and you know enter regions on as granular a level as you know as county and zip code combination where it only shows or where it only reflects the area inside both the county and the zip code or at as high a level as the entire state. And region numbers are on issue basis – on an issuer basis. The pre-population is pulling the data from CMP, from the CMP individual submission for issuers and we have filtered out invalid zip codes and invalid county codes, invalid zip and county combinations ahead of time because we know that that was a pain point that a number of issuers ran into. So we ask that you check the pre-populated region template closely.

Additionally, because we're pulling from that data instead of from the (inaudible) data, you'll see a row listed for each combination of zip code and county because that was the data that we pulled from CMP. So if you want to indicate the entire zip code instead, again you can delete specific parts of that or delete the entire row and then the system will accept it. So that's the basics on the regions template. Again validate, validate and finalize and the finalized template should be available for submissions.

So one addition to individual and probably the most complex addition is the business rules and rates. The business rules and rates allow us to calculate an estimated base rate for you based on what users input on healthcare.gov. It's very similar to how CMP approached except that we're using the business rules template to dictate how we should do this calculation. The business rules template is done on a per issuer basis, so you only need to enter one issuer ID, one row per issuer ID and fill out the various questions. This can get extremely detailed, so I'll be briefly touching on a few of the items. But appendix A of the user manual has very detailed tables, examples and text about the dependencies between each of these cells, what's optional, what's

required and the meaning of each of the items and how that can impact the way we calculate, the formula that we use, basically what rates we select when a user enters data on healthcare.gov. So I would strongly recommend that you go ahead and after this call, download the user manual and go ahead and read appendix A.

The rates template is much more granular and it has two sheets when you down the pre-populated version. The first sheet, like you see here, is the data entry sheet and the second sheet has plan IDs. The plan IDs are available for you to copy and paste value into the actual data entry sheet when you're filling it out to go ahead and enter your combinations of plan ID, date, age, gender, tobacco use, region and then the rates and then in the columns for each of those combinations, the specific rates. We recognize that this gets to a very granular level on the rates template and as a result, we allow you to go ahead and add a sheet. If you see in the top – or top right side, right middle of the example that we're showing, if you go into the template and press the add sheet button, it will generate a new sheet for you to add more plans on to. So if you do have an issuer that you know you complete all the rows in a single sheet, press add sheet and just continue that issuers information on the next sheet. When the system validates and finalizes, it will all finalize into one file that RBIS will read as a single rates template. Again, you can't split an issuer across multiple templates, but you can split an issuer across multiple sheets and you can have multiple issuers in a single template.

One key item for all the templates and especially the rates template since the sheets will be added, you cannot change the names of the sheets. If you've changed the name on a worksheet inside the template, the validate and finalize will not work correctly. We get an error to the effect of there is no data for the system to validate. You want to avoid that because the finalized file will not be generated. You can't upload to RBIS. So please do not change the names of the worksheets. If you run into issues where you have, please reach out to the help desk and we can help try and revert the name of the worksheet, but please don't change the names of the worksheets.

So the items that – the first item I'd like to touch off of you know getting (inaudible) into the business rules, but again I would recommend that you read

appendix A of the user manual that contains the detailed information, is aggregate first group rates. So if you've looked in the rates template already, you can see that there are columns for primary, secondary, dependent for subscribers, as well as columns for primary, secondary you know – primary, secondary, two dependents and all of these different options. And that goes back to the first real question on the business rules template, how are rates for contacts covering two or more enrollees calculated?

So it's really a concept of aggregate first group rates. So if you select you know individual, then what RBIS will do is it will select you know let's assume a family of four, you know? Two adults, two dependents, it will select – as aggregate it will select you know primary, secondary, dependent one, dependent two based on the information entered about them that it looks up in the rates template. If you selected the group options, then what it will do is it will go and try and find the specific combination, so primary and secondary, plus two dependents. If the system does not find the rates listed that it needs to complete that calculation, then it won't display. And you know the opposite of that, of course, is if you've accidentally entered two rates that could cover a single individual, the system will go ahead and will select at random whichever one it sees first. So and that's going to be a key when you're entering your rates is checking to ensure that you don't have – accidentally put you know age range of 18 through 25 and then 25 through 30 because then if it looks up that specific you know 25 individual that has two possible rates, the system will pick whichever one it sees first.

But getting back to the discussion, so aggregate just adds up based on the other information in the business rules template. It adds up those dependents and the primary and secondary subscribers, where as group rates looks for the specific combination of the group that we're searching for as one of the subscriber columns. And again, I strongly recommend you read appendix A of the user manual. I think it's been laid out as very clearly and I think that this information might be more clear when read and when you can look at you know examples and tables and the like.

Data upload for individual is accomplished very similarly to you know small group. So you know you need to go into the data upload, again notice that

there's an individual link as opposed to the small group link below the tab. And then before you upload, you'll need to check to confirm that you upload (inaudible) product data and it's checking for that again. And the system can accommodate you uploading templates you know only a couple of templates for an issuer, but not all the templates for a single issuer. But we recommend strongly that you upload all of the templates for each issuer that you have at the same time. If you don't, you'll see that the stage two warning messages, saying for example, the system has checked and it sees that you know you've uploaded benefits template for issuer 12345, but you know there's no regions information that you've shown.

And double check the template type that you select from the drop down, so you browse, select your finalized file, then you select the template type from the drop down and then press upload. Double check the template type that you select, if you enter regions from the drop down and you're uploading a benefit – a finalized benefit file, that's going to error out because the system will do the checking for a regions template and obviously, a benefits template won't look like a regions template and won't have the necessary data and the system will – and RBIS will throw an error. If you do run into one of those issues, just go ahead and re-upload and correct you know the drop down selection and you shouldn't have any issues.

View uploaded files is again very similar to small group. You'll see your file names, your template type and submission date and time listed and you'll have to scroll to the bottom to see your most recent uploaded files. So if you need to confirm that the file has been successfully uploaded in the upload files small group section, please go ahead and just (inaudible) view uploaded files – or sorry – uploaded files individual, just go to view uploaded files individual and scroll to the bottom and you should see that.

The validation process for individual is again very similar to the small group validation process. After you initially upload there is first a file format validation that checks each template one at a time and says, is the data here consistent with what I expect for this template type? Is the data complete? Does it match the answers that the system expects to see for that template? If it doesn't pass that, then that fails out, the data doesn't get loaded and you

receive and e-mail back to you saying there are errors, please correct – back to your submitters, I should say. If it passes that, then it waits for the schedule to run the cross check validation and that's when the system checks to see if – you know if for any of the issuers that you've uploaded, if they have all of the different types of data. So make sure that it has benefits, business rules, regions and rates, all of those.

If the system finds that there's no rates data, then you'll receive a warning message and all of the rest of that issuer's data will sit more or less in limbo until there is you know the appropriate data uploaded to complete that. You'll receive – your submitters will receive a warning message for that if it occurs.

Following the happy path, you know if you pass all of those validations, then the issuer will be ready for you know validation and the submitter will receive notification that you know they have successfully submitted for the issuer and the validator will receive notification that validation is ready, that submission has uploaded successfully. Assuming again that you know all issuers for an attester have uploaded successfully, you know passed system validation, the attester will also receive an e-mail letting them know that attestation is available, please go ahead and log in to attest.

One item that turned out to be a bit of a pain point during the last validation was the warning message at the top of the screen. So I wanted to spend a few minutes discussing this. Just like small group, when you get to the validate data page for the individual market, if data has not been successfully uploaded for all issuers associated with the validator, they'll see this warning message and so warning, note, data's been received for you know these issuer items. If there is not going to be any data uploaded for those issuers, this is how you free up your attester to go in and attest. You select the check box and agree to the warning. If you just haven't completed uploading data for those issuers yet, you want to wait on that and then this warning message will go away for those – for the listed issuers once data has been successfully uploaded and passed system validation.

Again you know if an attester has you know 50 issuers associated with them, 49 are uploaded successfully and that last one hasn't been uploaded, you know whether the – if it's not going to be submitted, the system doesn't

realize that and so you need to go ahead and select the check box and agree to the warning for your attester to be able to you know attest to the issuers. You know if data is going to be uploaded, you want to wait until it gets uploaded and then it will be free for your attester. But the warning just means that the system recognizes that there is no data that's been uploaded and it's just wondering if you know if you plan to upload the data. After – if you are using this, after you complete the warning, you'll see that the message is at the bottom. Warning you've indicated that there is no data report for the following issuer IDs and that just indicates that you said we are not uploading data for these issuer IDs. That is the top of the first data validation page. So validate all products for an issuer.

