Market Conduct Annual Statement

Industry User Guide

2022 Data Year Filings

National Association of Insurance Commissioners
2022

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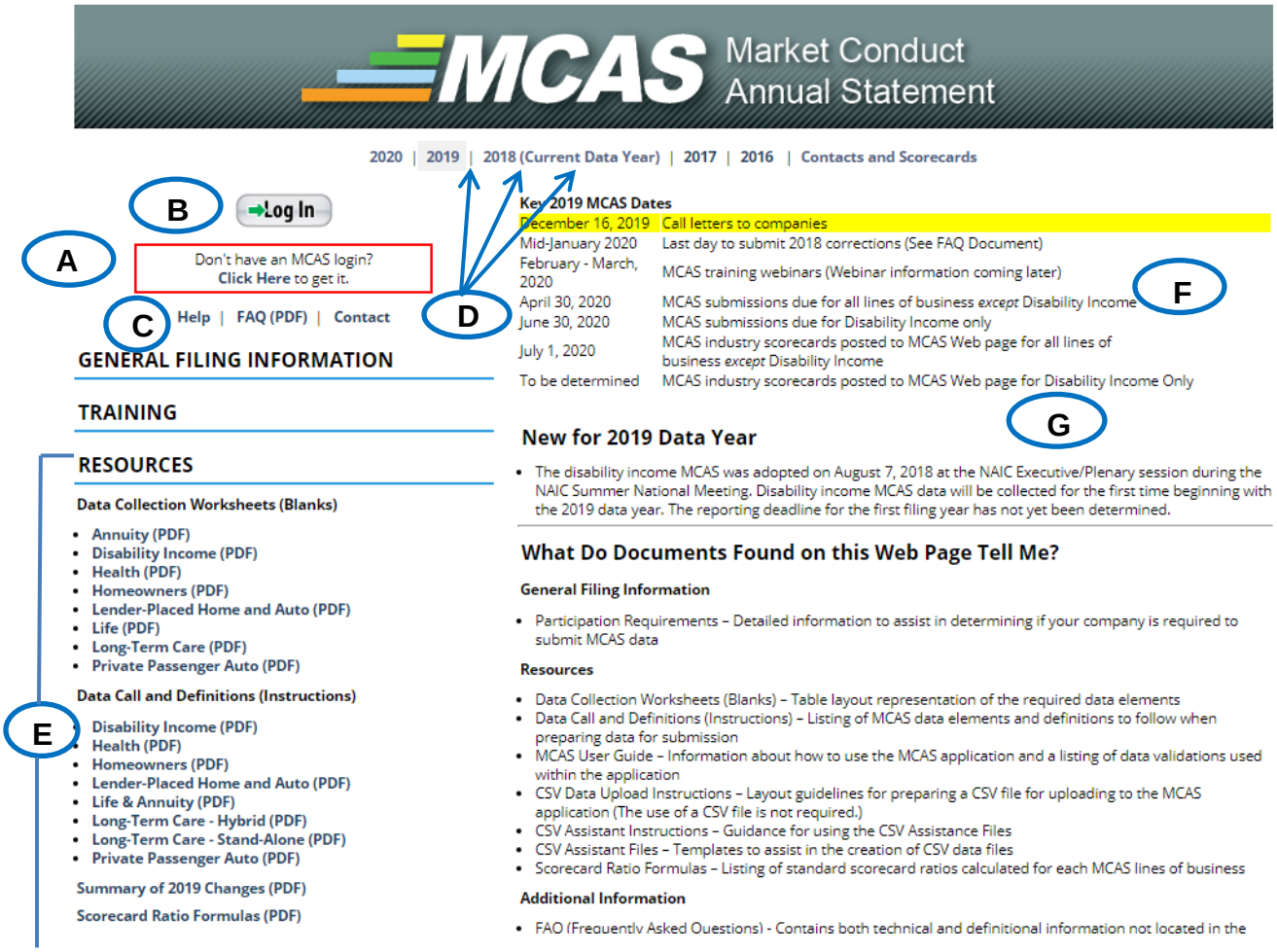
MCAS Web Page

Getting Started

The NAIC MCAS Web page (https://content.naic.org/mcas-2022.htm) is the primary source of information related to MCAS. A company might find it helpful to bookmark this page and check it frequently during the MCAS filing period.



