CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Issuer Submiss

Company Information

Legal Business Name (LBN):
Tax Identification Number (TIN) (9 Digits):

Company Contact Information

Payment Information

Attestation

DEPARTMENT OF HEALTH AND H
CENTERS FOR MEDICARE & MEI

ion to Receive the Federally-Facilitated Marketplace User

Contact Name:	
Title or Organizational Role of Contact Person:	
Telephone Number:	
Email Address:	
Alternate Contact Name:	
Title or Organizational Role of Contact Person:	
Telephone Number:	
Email Address:	

Total User Fee Adjustment Amount for Contraceptive Clai

calculation from User Fee Tab (15% applied)

On behalf of my organization, for which I am submitting this submission for the Fede
my organization qualifies for an adjustment in its Federal-facilitated Exchange user f
best of my knowledge and belief, the payments for contraceptive services were mad

or 29 CFR § 2590.715-2713A(b)(2). I certify that the information contained in this sub
of my knowledge and belief. I attest that I have taken reasonable steps to ascertain t
information. I attest that my organization will promptly inform CMS if my organizati
contained in this submission is untrue, incorrect or incomplete.

Signature of Attestor:	
Title or Organizational Role of Attestor:	
Date signed:	
Email Address:	
Telephone Number:	

Please Email this form to FFMuserfeeadjustments@cms.hhs.go

HUMAN SERVICES
DICAID SERVICES

r Fee Adjustment

extension:

extension:

ms Incurred through 12/31/14 $0.00

rally-Facilitated User Fee Adjustment, I attest that
ee pursuant to 45 CFR § 156.50. I attest that, to the
e in compliance with 26 CFR § 54.9815-2713A(b)(2)

omission is true, correct and complete to the best
he truth, correctness and completeness of this
on becomes aware that any of the information

ex: mm/dd/yyyy

extension:

v

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Required Data Elemen

Payment Information

Self Insured Plan HIOS ID	TPA or PBM Tax Identification Number

DEPARTMENT OF HEALT
CENTERS FOR MEDICAR

ts for Issuers to Receive the Federally - Fa

Total Amount of Contraceptive Claims Incurred through December 31st Paid to the TPA by the Issuer

Please Email this form to FFMuserfeeadjust

TH AND HUMAN SERVICES
RE & MEDICAID SERVICES

cilitated Marketplace User Fee Adjustment

User Fee Adjustment Amount (15 %) from Contraceptive Claims Paid to TPA (*do not populate this row*)	Is the issuer part of the same entity as the TPA (same parent company?)
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ments@cms.hhs.gov

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Issuer Submission to Receive the Federally-

Form Objective	This form allows issuers to submit eligible organization as described i contraceptive coverage. HHS will use the amounts reporte described in 26 CFR 54.9815-2713 fifteen percent adjustment to com This form is designed for issuers th for contraceptive services should u

Submission Guidelines	Email this form to FFMuserfeeadju 45 CFR 156.50(d)(2) requires a par contraceptive services to HHS in th provided. 45 CFR 156.50(d)(2)(i)(A) through • Identifying information for each the issuer is seeking an adjustmen issuer was the entity that made th • Identifying information for each which the issuer is seeking an adju • For each self-insured group plan during the applicable calendar yea • If a TPA made or arranged for su participating issuer by the TPA.

This section lists each data element required for the form and deta

Column Name	*Column and Cell #*
	Inform
	Company
Legal Business Name (LBN)	C11
Tax Identification Digit (TIN)	C12
	Company Co
Federally-Facilitated Marketplace (FFM) User Fee Adjustment Contact Person Name	D17
Title or Organizational Role of Contact Person	D18
Telephone Number/Extension	D19 and E19

Email Address	D20
Alternate FFM User Fee Adjustment Contact Name	D23
Title or Organizational Role of Contact Person	D24
Telephone Number/Extension	D25 and E25
Email Address	D26
	Payment
Total User Fee Adjustment Amount for Contraceptive Claims Incurred through 12/31/14	F31
	Atte
Attestation Text	C38 – E43

Signature of Attester	D45
Title or Organizational Role of Attester	D46
Date Signed	D47
Email Address	D48
Telephone Number/Extension	D49 and E49
	User
Self Insured Plan HIOS ID	B10 – B51
Third Party Administrator (TPA) or Pharmacy Benefit Manager (PBM) Tax Identification Number (TIN)	C10 – C51
Amount of Total Contraceptive Claims Incurred Through December 31st Paid to the TPA by The Issuer	D10 – D51
User Fee Adjustment Amount (15 %) from Contraceptive Claims Paid to TPA	E10 – E51

Is the issuer part of the same entity as the TPA (same parent company)	F10 – E51

ENT OF HEALTH AND HUMAN SERVICES
FOR MEDICARE & MEDICAID SERVICES

-Facilitated Marketplace User Fee Adjustment

information on payments for contraceptive services made under contract with an
in 26 CFR 54.9815-2713A. Eligible organizations receive an accommodation relating to

d in this form to adjust Federally-Facilitated Marketplace (FFM) user fees, as is
A(b)(3). For the 2014 benefit year, these user fee adjustments to issuers will include a
npensate for administrative costs and margin.

nat offer a plan through the FFM. TPAs or PBMs submitting information on payments
use the version of this form specific to TPAs.