Similar to small group, below that warning message it allows you to download a CSV file of the benefit details for all the issuer IDs. Below that it has a multi select check box that allows you to pull up you know for a single issuer or multiple issuers the benefits information. And so I've pulled up data for this issuer 57763 and you can see that the plan IDs are listed, the product IDs, the attestation status for the entire issuer, production status, we have deductibles listed as well as a link to see the benefits pop up box. Similar to small group, click on that and it pulls up a popup box with all benefits information for the issuer. And then finally, there is the validation status radio buttons. So to indicate that you are validating you know positively to a plan, you select yes or if you want to validate yes to all plans under an issuer, you select yes up in the header box on that radio button which will switch all the radio buttons in the table over to yes and then press submit and the system will record that you've validated positively to the plans. That is the first page that you can validate using.

The second page is validation scenarios and this is again similar to small group. So we have the same you know select issuer IDs, multi select, zip code and when you pull that up, it asks for a county and then coverage effective date. But one additional change because this is individual is that we have the healthcare.gov you know family options listed. So you need to enter at least one primary, (inaudible) gender, date of birth, tobacco status and it allows you to enter all the other combinations you can enter on healthcare.gov, so who is the secondary, you know who are the children. And then you know once you

submit that, the system runs through the same process it would for healthcare.gov and it pulls up all of the individual market results, as well as the base rate that the – that's been estimated to be calculated. So again you can use this to validate as well and it has the same radio buttons and the same submit button at the bottom of the page to finalize the validations that you've made. So the validation is that is one of the two necessary pieces.

And resubmission is at an issuer level again and it will overwrite any previously submitted data. So again if you have a validator that's validated a few products or plans and you resubmit the entire issuer, again you know you can't resubmit only a few plans or products under an issuer. Each time you resubmit, you need to resubmit all of the plans for an issuer because it's overwriting and the validation status gets reset for the entire issuer. So your validator will need to go in and re-validate each of the plans under that issuer. Validation is at the plan level whereas submission is at the entire issuer level. Attestation, on the other hand, only needs to be completed once per submission window. So once all of those issuers are submitted successfully and pass system validation, but then you know your attester goes in and signs and resubmission will not reset that. It's just – should be straightforward, it's done, taken care of.

Speaking of attestation, you know if your attester hasn't – doesn't have all of the issuers listed for them as submission complete or you know had a validator going for the remaining issuers that have not been submitted indicating that the issuers won't be submitted, then the – if they log in, they'll see this screen; data attestation unavailable. And it will list their issuer IDs and you know whether submission has been completed and whether there's no data available. Once that you know submission for all of the issuer IDs is complete and/or you know for the remaining issuer IDs, it's been indicated there won't be any data submitted and the attester will receive an e-mail along with the validators and they'll be able to come into the same screen that you saw in small group. Obviously, you know it will have individual issuers listed with submission complete and they have you know the language where go ahead and read it, fill in the electronic signature and then press the attest button. Once they've gone ahead and done that, they'll be taken to this data attestation complete screen and they will also receive an e-mail indicating that

attestation has been completed. So you know we know that (inaudible) that you made during small group and we are you know allowing – we are sending an e-mail out once attestation has been completed.

Finally, the RBIS help desk is available at the same times and same phone number. So 8:30 am to 7:30 pm Eastern Time Monday through Friday and you see our phone number and e-mail address listed. In addition, we are providing support from nine am to five pm on Saturday the 17th of December. We're offering extended support that weekend before the submission window closes. And please get in touch with us if you need any help or have any issues with RBIS.

Quick recap. You will need to just like small group submit, validate and attest and all actions need to be completed during the submission window. So you know it needs to be completed between the 12th and the 23rd when the submission window is closing. And finally, attestation is not available until all issuers for an attester has submitted or have had it indicated that they – you know they're not going to be submitted. So with that, (Joe), did you have anything else that you wanted to mention?

(Joe Mercer):   No, I think we could go to questions.

Andrew Adrian-Karlin: Operator?

Operator: At this time, as a reminder, if you would like to ask a question, please press star one on your telephone keypad. And your first question comes from the line of (John Featherington).

(John Heatherington): Hello, it's actually (John Heatherington). But in Blue Cross of Idaho. I've got a couple of issues. We've looked over the benefits template and so I'll try to keep it focused and to the point. For our annual out of network, for the deductible, in and our of network we have a combined amount and we don't have an option to show that combined amount. How would you like us to indicate it? This would be columns K and L on the benefits template.

(Joe Mercer):   I believe for small group, we had you put the – what the deductible is, you know what the total is in both columns.

(John Heatherington): Correct. Would you like us to do that again?

(Joe Mercer):   Yes, please.

(John Heatherington): OK. And then for all of our individual product that are PPO, network based, so primary care provider really doesn't ring true for us. Are you essentially meaning a physician visit?

(Joe Mercer):   That's correct.

(John Heatherington): OK. And then habilitation services, is that occupational therapy? Or is that custodial therapy? How do you consider that? These would be columns CP and CQ.

(Joe Mercer):   One second. OK. For habilitation services, we're referring – that's referring to if you're just maintaining their – they're not like – they're not actually making anyone better. It's like – so it's whatever – basically, what we're trying to do with these, if it's a question like that, it's whatever is truest to you know how you actually do business.

(John Heatherington): OK. And to me that sounds like custodial care.

(Joe Mercer):   Yes, I think that that's fine.

(John Heatherington): OK. Again, reassurance that all of the coinsurance amounts are from a member centric perspective rather than an insurer or company perspective.

(Joe Mercer):   That is correct.

(John Heatherington): When we're talking about in coinsurance, it's – you know like a 20 percent amount as – OK. For copays after deductibles for – and pardon me, I believe that – we were dealing with drugs, do we have a copay after the deductible is met? And there's no option for AN, AP or AR? Those would be specialty drugs, non-preferred brand drugs and preferred brand drugs? So it – and there's no option that really makes sense (inaudible) …

Female: Because we have a deductible.

(John Heatherington): … because – yes.

(Joe Mercer):   I understand. What we're going to do that – what I'm going to have you do for that is submit that question to the (inaudible) help desk and I think you may have sent one, something like that before. We have some discussions on how we're going to drugs. I think that the way that people do drugs varies widely, so we're going to have to work on that on like kind of a case-by-case basis.

(John Heatherington): OK. Great. And then …

Female: (inaudible) payments not in network (inaudible) deductible and coinsurance (inaudible).

(John Heatherington): Right. So we don't have a co-payment out of network, but there's no option for providing that.

Female: Or for paying deductible and coinsurance.

(John Heatherington): Or for paying – yes, for paying deductible for the coinsurance.

Female: Yes.

(John Heatherington): And this is on column N.

(Joe Mercer):   OK. Let me make sure I understand what you're saying. So you're – you don't have anything. There's just – there's none?

Female: (Inaudible).

(John Heatherington): It's deductible plus coinsurance.

(Joe Mercer):   Oh, OK.

(John Heatherington): And there's not a deductible plus coinsurance option in that field. It's basically either a dollar amount or not covered, as opposed to some other arrangement.

(Joe Mercer): Well, what we're going to ask you to do with that is just put what's predominant in your – so if you don't have that, just put in what you do have even if it's not specific, it's as close as you're going to be able to come and that still represents what you guys do. And if you're still having trouble with that, that's another thing we can e-mail and I can work out specifically what you're trying to do.

(John Heatherington): Right. All right. And in fact, why don't we -- indeed I think for some of these other ones, we'll just go ahead and work through those and send that to the CCIIO.

(Joe Mercer): Great.

(John Heatherington): All right. Thanks.

(Joe Mercer): Thank you.

Operator: And your next question comes from the line of (Daniel Falcon).

(Daniel Falcon): Hi, guys. (Daniel Falcon), (inaudible) Health Plans. Real quick, you mentioned the pre-populated plan ID. I guess I want to understand it a little better. Are you giving us the amount of IDs that were on the CMP? Or is it just a certain amount of IDs? For example, one product might have two plans, but another one of our products might have 150 plans. So how do you guys know that? Or could you get into that just a little bit more?