A

Request for MCAS Login or Password Reset

Every individual wanting entry into the MCAS system must first request an MCAS login through the NAIC. This is done by completing and submitting the Request for MCAS Login form available through the Click here link in the red box. Anyone who received an MCAS login in a previous year does **not** need to request another one. For password reset, enter your MCAS ID on the form, and a request will be generated and sent to the NAIC Help Desk. Typically, the NAIC Help Desk creates a new MCAS login and completes the

password resets within four business hours of request receipt, but please allow two business days for completion of this task.

Log In

A click on this button launches the sign-in screen for the online application. The confidentiality of MCAS data is taken very seriously. Therefore, an individual must have both an NAIC MCAS login **and** must be authorized to access a company's data by the company's MCAS Administrator. Further information about obtaining company authorization is available in the User Assignment section of this guide.

Help | FAQ | Contact

A click on the **Help** link will open an online NAIC Help Desk form designed specifically for those seeking MCAS technical assistance. Help requests received on this form are prioritized higher than phone calls or general e-mail correspondence. The **FAQ** link will open a document of common MCAS questions and answers for those who prefer do-it-yourself assistance. The **Contact** link opens an email pre-addressed to the MCAS area of the NAIC where MCAS business questions should be directed.

MCAS Navigation Bar

Because the information in the 

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 areas vary from one filing year to the next, a navigation bar was introduced to allow ease of movement between year-specific web pages. In addition, this navigation bar includes access to state MCAS contacts, state specific MCAS instructions and annual publicly posted MCAS scorecards.

Link Categories

There are additional links grouped into the categories of General Filing Information, Resources, and Communication. Among the Resources category is a tool called Data Collection Worksheets (Blanks). These worksheets are printable PDF files patterned after the MCAS application entry screens. They are designed to assist a company with manual data collection in preparation for data entry into the MCAS online system.

Key Dates

The key dates associated with the selected MCAS filing year are located in this area. The highlighting of key dates changes as the current filing year progresses.

Body

This area contains information relevant to the filing year for the web page displayed. Items regarding changes and clarifications from the previous year, announcements, and MCAS status updates may be found in this section.

MCAS Application

Overview

The Market Conduct Annual Statement (MCAS) application is the method by which industry files its market data with the states. The current web-based MCAS application was introduced for the 2018 data filing year. This portion of the User Guide contains instructions on how to access the MCAS application and details about each of the application's components:

- Log In
- Terms of Use
- Home
- Filing Matrix
- Lines of Business
    - Annuity
    - Life
    - Homeowners
    - Private Passenger Auto
    - Long-Term Care
    - Health
    - Lender-Placed Insurance
    - Disability Income
    - Private Flood
    - Short-Term Limited Duration
    - Travel
- Data Upload
- Waivers and Extensions
- Attestation
- Company Ratios
- User Assignments

Helpful Hints

Before beginning the MCAS filing process, here are some things to note to improve your experience with this application.

System Requirements

The NAIC recommends using Chrome or Firefox when working with MCAS. However, Internet Explorer (IE) v9, IE v10, or IE v11 can be used.

An 800 x 600 screen resolution setting is **not** supported by the MCAS application. A higher resolution (i.e., 1024 x 768 or more) is recommended for the best viewing experience. Higher resolutions reduce the amount of screen scrolling needed to view an entire page.