ıstments@cms.hhs.gov

ticipating issuer seeking an FFM user fee adjustment to submit payment amounts for
ıe year following the calendar year in which the contraceptive services were

(E) specifies that issuers must submit:
issuer and each TPA that received a self-certification for the organization for which
t. Issuers should include this identifying information whether or not the participating
e payments for contraceptive services.
self-insured group plan for which a self-certification was received by a TPA, and for
ıstment.
, the total dollar amounts of payments made for contraceptive services provided
ır.
ch payments, the total dollar amount should reflect the amount reported to the

ailed instructions on how to populate each data field in the workbook.
Instructions
nation Tab
y Information
Enter the Legal Business Name (LBN) of the issuer submitting the form.
Enter the nine-digit Tax Identification Number (TIN) of the issuer submitting the form. Please exclude hyphens. The form will reject any values that are not nine digits.
ntact Information
Enter the name of the person CMS can contact if CMS identifies a discrepancy or has a question about the issuer's submission.
Enter the title or organizational role of the user fee adjustment contact identified above.
Enter the telephone number of the contact person and include an extension, if applicable.

Enter the email address of the contact person.
Enter the name of an additional contact available to answer questions about the issuer's submission.
Enter the title or organizational role of the alternate user fee adjustment contact identified in D23.
Enter the telephone number of the alternate contact person and include an extension, if applicable.
Enter the email address of the alternate contact person.

: Information
Do not populate this field; this field auto populates with the sum of all amounts in Column D in the User Fee sheet, plus an additional 15 percent adjustment. This amount reflects the total dollar amount of payments made by a participating issuer during the applicable calendar year.

estation
This attestation certifies that: • The person signing attests on behalf of the organization that the organization qualifies for a user fee adjustment, • To the best of the attester's knowledge and belief, the reported payments for contraceptive services were made in compliance with federal law [26 CFR § 54.9815-2713A(b)(2) or 29 CFR § 2590.715-2713A(b)(2)], • The information contained in the submission is true, correct, and complete to the best of the attester's knowledge and belief, • The attester has taken reasonable steps to ascertain the truth, correctness, and completeness of the reported information, and • The organization will promptly inform CMS if the organization becomes aware that any information submitted on the form is untrue, incorrect, or incomplete. Read the text of the attestation carefully before signing.

Signature of the person responsible for attesting to the stipulations presented in the attestation statement.
Enter the title of the attester.
Enter the date the attestation was signed in eight-digit, mm/dd/yyyy format.
Enter the email address of the attester.
Enter the telephone number of the attester and include an extension, if applicable.
Fee Tab
Enter the five-digit Health Insurance Oversight System (HIOS) ID for each self insured plan for which the issuer intends to seek an adjustment. The form will reject any values that are not five digits.
Enter the nine-digit Tax Identification Number (TIN) of the TPA or PBM through which payments were made for the self insured plan on this line. Please exclude hyphens. The form will reject any values that are not nine digits.
Enter the total dollar amount of contraceptive claims that the issuer paid to the TPA or PBM for the self-insured plan on this line. The amount should reflect the dollar value of contraceptive claims incurred through December 31st of the year preceding the current benefit year. This amount should reflect the total dollar amount paid to the TPA or PBM by the participating FFM issuer. If a TPA made or arranged for such payments, the total dollar amount should reflect the amount reported to the participating issuer by the TPA or PBM.
Do not populate this column. This amount displays the total amount of the user fee adjustment that HHS will make to the FFM issuer's user fee amount. This amount equals the dollar amount of contraceptive claims paid to a TPA or PBM by the issuer (or the amount the TPA or PBM reported to the issuer) in Column D, plus an additional margin for the administrative costs of the issuer (15 percent for benefit year 2014). If this amount exceeds an issuer's total user fee liability in any given month, HHS will credit the remaining adjustment to the issuer's user fee obligation for the next month. Any adjustment amounts that have not been credited by the end of the calendar year will be rolled over and applied in the next calendar year.

Indicate with a yes or no whether the issuer is part of the same entity as the TPA, or shares the same parent company with the TPA.