(Joe Mercer): Sure. (Andrew), you want to take that one?

Andrew Adrian-Karlin: Absolutely. We didn't invest heavily in you know matching exactly the number of plans that were in the CMP. We know that for many of you, the plan counts have actually changed. So what we did was we tried to estimate above. So for products that we saw that had a large number of plans under them, we have sort of a high number of plan IDs that we assigned and then for all other products, we assigned sort of a mid level that we saw above the average. I think the mid level was something around 50. I think the high level was somewhere around 90. And again, it's really easy to either ask for more or to reduce the number; reduce the number by just deleting the rows

and you know ask for more by contacting the help desk and it's a really quick process for us to generate you more plan IDs.

(Daniel Falcon): OK. So you did look at some type of history from our previous submissions to kind of get a feel of how many plans we had then, correct?

Andrew Adrian-Karlin: Yes. I think getting a feel would be the right sort of terminology for it.

(Daniel Falcon): OK. OK. No and I understand if it's more, it's better if it was just deleted based on your instructions. So, OK.

Andrew Adrian-Karlin: Yes. We shot for over rather than under, so you know we should be …

(Daniel Falcon): Sure. Sure. OK. Thank you very much.

Andrew Adrian-Karlin: Yes.

Operator: And your next question comes from the line of (Mary Blair).

(Mary Blair): Hi, (Andrew). Thanks for the training, you did a wonderful job. I have a couple of questions. One of them has to do with what we submitted – what we'll be submitting for (inaudible). For individual, we're refreshing all of our zip codes. If we go and download the templates that will be available on December the 5th, should we wait on the regions template or will it reflect – what will it be reflecting for zip codes?

Andrew Adrian-Karlin: The regions template this time for individual will reflecting the data we got from CMP. So it will be the regions data that we have from CMP cleaned up. So we know that for many of you, you know referring to the group, there are a lot of issues with invalid zip codes or invalid zip code issuer or combinations, things of that nature. So we went ahead and practically got the CMP data listed for your issuers for the regions and then we cleaned it up by removing any you know invalid issuer and state combinations or removing any you know mismatches between where a zip code is and you know where a county is. So if a zip code and county didn't intersect and they were listed

together, we removed that listing and that's what we're providing pre-populated in the regions template.

So …

(Joe Mercer):   So (Mary), to answer I think your question is if you are redoing all of your zip codes in (inaudible) …

(Mary Blair):   Yes.

(Joe Mercer):   … then on the 12th, so you know the next Monday, we'll have new pre-populated templates for whatever you updated in (inaudible) whether it's region or anything else. So if you're anticipating making big changes with all your zip codes, I would say that waiting until you have everything in there and get the new pre-pop would save you guys a lot of time.

(Mary Blair):   Perfect. That's what we were planning. Thank you for confirming that. I have a couple of more questions. As far as the resubmission process, like (Andrew) explained, it's – we can do it from an issuer-to-issuer basis. So if one of our issuers requires a correction, we would then separate it out from the appropriate templates and submit it – resubmit it so that we could make the appropriate correction. For the other issuers, will they be negatively impacted? I know last time for small group it would cause the other ones to not be in the validation process. We had some bottlenecks there. So can you reassure us that when we go through the resubmission we won't have issues with any of our other issuers that we're not doing a resubmission on?

Andrew Adrian-Karlin: You know the issue that you're speaking about, we did fix. So I am confident that you know and we're testing to ensure that resubmission doesn't cause any issues.

(Mary Blair):   Yea. I have a couple of more questions. There is the benefit details, when we go in and do our validation, we sometimes like to compare plans and try to get the most. I think you mentioned that we'll be able to do comparison of plans, at least have multiple plans up at the same time.

Andrew Adrian-Karlin: Yes. So you can pull up multiple issuers. So each issuer will list all of the plans under it.

(Mary Blair):   All right. Is there any limitations on how many we can have?

Andrew Adrian-Karlin: I believe the limitation is how long it will take to load and you know what your Internet browser will – how long your Internet browser will wait for it to load.

(Mary Blair):   Got you.

Andrew Adrian-Karlin: If that makes sense.

(Mary Blair):   Yes. OK. So it's really based on you know how many we're selecting and how quickly it can load.

Andrew Adrian-Karlin: Yes.

(Mary Blair):   All right. The other question was on the business rules template. We had a problem with column B, it's the family size rate factor is applied. We don't use the family size. Do you know if the new version of that was corrected? Because even if we selected not applicable in the other columns that it's dependent upon, we still got, when we went validate, we would still get an issue with not having a value in that column.

Andrew Adrian-Karlin: Can you give me just one second to confer?

(Mary Blair):   Sure. I did send an e-mail as well.

Andrew Adrian-Karlin: (Sean), do you want to …

(Sean):   Yes, hi. This is (Sean). I'm the VA here that worked on a lot of the business rules and stuff. If I understand your question, I believe what you – when you enter the business rules, the very first question you answer after the issuer ID is one of four options whether you do rates based off of an individual or we add them up, whether it's a couple or family rate and I believe the third option is if it's individual, but you apply a rate factor. If you answer for the first question options one, two or four, you should be able to put not applicable for

the family size rate factor. If you answer three for the first question, then yes, we do have validation in place that – because that rule is telling us that there is a rate factor in place and we're expecting to see one.

(Mary Blair): OK. So we'll go back and we'll check that out and make sure that it's not an issue. And my last – thank you. And my last question is transformation. So we set up test scripts to test our data in both RBIS and then when we go into production. Do you know of any fields or any data elements that we'll be providing that will actually display differently than what we're providing in any of the screens that you can advise of in advance so that we can do our scripts correctly? So if you take a field label or a value and you transform it into something else, we need to know that in advance in order to have our scripts aligned to what our attesters will actually see.

Andrew Adrian-Karlin: I believe I have that information somewhere, but I – it will take me some time to …

(Mary Blair): That's OK.

Andrew Adrian-Karlin: … hunt it down.

(Mary Blair): I know how to hunt you down.

Andrew Adrian-Karlin: I'll get back to you (inaudible) via e-mail.

(Mary Blair): OK. Wonderful. Thank you so much. I have no further questions.

(Joe Mercer): Thanks, (Mary).

(Mary Blair): Thank you.

Operator: And your next question comes from the line of (Chip Haveroc).

(Chip Haveroc): My question was just answered. Thank you.

(Joe Mercer): Thanks, (Chip).

Operator: And your next question comes from the line of (Nancy Song).

(Nancy Song):   Hi. I have two questions just to clarify some dates and times. The additional training – or additional support hours, you said nine am to five pm, that's Eastern Time?

(Joe Mercer):   Yes. All times are Eastern. Sorry.

(Nancy Song):   OK.

(Joe Mercer):   East coast (inaudible).

(Nancy Song):   And when – what exact dates are the pre-populated templates available for both (inaudible) and RBIS?

(Joe Mercer):   The pre-populated templates for RBIS are available on Monday 12/5.

(Nancy Song):   OK.

(Joe Mercer):   Then if you change anything in (inaudible) …

(Nancy Song):   OK.

(Joe Mercer):   … you know obviously we don't have that – we can't represent that already, so what we'll do is we will run another set of pre-populated templates that will be available on 12/12. You know that will represent any changes in – that you made in (inaudible).

(Nancy Song):   OK.

(Joe Mercer):   And …

(Nancy Song):   So if we have changes to make to (inaudible) during this next coming week, those changes will be reflected in the second set of pre-populated templates on the 12th.

(Joe Mercer):   That is correct.

(Nancy Song):   OK. Thank you.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Lynn) (inaudible).

(Lynn): I just have one question at this time and it has to do with the – in the benefits template, you've broken down the drug coverage by generics, non – or preferred brands, non-preferred brands, specialty. We don't define our member copays or cost share that rigidly.

(Joe Mercer): OK.

(Lynn): For example, the generics column, most generics fall in tier one in our tier one cost share.

(Joe Mercer): OK.

(Lynn): But we have some brands in there and other drugs as well. So we don't – how do we display that on there? Do we just enter what generally the generic cost share is and then indicate that there is limitations and exclusions that apply because it's not that rigid? How do we accurate (inaudible) that?