Browser Back Button

Once inside the MCAS application, the NAIC discourages use of your browser's [Back] button. The recommended method for movement within the application is through use of the blue navigation bar, located at the top of the screen, and the grey sidebar, located on the left side of the screen. Because different browsers behave differently with this application, using your browser's [Back] button might cause an error screen to display or force an immediate exit from the MCAS application. In either situation, there is a risk of losing any unsaved data.

Help Desk Form

The NAIC Help Desk form (described in a previous section) is available within the MCAS application by selecting MCAS Resources on the navigation bar. This selection will take you to the MCAS web page where the form may be selected as previously described.

Log In

The 

button on the MCAS webpage launches a sign-in screen where an individual enters his/her NAIC user ID and password. New NAIC users will be asked to set up security questions and change their password at initial log in. Once security questions are in place, future password resets can be handled by the individual without the need for involvement of the NAIC Help Desk.

Terms of Use

The first time an individual logs into the MCAS application, the Terms of Use screen is displayed. It is necessary to click the "I accept" box in order to proceed into the application. This acknowledgement of acceptance is valid for 365 days during which time the Terms of Use screen will not appear again. At the end of the 365-day period the individual will be prompted to accept the terms of use once more.

Filing Matrix

Select Filing Matrix

On this portion of the screen, the company and year options for use during the current MCAS session may be selected in the left-hand side bar. These choices may be changed at any time by returning to the Filing Matrix screen and making different selections. A click on the [Select] button displays the Filing Matrix screen for the selected company and year.

The list of companies that appears in the drop-down box is customized to display only the signed-on individual's authorizations. If an expected company is missing from the list, or an unexpected company is included in the list, please contact the MCAS Administrator for the company in question. The company's MCAS Administrator manages who has access to its MCAS data.

Filing Matrix Selection Results

The purpose of this screen is to display a list of participating states for the selected company and data year. The selected company and data year is displayed at the top of the screen.

When a state is selected, the state expands to display a list of all lines of business. A required filing is represented by a red asterisk. In the status column of the drop-down list, the current filing status appears.

This dynamic screen provides up-to-the-minute, at-a-glance information by state and line of business. The information available in the state expansion displayed as columns is as follows:

*	Required*	This icon will appear on the right-hand side of a line of business where data submission is expected (see ***Premium** note below).
	Status	Possible statuses include: In Progress - Some data entered, but not submitted. Filed - Data successfully submitted. Processing - Data submitted for processing, but has not yet filed. Not Started - No data entered.
	Warnings	Displays number of warnings after data is validated.
	Errors	Displays number of errors after data is validated.
	Waiver	Status of 'PENDING', 'APPROVED', or ‘DENIED’ when request submitted.
	Extension	Status of 'PENDING', 'APPROVED', or ‘DENIED’ when request submitted.

***Premium**: The “required” or lack of the “required” indicator is based on a company’s licensure in a state **and** its state premium as reported in its financial annual statement. It is important to note that premium reported in the financial annual statement may include coverages that are **excluded** from MCAS premium. Therefore, depending on a company’s product lines, MCAS premium might or might not match financial annual statement premium. Regardless of the status displayed, it is the responsibility of each company to calculate its own MCAS premium to determine if filing in a state **is** or **is not** required. Please refer to the *MCAS Participation Requirements and General Information* document for further information.

The lines of business screens for any given state are accessible by clicking on the state followed by clicking the name of the desired line of business. The Actions section provides a summary view of filing, waiver, and extension status for all states per line of business by clicking the [Filing Summary] button. The Filters section may also be utilized to filter by state, line of business, filing status, required indicator, warnings, errors, extension

status, or waiver status. Returning to the Filing Matrix from any screen is accomplished through the navigation bar.

Lines of Business

Common Functionality

The Lines of Business screens contain the line of business name and the state name above the data entry and message areas. Before beginning the entry process, it is important to verify that the data to be entered is associated with the state displayed. There is no automated method to move or copy data from one state to another if entered for an incorrect state.

The data entry area for each line of business is arranged in columns and rows similar to a spreadsheet where the rows are the questions for each filing. Error and Warning messages on the screen include questions (Q) in addition to the appropriately highlighted cells to assist in identifying which cells contain an error or warning. For additional information about messages, their severities, and their meanings, refer to the MCAS Message section at the end of this User Guide.

The following buttons are available on the Line of Business screens, although *not all buttons are always available.* They function as described below.

Button	Action	Description
Save	Saves data without validating it.	Displays message for form or format errors (i.e., alpha characters in a numeric field).
Save & Validate	Saves (see above) then performs calculation checks and tests data business rules.	Displays informational, warning and/or error messages that might require correction before data submission.
Submit*****	Saves & Validates (see above) then releases the data to the NAIC for use by the states if there are no errors.	Appears only on the Summary screen. Displays informational message when submission is successful (see ***Submit** note below).
View Submitted Data	Downloads a pdf file of submitted data for the year specified on the button selected.	PDF downloads and is available for selection in the browser's designated downloaded files section.
Close	Closes the filing for the selected state and line of business.	Exits the filing and returns to Filing Matrix for the selected company and data year.
Print Displayed Data	Displays prompt message to confirm printing options and print displayed screen.	Prints the viewable information currently on the screen regardless of filing status.
Previous	Displays previous screen as listed in Filing Navigation tool.	Displays screen for the previous section of the filing.
Next	Displays next screen as listed in Filing Navigation tool.	Displays screen for the next section of the filing.
Summary	Shows a summary of all data fields for the selected filing.	Displays all sections of the filing in one screen to review data. *****Single page view not available for any previous data year

***Submit**: When a record is submitted for a particular state and line of business, that record goes into a "Processing" status temporarily. During this time, the record is unavailable for update by the company while the data is transferred to the appropriate state. Typically, the transfer process completes in less than two hours. However, if the record remains in "Processing" for 24 hours or more after submission, please complete and submit a Help Desk form.

Life

As of the 2021 data year, the Life screen contains three sections: Interrogatories, Data, and Attestation. There are two coverage columns in the Data section:

Individual Life Cash Value and Individual Life Non-Cash Value. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Annuity

As with Life, the Annuity screen contains three sections: Interrogatory, Data, and Attestation. As of the 2021 data year, there are four coverage columns in the Data section: Individual Indexed Fixed Annuities, Individual Other Fixed Annuities, Individual Indexed Variable Annuities, and Individual Other Variable Annuities. The data in each column is unrelated to the other, although the combined premium for the two columns is used to meet the $50,000 threshold for filing. Responses to questions in the Interrogatory section determine which columns require completion in the Data section.

Private Passenger Auto (PPA)

The Private Passenger Auto screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. There are nine coverage subsections in the Claims Activity section: Collision, Comprehensive, Bodily Injury, Property Damage, UMBI & UIMBI, UMPD & UIMPD, Medical Payments, Combined Single Limits, and Personal Injury Protection. Responses to questions in the Interrogatory section determine which columns require completion in the Claims section. All data in the Underwriting Activity section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered “Y” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage. Conversely, you will leave all data elements null (i.e., unanswered) in the claims section for those coverages for which you answered “N” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage.

Homeowners (HO)

The Homeowners screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. There are five coverage columns in the Claims Activity section: Dwelling, Personal Property, Liability, Medical Payments, and Loss of Use. Responses to questions in the Interrogatory section determine which columns require completion in the Claims Activity section. All data in the Underwriting Activity section is mandatory.

If your company has no claims information to report, but does have underwriting data to report, you will then enter all zeros in the claims sections for those coverages for which you answered “Y” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage.

Conversely, you will leave all data elements null (i.e., unanswered) in the claims section for those coverages for which you answered “N” to the interrogatory question, “Were there policies in force during the reporting period that provided “xxx” coverage.