(Joe Mercer): I think the way that you've described works. Again this – much like small group for these issues where the you know it's a little bit of a square peg in a round hole, we're going to ask you to put what's predominant.

(Lynn): OK.

(Joe Mercer): You know something – it's the predominant thing that you guys will do. But just as I had mentioned before, I think we're – especially with the drug coverage and that you know the difference between tiers and then the structure we have, that's something that I would ask you – you know – I think that what you discussed is correct, but if you want to send an e-mail to the CCIIO help desk, we can work on that, too. Because I think that that's how we're going to have to go through a lot of the stuff to make sure everyone – that we have consistent messaging to you all so everyone is doing it the same way.

(Lynn): OK. And then as kind of an addition onto that question, then, we have some plan designs that are a four tier design, so we have prescription drugs on tiers

one, two, three and four and then we have a separate cost share for specialty drugs.

(Joe Mercer):   OK.

(Lynn):   So there's really no place to put that fourth tier information. So – and those would be considered – you know I mean they are generally non preferred drugs, but there would be a different cost share for non preferreds on tier three versus non preferreds on tier four.

(Joe Mercer):   OK.

(Lynn):   So how would that be displayed?

(Joe Mercer):   That is something I'm going to have to ask you to send into the help desk so I can spend some time …

(Lynn):   OK.

(Joe Mercer):   … and talk to (Andrew) …

(Lynn):   OK.

(Joe Mercer):   … and we can figure out exactly how everyone should put it in there.

(Lynn):   OK. And I know those are concerns that we have shared through the Blues Association and I believe they've forwarded some of that information …

(Joe Mercer):   Absolutely.

(Lynn):   … not only to you guys, but also to the uniform – the group that's handling the uniform summary of benefits and coverage.

(Joe Mercer):   Yes. And we are working – you know it's – the drug coverage, as I mentioned before, is tricky because you know different issuers do it very, very – you know a whole bunch of different ways.

(Lynn):   Right.

(Joe Mercer):   So you know obviously for this time around, we're going to be working with this and we're going to – you know we'll figure out a way to put it in there so it best represents what you all do. And then working with the Blues and you know working with the associations and the SPC folks, we're going to try and make sure that you know as we move forward, the templates will continue to evolve to – you know to better represent how people are doing this.

(Lynn):   OK. And send that to (inaudible)?

(Joe Mercer):   Yes, to the CCIIO plan finder.

(Lynn):   OK.

(Joe Mercer):   That (inaudible).

(Lynn):   OK. Very good. Thank you very much.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Caro Rue).

(Caro Rue):   Oh, hi. Thank you. This is (Caro Rue) from Blue Cross Blue Shield Massachusetts. I just have one follow up from the first question. Some of our plan designs have the benefit categories covered by coinsurance only and copay after deductible. It's not just a prescription, there's some other benefit categories. So I just wanted to – what was your suggestion on how we should fill out this cell? Or what's your guidance? And are we allowed to leave the cell blank? Or what should we do?

(Joe Mercer):   OK. Can you give me an example of which – like just a cell number so I can look and …

(Caro Rue):   Well, for example, like inpatient admissions at a hospital.

(Joe Mercer):   OK.

(Caro Rue):   We have some plan designs that are a $500 co-payment after deductible.

(Joe Mercer):   OK.

(Caro Rue):   And in the drop down box, we don't have that option. We either have coinsurance after deductible or copay only, but we don't have the true benefit category.

(Joe Mercer):   OK.

(Caro Rue):   So we don't want to mislead the member or the potential members by stating other – either a copay only or nothing after – or the no charge after deductible because it would – it's not true, it is $500 after deductible.

(Joe Mercer):   Sure. Well, I don't want to answer that right now. I have suspicions on how we're going to answer it finally, but I would like to make sure that I have confirmation from my boss on the policy implications. So if you could send that to the mailbox and then I will make sure that I announce – especially for the copay after deductible option, I will announce how we would like to put that in there at the next training, as well as getting back to you directly.

(Caro Rue):   And just also just – maybe just adding that the option for coinsurance only.

(Joe Mercer):   Yes and I mean – and I would guess that the next time around that's something that we will add to those drop downs, but for right now we're just going to have to work with what we have here.

(Caro Rue):   And is there a possibility for leaving a cell blank?

(Joe Mercer):   No, I don't believe so.

(Caro Rue):   So we must answer every single cell.

(Joe Mercer):   Yes.

(Caro Rue):   So for example in HMO plan design that does not have an out of network, should we say just not covered?

(Joe Mercer):   Yes.

(Caro Rue):   OK. Now I have another question in regards, similar to prescription, but it's just for our tier network plan designs where we have different cost share depending on where the member seeks (inaudible) have service from, which provider. So which category – which cost share should we enter in that (inaudible) or should we put that (inaudible) the lower cell …

(Joe Mercer):   I'm sorry. You're breaking up there a little bit.

(Caro Rue):   Oh, I apologize. Any better now?

(Joe Mercer):   A little bit, yes.

(Caro Rue):   So we offer today tier network plan designs where we either have two or three different benefit categories – I mean cost share in a specific benefit category. So we were wondering which cost share can we enter in that cell?

(Joe Mercer):   I would go with the predominant option.

(Caro Rue):   The predominant option.

(Joe Mercer):   Yes.

(Caro Rue):   OK. Then can you also provide us more guidance in regards to the exception field? Are you just referring to visit or dollar limits only?

(Joe Mercer):   I mean basically anything that – yes, that would be a good example. I'm not sure I know the entire universe of limitations or exceptions, but that would be a good starting example there. So if you have something else – I believe that it covers most of it, but if you – you know and this is not just for you, this is for everyone obviously. If something comes up that there is a limit, there is times where things would not be available something like that, then that would be when you'd use the limitations and exceptions.

(Caro Rue):   OK. And I think for last (inaudible) column, if for example a plan design is predominant a copay only, but there are like two benefit categories where the coinsurance may apply, should we fill out that coinsurance amount there?

(Joe Mercer):   Yes, you should.

(Caro Rue):   OK. That will be it. Thank you very much.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Jennifer Carr).

(Jennifer Carr):   Hi, I was wondering if the secondary subscriber is the spouse?

(Joe Mercer):   Well, that would be – if that's the case, then yes. Yes, that would be spouse, but I know that some define it differently. Like for example, if you're allowed to have you know domestic partners, something like that, that wouldn't be a spouse, but that could be a secondary subscriber.

(Jennifer Carr):   I got it. Thank you very much.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Tiffany Howell).

(Tiffany Howell):   Hello, this is (Tiffany) at Blue Cross of Oklahoma. I have a question for column Q, annual pocket or annual out of pocket limit.

(Joe Mercer):   Yes.

(Tiffany Howell):   For one of our plans, we still have our stop loss. So how would I answer that question?

(Joe Mercer):   I am not entirely certain, I will ask you to send that in to the CCIIO plan provider mailbox and I will come up with an answer for you.

(Tiffany Howell):   OK. And that was it.

(Joe Mercer):   Thank you.

Operator: Your next question comes from the line of (Steve Sowers).

(Steve Sowers):   Hi, this is (Steve Sowers). I've got a couple of questions for you guys. In columns M and N that deal with PCP copay, if we have a product that does

not have a copay, what should we select? Because you can only either put in a dollar copay or not covered.

(Joe Mercer): If it has – if there's no copay at all?

(Steve Sowers): Right.

(Joe Mercer): Hold on one second. I believe that you would enter – if you have no copay at all, that would be zero dollars.

(Steve Sowers): OK. Let me find my other question here. If we go over to – there's a column about dental checkup.

(Joe Mercer): OK.

(Steve Sowers): Copays. Out of pocket. Dental checkup for children in network and out of network.

(Joe Mercer): OK.

(Steve Sowers): The choices – there are several choices. I think I wanted to talk about the one before that. Well, I can't find – let's see here.

(Joe Mercer): If you – I mean if you come up with it later, you can always send it in or ask at the other training on Wednesday as well.

(Steve Sowers): OK. Give me one second here; I've got one more question somewhere. OK. That's – I guess that's it for now.

(Joe Mercer): OK. Thank you.

(Steve Sowers): Thank you.

Operator: And your next question comes from the line of (Brad Carter).

(Joe Mercer): Hey, (Brad).

(Brad Carter): Yes. How are you doing?

(Joe Mercer):   Good, how are you?

(Brad Carter):   I want to follow up with (Steve) there. We were also interested in the deductible question. Let me see, in column K, annual deductible, when you're entering that, if you have a single deductible, but you don't have a family or you have a family deductible and you don't have a single deductible, we want to make sure that that gets conveyed correctly on the Website and how we should handle that.

(Joe Mercer):   OK. So look, there's maybe a plan that has a deductible for family and doesn't have anything for individual.

(Brad Carter):   Yes and then we have other plans potentially that are the reverse of that and we want to make sure when you look at that situation on the Website that we don't mislead the public and think that there's no deductible applicable because they need to kind of be able to see both the single and the family at the same time.

(Joe Mercer):   OK. Now I'm just – let me just ask a follow up question because I want to make sure I'm understanding what you're saying. So if there is one plan, right?

(Brad Carter):   Right.

(Joe Mercer):   And you have in this one plan it wouldn't be proper to enter a deductible in for individual and family because you only have let's say a family deductible.

(Brad Carter):   Right.

(Joe Mercer):   So this plan is – is this plan offered to individuals?

(Brad Carter):   Yes.

(Joe Mercer):   I guess it would have to be, right?

(Brad Carter):   Right.

(Joe Mercer):   So if you're applying it …

(Brad Carter):   Keep in mind the plan is not at the details subscriber, you're not going inside the family because it's a product that's offered to the entire family and/or single person.

(Joe Mercer):   Sure. I understand.

(Brad Carter):   So that's how – OK.

(Joe Mercer):   I understand. I was just trying to see what – when it would pop up, but you know depending on the census information given, what would pop up. So if you're an individual and you buy this plan, what is your deductible situation?

(Brad Carter):   You would be – if only there is a family deductible – well, you wouldn't end with it – well, I guess that's a good point. If you're an individual subscriber and you're not a family, then the family deductible wouldn't end up applying to you.

(Joe Mercer):   Right.

(Brad Carter):   But if you – but the same plan is purchased by a family, so the plan design is the same regardless if when you come as a subscriber if you're an individual or a family. You follow what I'm saying? So the questions need to be able to handle either scenario.

(Joe Mercer):   Right. And I believe if you enter – if you enter in – if you don't have a family deductible, you're only – I mean if there's not like a corresponding individual deductible, then I would put zero there and so then if – but they know if they're going through as a family, then they would be – then they would be subject to that deductible. But if you're an individual, you would not be.

(Brad Carter):   Well, let me make sure. Let me – one second this – yes, I mean that's what we were contemplating putting a zero in there, but at the same time we were concerned that when you looked at that on the Website, how would that be conveyed …

(Joe Mercer): I believe that will be – I believe that will have a separate display and as we're working through these displays, users will become more clear. But that's something that I have just noted as something we need to make sure is clear.

(Brad Carter): OK. Great.

(Joe Mercer): For the display.

(Brad Carter): That's our major concern.

(Joe Mercer): Yes.

(Brad Carter): Because that's how we were thinking about it.

(Joe Mercer): I understand exactly what you're saying and I don't believe – I don't anticipate it being a problem and I'll make sure I make a note of it for the display people.

(Brad Carter): OK. And also, for plans – you know going back to an earlier question, for plans that don't have a copay, but they do have a coinsurance. I'm imagining the way that you will display on the Website is you'll be able to see both the copay – I mean you only ask one question at a time. Let's say for physician copay. And you have another field for physician coinsurance.

(Joe Mercer): Correct.

(Brad Carter): But when you convey that stuff on the Website and when you actually visualize it, somebody will be able to see that there is a zero copay, but there is let's say a 10 percent coinsurance.

(Joe Mercer): Correct. That will be clear.

(Brad Carter): OK. And then they'll know that, yes, well you do cover their service, you just don't charge a copay …

(Joe Mercer): Correct.

(Brad Carter): … you charge a coinsurance.

(Joe Mercer):   Yes, if there's – that's why we are saying you know put in – if there is you know there's not a copay because it's just coinsurance, then put zero dollars in for the copay. And it will display it and it will be clear.

(Brad Carter):   Yes, that's how we handled it for small group and we wanted to make sure there wasn't a twist for individual.

(Joe Mercer):   No.

(Brad Carter):   OK. Another question or first of all, I'm really glad to find out with the zip code issue that all the invalid zips that you potential might have had through pre-populating the area or the regions template will be purged out. In other words, they won't come over into the pre-populated template. Is that correct?

(Joe Mercer):   That is our intention.

(Brad Carter):   (inaudible). Now, what happens for you know what I'm trying to compare and contrast is some carriers will have legal entities that you know maybe they price based on county. So there may not be any zip codes presently in the – you know in CMP. There will just be counties in CMP. So are you all converting the counties into the equivalent complete list of zip codes that are out there for those counties and pre-populating the regions template with the zip codes? Or are you just going to pre-populate it with counties?

(Joe Mercer):   And (Andrew) and (Sean), feel free to correct me if I'm wrong, but I believe what's happened and -- I believe what's happened in the CMP is that even if you put in just a county, for example, CMP had you know added in the applicable zip codes.

(Brad Carter):   Yes, well, I know that you do have a routine and we were looking at that and trying to figure out how we could use it. Right now in CMP, we can still go in there and we can see a complete listing of all the potential zip codes for a given state.

(Joe Mercer):   Right.

(Brad Carter): And we were trying to think about how we could potentially use that to make sure that we don't have any gaps. Because if you all take any zip codes that are invalid and you purge them out, just like what we went through for small group, we're trying to think about how we can prevent from having any holes in our network. And so we're trying to understand if we feed you the data in various ways what you are going to do with it. What are you going to do with it when it comes through CMP if it comes to you with zip codes? Yes, that's even easier. Let's take us – a legal entity that we give you and let's say the way that we handle it in the regions template or the way that we handled it in CMP was in zip codes.

Now based on what you did in small group, I'm going to imagine and what you're going to do now that you've enhanced it is you're going to go through, find out any invalid zip codes and instead of erroring it out, you're just going to purge them out and you're going to provide back to the carrier a pre-populated list of zip codes for that legal entity that are valid. So it would be their previous list that was in CMP minus any purged zip codes. Is that correct?

(Joe Mercer): That is substantially correct.

(Brad Carter): OK. But what happens with the fact that, OK, you've purged these zip codes, many of these zip codes might be – there might be new zip codes that would have filled the gap …

(Joe Mercer): So …

(Brad Carter): Our concern is whether or not and how the best way is to find the missing zip codes. We're thinking that we can use your listing in CMP that should be a complete listing of all of the zip codes that are available and use that and just pull out any zip codes that are not part of our service area. Because potentially when you purge out these old invalid zip codes, there were new zip codes that should have taken their place.

(Joe Mercer): Right and I don't believe that we – I know we are not going to add in zip codes …

(Brad Carter): I didn't think you would.

(Joe Mercer): No.

(Brad Carter): So that's going to be on the burden of the carrier to do that.

(Joe Mercer): That is going to be you know and part of it is just moving over from CMP obviously that – you know how – why this has happened. And so the zip code in the regions template is going to be you know a slightly heavier lift even with the pre-population this time than it will be going down the line.

(Brad Carter): That's what I was thinking. It will be hard.

(Joe Mercer): Yes,

(Brad Carter): But at least you would have purged and that's a good step. You would have purged out the invalid zip codes.

(Joe Mercer): Yes, you're not going to get rejected for invalid zip codes off the pre-population. We're – we have – you know (inaudible) has gone through and made sure that that isn't going to error you out, but there might be things that – there may be holes depending on things that were wrong before that we had to knock out.

(Brad Carter): Perfect. And that makes sense. And my next question to you is actually succinct because some of this has sounded complicated, but is the listing that is currently living in CMP, has that been tested against your purging mechanism? That already has also no invalid zip codes in it today, is that correct?

(Joe Mercer): I can't – I'm not really sure about the CMP or you know what's in there and when the last time that was …

(Brad Carter): (inaudible) …

(Joe Mercer): … updated. I mean we are not anticipating using that – you know we're not advocating using that as you go through the submission process.