Long-Term Care (LTC)

The Long-Term Care screen contains six sections: Interrogatories, General Information, Claimants and Claimant Requests Activity, Benefit Payment Requests Activity, Lawsuit Activity, and Attestation. There are three coverage columns in the sections following the Interrogatories section: Stand Alone LTC, Life LTC Hybrid, and Annuity LTC Hybrid. Responses to questions in the Interrogatories section determine which columns require completion.

Health

The Health screen contains 13 sections including Interrogatories, Attestation, and the following coverage types:

- In-Exchange (Individual) [IEIH]
- In-Exchange (Small Group) [IESG]
- In-Exchange (Catastrophic) [IECA]
- In-Exchange (Multi-State Individual) [IEMI]
- In-Exchange (Multi-State Small Group) [IEMS]
- Out-of-Exchange (Individual) [OEIH]
- Out-of-Exchange (Small Group) [OESG]
- Out-of-Exchange (Grandfathered) [OEGT]
- Out-of-Exchange (Catastrophic) [OECA]
- Out-of-Exchange (Large Group) [OELG]
- Out-of-Exchange (Student) [OESP]

Each coverage type has 7 subsections: Policy Administration, Prior Authorizations Excluding Pharmacy, Prior Authorizations – Pharmacy Only, Claims Administration (Excluding Pharmacy), Claims Administration (Pharmacy Only), Consumer Requested Internal Reviews/Grievances (Including Pharmacy), Consumer Requested External Reviews (Including Pharmacy).

Each In-Exchange subsection, with the exception of the Catastrophic section, has five columns broken down into metal levels (Bronze, Silver, Gold, Platinum and Total). Catastrophic is reported in total only. The Out-of-Exchange Individual and Small Group sections each have five columns broken down into metal levels (Bronze, Silver, Gold, Platinum and Total). The Out-of-Exchange Grandfathered Plan is broken down into four columns: Large Group, Small Group, Individual, and Total. Catastrophic, Large Group, and Student Coverage are reported in total only. Responses to questions in the Interrogatories section determine which tables require completion.

Lender-Placed Insurance (LPI)

The Lender-Placed Insurance (LPI) screen contains four sections: Interrogatories, Claims Activity, Underwriting Activity, and Attestation. Data elements in the claims and underwriting activity sections are collected for ten coverage types (or subsections):

- Single-Interest Auto (SIA)
- Dual-Interest Auto (DIA)
- Single-Interest Home Hazard (SIHH)
- Dual-Interest Home Hazard (DIHH)
- Single-Interest Home Flood (SIHF)
- Dual-Interest Home Flood (DIHF)
- Single-Interest Home Wind-Only (SIHWO)
- Dual-Interest Home Wind-Only (DIHWO)
- Blanket Vendor Single-Interest Auto (BVSIA)
- Blanket Vendor Single-Interest Home (BVSIH)

Accordingly, responses to questions in the Interrogatories section determine which columns require completion.

Disability Income (DI)

The Disability Income (DI) screen contains ten sections: Interrogatories, Claims Information, Claims Decisions Processed, Resulting in Closed Without Payment, Claims Denied-Reasons, Claims Closed After Initial Payment(s), Underwriting Activity (Group & Individual), Covered Lives Related to Underwriting Activity (Group Only), Complaints and Lawsuits, and Attestation. Data elements are collected for eight coverage types namely:

- Individual Voluntary Short-Term (IVST)
- Individual Voluntary Long-Term (IVLT)
- Individual Employer-Paid Short-Term (IEST)
- Individual Employer-Paid Long-Term (IELT)
- Group Voluntary Short-Term (GVST)
- Group Voluntary Long-Term (GVLT)
- Group Employer-Paid Short-Term (GEST)
- Group Employer-Paid Long-Term (GELT)

Accordingly, responses to questions in the Interrogatory section determine which columns require completion.