(Brad Carter): Well, let me ask you this, if we weren't to use that, is it possible that you all could provide on your Website – we were thinking about asking you to send it, but it might be better because many carriers could use this. If you could provide on your Website a complete listing by each state and each county the zip codes that are valid zip codes for you know the entire United States and then carriers that work with you know that that's already passed mustard, if you will. And they could use that as their source of total truth and purge out of that areas that are not part of their service area.

(Joe Mercer): That is possible. If you would send me that in – you know like to the CCIIO plan finder …

(Brad Carter): OK.

(Joe Mercer): … I can get to work and talk to the CGI folks and see what we can do in that regard. I just – I'm not sure I'm ready to answer that right now.

(Brad Carter): Perfect. OK. I didn't make – mean to make this a challenge. OK.

(Joe Mercer): (inaudible).

(Brad Carter): On another quick question for you, during the small group submission, there were situations where we had errors, but the system for e-mailing out that you had an error during your RBIS process wasn't working and we never got our first error message. And you all were going to be working on that. Do you know if that has been fixed and we won't have that issue for individual?

(Joe Mercer): (Andrew)?

Andrew Adrian-Karlin: Yes, it has.

(Brad Carter): Wonderful. Great news, (Andrew). Great to hear. And then let me see, my last question for you and sorry, there's been a few, is during the small group submission and another issue we had is we had some legal entities that did not have any open products. But they still showed up in the process of where you're verifying and you're doing the testing and it kind of prevented us from getting an e-mail directly to our CFO in order to do the sign off and we had to

an offline kind of process in order to get the CFO sign off. And we're wondering what – if that situation has fixed itself, hopefully, (Andrew).

Andrew Adrian-Karlin: Yes, we've resolved that issue. We've retested it a number of times, so it will be working.

(Brad Carter):   OK. Fantastic. And will we see any – will any closed products end up showing up in that list? And we have to check the box even though – you know will closed – or will it just be open products as it was originally? You know issuers with open products that will show up in RBIS? Because originally, we weren't even supposed to see any issuer IDs unless they had an open product with them. So will we see issuer IDs with closed products and we'll have to check the box on them anyway?

Andrew Adrian-Karlin: I would – I need to confirm that. I'm not 100 percent of the attesting status of that piece right now.

(Brad Carter):   OK.

Andrew Adrian-Karlin: So I need to confirm that, but I believe so.

(Brad Carter):   OK. Well, that would be great to find out. Well, thank you all very much. You've been very helpful.

Operator: Your next question comes from the line of (Ann Marie Bolen).

(Ann Marie Bolen):   Hi, how is everybody? Just a couple of things. I've worked on both the small group and I'm working on the individual. I'm Blue Cross/Blue Shield Delaware. And just an overall concern is the small group data submission was a little bit different because we really did things at the product level and when we put in things that are you know the predominant at the plan level, it's just a little bit more complicated, I think, for members who are viewing the information because they're looking at the plan and we're really putting in information that isn't accurate. So I just kind of want to voice that as a concern upfront that you know it's much harder to make accommodations when something is at a plan level and not confuse the public.

(Joe Mercer): That is noted and I – you know I'm interested to see how that comes out. I'm hopeful that it will end up looking you know good and you know it won't be misleading to the public. But that is – your concern is noted.

(Ann Marie Bolen): OK. Just a couple of things and I sent some of these in, but some of the other plans may have them so I'm just going to read a couple of them off and that might be helpful. One is on the specialist visit, we have plans where the member cost sharing is a copay after deductible, I know some other plans mentioned they have that and there is no option for this entry. The out of network deductible, we have plans, as I think most carriers do, that don't cover out of network services and the drop down box only provides entry for cost sharing or none and I think both of those answers are probably misleading. I mean it would be nice just to have a not covered or NA, if that's something we could do going forward.

(Joe Mercer): OK.

(Ann Marie Bolen): Mental health, again, I've worked in different states and a lot of states have benefits for serious mental illness that are different from non-serious mental illness.

(Joe Mercer): Right.

(Ann Marie Bolen): Some of them are very drastically different, so it's very hard to answer questions regarding that without again being confusing. Another item that we have is x-ray and lab. We actually have a tiered benefit for this service with different cost sharing depending on where the service is rendered, such as an independent versus hospital base and there's no option for this entry. So again we're going to have to choose one. And I don't have it now and I sent these questions to you, so you know I just …

(Joe Mercer): Yes.

(Ann Marie Bolen): … wanted to kind of voice them, but there is also another box and I – unfortunately, I don't have it with me, but it is on the exceptions area and it looks like somebody put the information that would be for planned because it actually has copay information instead of what – you know whether there's

any limitations in there, the wrong drop down box on that. So I'll let you know that as well because it just doesn't go together.

(Joe Mercer): Sure.

(Ann Marie Bolen): So those are again some of the things, but again you know especially with our CFOs attesting to this data, if there's anything – especially if the benefit that we're portraying looks to be better you know because of limitations and what it is, we are concerned.

(Joe Mercer): I definitely understand that and I actually have you know the e-mail you sent over before sitting in front of me and we're working through those questions. We wanted to see what – you know what got addressed today, but we'll continue to work through those.

(Ann Marie Bolen): OK. And if on Wednesday if you have some of the things that – especially if it affects all of the plans like some of these questions are similar, if you could maybe just address those.

(Joe Mercer): Absolutely. Yes. I am hoping …

(Ann Marie Bolen): That would really be helpful.

(Joe Mercer): I'm hopeful that I can just come on in the beginning before (Andrew) even gets started and read off some things and say, you know, "This is what we have determined since the last time."

(Ann Marie Bolen): OK. Thank you very much.

(Joe Mercer): Thank you.

Operator: And your next question comes from the line of (Iesha Cagen).

(Iesha Cagen): Hi, this is (Iesha) from (inaudible) Blue Cross/Blue Shield. I have similar issues with some of the other Blues plans with the drop down payment values for multiple services. In addition to copay after deductible and coinsurance only, we also have a few services that have a copay and coinsurance after deductible. For example, the column AT and AU for outpatient facility and so

we're trying to figure out, as other plans, how to accurately display that without being misleading to the members. So is that something I just e-mail along with everyone else?

(Joe Mercer): Yes, I think so. And again, when you know as we collect those, I think that you know Monday and Tuesday are going to be spent making a lot of these determinations and being able to get back to you guys on the next training and the user call on Wednesday.

(Iesha Cagen): OK. And then my next question is regarding column F. The plans expiration date, these are active plans. The plans that we're entering on the benefits template are all active plans, so can you clarify what that is supposed to be?

(Joe Mercer): Sure. Well, for one thing that's – looks like it's an optional field. So …

(Iesha Cagen): Oh, OK.

(Joe Mercer): What – the intent of this, there's a couple of things going into it. The intent of having a plan expiration date is, for example, you know this information is going to be – it's going to go up January 19th and it's going to be up for the next quarter. Let's say you had a plan that was going to be taken off the market in March. If you want – you know if you put in March 1st as the plan expiration date, it will no longer display, so you don't have to worry about you know customers going in there and looking and seeing, "Oh here's a plan that's available" and when it's not really available. So that's to allow you a little bit more flexibility or if you're – for example, if your rates were going to change somewhere in the middle – you know somewhere in the middle, that's to reflect that. So you can make sure that you have the most accurate information up there given that you only can refresh every three months or so.

(Iesha Cagen): Right. OK. Thank you.

(Joe Mercer): Yes.

(Iesha Cagen): And I have a couple of more questions. For column O and P, where it's the coinsurance column, we just want to confirm that we should enter the predominant coinsurance. For example, we have an HMO plan that is

typically a copay only plan, but there is one service like durable medical equipment that has a 25 percent coinsurance. We're thinking you don't want us to list that as the coinsurance. We would still list I guess zero as the coinsurance.

(Joe Mercer):   Sure. I mean I – this is going to be one of the ones that you want to go with the predominant one. If – you know if the – you don't have a coinsurance necessarily for you know a physician visit.

(Iesha Cagen):   Right.

(Joe Mercer):   But you want to put in the one – you know the coinsurance that's used most frequently.

(Iesha Cagen):   OK. So …

(Joe Mercer):   So yes, durable medical equipment is only – you know only a 5 percent of the time – you know like then …

(Iesha Cagen):   Yes.

(Joe Mercer):   … that wouldn't be a good one for you because it ends up looking a little bit unclear, but the coinsurance that the consumer would use most frequently.

(Iesha Cagen):   OK. Going on to column BO through BY, for mental health and substance abuse.

(Joe Mercer):   Yes.

(Iesha Cagen):   Where we have – due to state mandates, especially in Maryland and Virginia, where they break out the visit limits, let's say the first five visit limits is a set figure and then in Maryland, it might be a coinsurance like 30 percent or something to that effect. And then the remaining visits are another – a lower – a lesser coinsurance. How would you like us to indicate that? Would you want us to just indicate a first set of visits? Or I mean we're at a loss there.

(Joe Mercer):   I think – I believe that what I would like you to do is put in the first set of visits and that's when you would use limitations and exceptions. Though this

is an example of one that isn't exactly you know the typical limitations and exceptions, but what it allows you to do is that you know it lets the consumer know that there is something else going on here. So in this case, the limitation or exception would be a positive thing for the consumer, but I want to make sure that the initial is covered there.

(Iesha Cagen): OK. All right. That's fine. And then the last question is for column CP, habilitation services. We noticed that it does not specify in network or out of network. So which would you like us to provide?

(Joe Mercer): In network, please.

(Iesha Cagen): In network. OK. And that is it. Thank you so much for your help.

(Joe Mercer): Thank you.

Operator: Your next question comes from the line of (Hine Goo).

(Hine Goo): Hi. I have a couple of questions on the rate template. So in this template, do they have request for secondary subscriber rates and dependent rates, but we don't have rates for secondary subscriber or dependent. So should – can we just leave those fields blank?

(Joe Mercer): You sure can. Those are optional fields.

(Hine Goo): OK. And then for the – they also have some columns that have different rates (inaudible) by number of dependents. So if we don't have – like for primary subscriber and one dependent, primary subscriber and two dependents up to four and more dependents?

(Joe Mercer): Yes.

(Hine Goo): And we don't (inaudible) rates by number of dependents, should we fill the same rates for those four columns? Or just the fill the last column?

(Joe Mercer): I am tempted to kick this over to (Sean). I believe what we want to do is if you – so basically if you have dependents at all, it's just going to be one rate.

(Hine Goo): Yes.

(Joe Mercer): Whether you have one or whether you have six.

(Hine Goo): Right.

(Joe Mercer): (Sean), how would you prefer that they fill that out?

(Sean): I think that has to go back to the actually the business rules template and what they would fill out there is on the business rules template I think we asked a question about the number of dependents and it's like one, two, three, four or more. So depending on what you – you'd want to put I believe if I understand the question correctly is on the business rules template, you would select four or more and then on the rates template, you would also – you could fill that in there as well. And then we do the pricing engine; we will know to pull that.

(Hine Goo): OK. So we just leave the one and two, three dependents field to be blank.

(Joe Mercer): Correct.

(Sean): You can either leave them blank or you can fill them in with exact same rate. Actually, it will probably be better if you filled it in with the same rate. If it's the same rate for one, two, three or four or more, probably just put the same rate in so we make sure that if we do pull it, we're pulling the correct thing.

(Hine Goo): OK. OK. Thank you.

(Joe Mercer): Thanks. Sure.

Operator: And your next question comes from the line of (Steven Romo).

(Steven Romo): Good morning – good afternoon, guys. I just had a question. I might have a particular region that has a CFO that's going to be out of the country during the submission window for the RBIS. How do I delegate or can that be delegated that task?

(Joe Mercer): It can. Hold on one second. Whoever is the stand in – you know when the CFO is out of the country can do it and I believe you can just – you can

contact the (inaudible) help desk and they'll help you make sure that the e-mails are going to the right people.

(Steven Romo): Oh, OK. Perfect. That's what I needed to know. Thank you.

(Joe Mercer): Thank you.

Operator: And your next question comes from the line of (Noreen Hamad).

(Noreen Hamad): Hi, good afternoon. My question is related to the urgent care columns. Do you consider urgent care to be a – the same as a doctor or specialist visit?

(Joe Mercer): Hold on one second, let me pull up this template. I'm not sure I understand what you mean.

(Noreen Hamad): In comparison to an emergency care, would the urgent care be a – considered the same as a doctor or specialist visit when you're filling this out? For columns BF, BG, BH?

(Joe Mercer): B …

(Noreen Hamad): How does that differ from an emergency room service?

(Joe Mercer): The urgent care as opposed to emergency service?

(Noreen Hamad): Yes.

(Joe Mercer): I'm going to have to get back to you on that. I think I know, but I don't want to make – I don't want to say the wrong thing.

(Noreen Hamad): OK.

(Joe Mercer): So that would be a good opportunity for you to send in an e-mail and I'll make – and I'll make sure I announce that on Wednesday so we can have – you know to everyone out there so we have that clear.

(Noreen Hamad): OK. And my next question is related to the rehabilitation services. How do you define rehabilitation services?

(Joe Mercer):   Hold on.

(Noreen Hamad): What does that include?

(Joe Mercer):   Sure. Hold on one second. What that's going to be is you know if you're injured or something like that, the rehabilitation is all the services provided to help you get back to your normal – you know your normal level.

(Noreen Hamad): OK. So that's distinct from mental health, substance abuse, of course?

(Joe Mercer):   Right.

(Noreen Hamad): OK. Those are all the questions I have. Thank you.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Steve Sowers).

(Steve Sowers):   Hi. I wanted to ask you a question about the columns related to dental checkups. There's dental checkup for children in network and dental checkup for children out of network and then compare those two columns to the one that's about five or six down from it called routine dental services for adult.

(Joe Mercer):   OK.

(Steve Sowers):   The one for routine services adult has an option of available for additional premium. The children columns there is no option for that. Our dental products that we offer with our health products are additional premium for all of them. So we have no way in the way this is set up to really show that for the children portion of it.

(Joe Mercer):   Hold on one second. I believe that the ACA requires these you know the dental checkup for children to be covered, which is why we had it like that – which is why we had it in terms of – you know in that way as opposed to how we had routine dental services for adults.

(Steve Sowers):   OK. So that's what that – you all mean by that part.

(Joe Mercer): Absolutely. Yes, that's correct.

(Steve Sowers): OK. OK. That sounds good. Thank you, sir.

(Joe Mercer): Thank you.

Operator: And there are no further questions at this time. If you would like to ask a question, please press star one on your telephone keypad.

(Joe Mercer): And let me break in real quick. I have an answer for urgent care. So urgent care is defined as care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. So it's – you know it's a step up from just a regular doctor visit, but it's below the full on emergency room visit.

And Operator, do we have further questions or is that it?

Operator: You do. You have a question from (Patty Fitzgerald).

(Joe Mercer): All right.

(Patty Fitzgerald): Hi. I have a couple of questions.

(Joe Mercer): No problem.

(Patty Fitzgerald): My first question is on DME. If we have plans that have coinsurance only for DME, that's not currently an option. The options do allow you coinsurance, but it needs to be either before or after deductible. How would you like us to put that in? If it's coinsurance only?

(Joe Mercer): OK. For coinsurance only?

(Patty Fitzgerald): Yes.

(Joe Mercer): Hold on one second. (Patty), I'm going to have to have you e-mail the inbox on that because we really need to make it policy call that I don't think I can make at this very second.

(Patty Fitzgerald): OK. My next question had to do with services that are really just covered at a discount. A good example would be the weight loss program. So it's only covered at a discount level and that's not an option. Would we put that as covered with limitations?

(Joe Mercer): Let me look. We're going to – why don't you put that in the e-mail as well? I'm not sure how we're going to handle that sort of thing.

(Patty Fitzgerald): OK. My next question has to do with PCP copay in network. If it's covered – if the cost share is only covered in full after deductible, that is not an option to select. What would you want to see there?

(Joe Mercer): What I want is what the copay would be when you have to pay a copay.

(Patty Fitzgerald): But it never has a copay.

(Joe Mercer): Never has – never, ever has a copay?

(Patty Fitzgerald): No. It's covered in full after you've met your deductible.

(Joe Mercer): OK. Then I would say that there is no copay then, so it's zero.

(Patty Fitzgerald): Put zero.

(Joe Mercer): Yes.

(Patty Fitzgerald): OK. And for PCP out of network, so there's no option to use coinsurance only as the only cost share. So what would you like to see there?

(Joe Mercer): For PCP out of network.

(Patty Fitzgerald): Yes. It has coinsurance only.

(Joe Mercer): OK. Oh, so it's only coinsurance?

(Patty Fitzgerald): Correct.

(Joe Mercer): Hold on one second. I believe we're going to end up handling this sort of like we did in small group, but what I'm going to ask is that you give me – let me

respond to that next week when we go through because I have to talk that through. I don't want to send you guys the wrong signal and I'll have you start working on and then have to turn around and change my mind.

(Patty Fitzgerald): OK. And my last question has to do with all the questions that were deferred to next Wednesday's training.

(Joe Mercer): Yes.

(Patty Fitzgerald): For people like me, I'm assuming there's others, who can't participate in next Wednesday's training, will there be a written FAQ put somewhere that we can get the answers to those questions that you're researching?

(Joe Mercer): I can look into that. What I will be doing I'll definitely put everything out there for the training and I'll repeat myself at the issuer call.

(Patty Fitzgerald): OK.

(Joe Mercer): And I believe that – and we'll have a transcript available that will be posted online and I will definitely consider – well, I mean I'll definitely look into putting it in some sort of FAQ, some sort of – or something going out to you all, although I'm not sure you know what -- how the timing is going to go for that.

(Patty Fitzgerald): OK. Thank you very much. That's it.

(Joe Mercer): Thank you.

(Patty Fitzgerald): Bye.

Operator: And your next question comes from the line of (Nancy Song).

(Nancy Song): I'm sorry. My question has been answered.

(Joe Mercer): Thank you.

Operator: And your next question comes from the line of (Amy).

(Amy):   Hi. Forgive me if you already answered this, but we have some subscriber only plans, so they have no family deductible. Do we put zero dollars for family? Because that, to me, looks like family is an option.

(Joe Mercer):   Well, zero dollars – I would say zero dollars is fine there because it's going to – I mean the plans are going to come up based on the census information. So if it's subscriber only, that plan – you know you're not going to – no one is going to be – if they put in that they need family coverage, it's not going to come up.

(Amy):   OK.

(Joe Mercer):   So people – you know, do you see what I mean? Like so if they're putting in information in the census for that they have a family, this plan that doesn't have a family deductible isn't going to come up, so it won't be an issue.

(Amy):   OK. Got it. And then my other question was for the PCP copay, we have some plans that have a copay for the first two to four visits and then after that, there's coinsurance. So should I just put the copay?

(Joe Mercer):   I would put the copay in and I'd put the coinsurance in.

(Amy):   OK. In the other column?

(Joe Mercer):   Yes. Yes. Yes.

(Amy):   OK. And then somebody else mentioned for mental health how there is severe and non severe. Were you going to look into which one we should address? Or …

(Joe Mercer):   I will look into that.

(Amy):   OK. That's it. Thank you.

(Joe Mercer):   OK. Thank you.

Operator: And your next question comes from the line of (Kelly Hagbert).

(Kelly Hagbert): This is (Kelly) with Blue Cross and my questions are about the business rules template.

(Joe Mercer): All right.

(Kelly Hagbert): On column C and DF, what is the maximum number of dependents for a single or family contract? If we don't have a maximum number of dependents, will NA answer that correctly?

(Joe Mercer): (Sean)?

(Sean): Actually, for that one, if you answer the first question that you use the family rates which I think is option – answer one for question one, then just put four or more for those two.

(Kelly Hagbert): And that will indicate to you that we don't have a maximum?

(Sean): Right.

(Kelly Hagbert): OK.

(Sean): It's just the way the rules work. If we put in not applicable there, not sure what to do with it. So four or more by the way the rules engine is set up means there's no limit.

(Kelly Hagbert): OK. And then on column Q, how is age determined for rating and eligibility purposes? If we determine those two ages differently, how should we answer that question?

(Joe Mercer): One second. Can you repeat the question?

(Kelly Hagbert): In column Q, it asks how are ages determined for rating and eligibility? If we determine two ages, one for eligibility and one for rating, how should we answer that question?

(Sean): That's actually a very good question. We don't break it out for rating and eligibility. We just take the one answer and apply for both.

(Kelly Hagbert): OK.

(Sean): (Joe), do you have any input?

(Joe Mercer): I do not have anything – any input at this time. That was something I'd have to go up the ladder with that.

(Sean): Yes.

(Kelly Hagbert): All right. Thank you.

Operator: And your next question comes from the line of (Alicia Henley).

(Alicia Henley): Hi, my question is also on the business rules template. We have – there is two different ways for a couple of different products that we rate. So we offer for one product a group or family discount, but the other ones it's just a rate for each individual and add that up. So should I put two different rows on this for – to represent the two different product – the way the two different products are rated?

(Joe Mercer): (Sean) and (Andrew)?

Andrew Adrian-Karlin: One second. Can you go ahead and send it into insurance oversight at HHS.gov and we'll get back to you on that?

(Alicia Henley): OK. I sent the question in already and I don't think that it was phrased properly or you didn't understand it because I didn't get a good answer. It didn't really answer the question that I had. So I'll try to structure it more clear.

Andrew Adrian-Karlin: You sent that in to CCIIO plan finder or?

(Alicia Henley): You know what? I'm not sure where it was sent. I'd have to – I've got to look again. I'm not sure exactly where it was sent.

Andrew Adrian-Karlin: Yes.

(Alicia Henley): But where should I send it to make sure I send it in to the right place?

Andrew Adrian-Karlin: For (Sean) and I, send it to insurance oversight.

(Alicia Henley):   Insurance oversight. OK.

Andrew Adrian-Karlin: Yes.

(Alicia Henley):   Thank you.

Operator: And your next question comes from the line of (Willa Kim). Your line is open, ma'am.

Male: Hello. We have a question regarding the questions that have been asked so far today. Will the questions that (Joe) has been asking us to refer to the e-mail system be posted? The answers, will they be posted for everyone's access? Or just for those who have asked them?

(Joe Mercer):   Well, it will depend. If they're for the issuer specific, then I'll just respond there. As I mentioned earlier, what I'm hopefully going to do is be able to read off the answers, go through some of these things before the training on Wednesday, as well as at the issuer call Wednesday afternoon. So there will be a couple opportunities to hear the answers to those. And as I mentioned a few minutes ago, I'll look into getting an FAQ out there and – but I'm not sure how – you know how timely that process will be, so I have to look into that.

Male: All right. Thank you very much.

(Joe Mercer):   Thank you.

Operator: And your next question comes from the line of (Brad Carter).

(Joe Mercer):   Hey, (Brad).

(Brad Carter):   Hey, guys. Not to be a pain, I just want to revisit one aspect of the question – one of the questions that I had earlier about zip codes. And I'm going to put this in writing and I will send you all an e-mail. But my question I just wanted to get it out there in your brains at this point in time, I'm a little bit fixated, to be honest, on the listing of zip codes that we've seen and we've

played with out there on the CMP. They look awfully good and I realize
that's a policy decision and it could be the government doesn't want to own
that process to start with. But what I'm advocating for potentially is that
CCIIO could potentially provide a complete listing of zip codes maybe on
RBIS similarly to how they've done that thus far in CMP. And I will put that
in writing as well, but I wanted to get your reactions to that idea anyway.

(Joe Mercer):   I – my reaction is that we can definitely look into that and regardless, I'll let
you – I'll let everyone know about you know how we're going to handle that
…

(Brad Carter):   Right. Yes, that would be great if you all could address it you know good,
bad or ugly …

(Joe Mercer):   Yes.

(Brad Carter):   … at the training follow up next week.

(Joe Mercer):   Sure. Absolutely.

(Brad Carter):   OK. Great. Thank you very much.

Operator: And there are no further questions at this time.

(Joe Mercer):   All right. So thank you all for coming out. Thank you, (Andrew), for the
training. I am hopeful that next week we can go through all of these questions
that we have not gotten a chance to answer today, so thank you for your
patience there. Look for the pre-populated templates to be available on
Monday and the user manuals should be up, if not now, very, very soon. So
everyone have a great weekend and I look forward to talking to you next
week.

Operator: Speakers, remain on line. This concludes today's conference call. You may
now disconnect.

END