Private Flood (PF)

The Private Flood (PF) screen contains five sections: Interrogatories, Claims Information, Underwriting, Lawsuits and Complaints, and Attestation. Data elements are collected for six coverage types:

- Stand-Alone (First Dollar Coverage)
- Stand-Alone (Excess Coverage)

- Endorsement to a Homeowner's Policy (First Dollar Coverage)
- Endorsement to a Homeowner's Policy (Excess Coverage)
- Endorsement to a Homeowner's Other Policy (First Dollar Coverage)
- Endorsement to a Homeowner's Other Policy (Excess Coverage)

Accordingly, responses to questions in the Interrogatory section determine which columns require completion.

Short-Term Limited Duration

The Short-Term Limited Duration (STLDI) screen contains seven sections: Interrogatories, Policy/ Certificate Administration, Prior Authorizations, Claims Administration (Including Pharmacy), Consumer Complains and Lawsuits, Marketing and Sales, and Attestation. Data elements are collected for nine coverage types:

- STLDI <= 90
- STLDI < 180
- STLDI 181-364
- STLDI Not Sitused <= 90
- STLDI Not Sitused < 180
- STLDI Not Sitused 181-364
- STLDI Sitused <= 90
- STLDI Sitused < 180
- STLDI Sitused > 181-364

Travel

The Travel (TRVL) screen contains five sections: Interrogatories, Claims Activity (Counts Reported by Claimant, by Coverage), Lawsuits and Complaints, Underwriting, and Attestation. Data elements are collected for seven main coverage types, each of which is broken down into Domestic and International (Emergency Medical/ Dental further broken down into Excess and Primary):

- Trip Cancellation
  - Domestic
  - International
- Trip Interruption
  - Domestic
  - International
- Trip Delay
  - Domestic
  - International
- Baggage Loss/ Delay
  - Domestic
  - International

- Emergency Medical/ Dental
  - Domestic
    - Excess
    - Primary
  - International
    - Excess
    - Primary
- Emergency Transportation/ Repatriation
  - Domestic
  - International
- Other
  - Domestic
  - International

Re-filing

Current Data Year

Regardless of the line of business, re-filing for the current data year is handled much the same as the initial filing. The appropriate screen is accessed through the Filing Matrix where the most recently saved data is displayed. Changes are made by replacing the old values with new ones where needed. The csv upload option is also available for re-filings. Once changed, the data may be saved, validated, and submitted again when ready. When the refiling is processed, the refiled data replaces the previously submitted data.

Previous Data Year

Re-filing for previous data years requires approval by the impacted state(s). Upon receipt of approval from the state(s), NAIC staff will “unlock” the filing for the year, cocode, state, and line of business specified. A filing must also be unlocked to view previous year data. Once in the unlocked status the company may view the filing and process the re-filing as described in the Current Data Year section above.

Re-filings for three years or more prior to the current data year cannot be accepted through the online system. Special arrangements must be made directly with the state(s). If a previous data year filing is being updated, but not submitted, and the filing closes, the data will revert to the original filing data that was submitted.

Data Upload

The data upload process is an optional alternative to the manual data entry process. The Data Upload screen accepts data exclusively in a .csv file format to populate the line of business screens. Use the [Browse] button on the Data Upload screen to locate and select the file. An uploaded data file may contain records for multiple lines of business, only some columns within a line of business, or only a few fields for a column.

Data submitted through the file upload process overlays whatever data currently exists on the respective Line of Business screen. The details about .csv file structure and record layouts are in the MCAS 2022 Data File Instructions Guide.

Waivers & Extensions

In some instances, a company might need to request an extension of the filing due date or a complete waiver in a particular state. The MCAS application includes the capability for a company to generate an electronic request to one or more states for consideration. After the affected state receives notification of the request, it can approve or deny the request online. Once the state action is determined and the request is updated, the decision is immediately available for viewing by the requesting company through the MCAS application.

List

By selecting [Waivers] or [Extensions] from the Actions section in the left-hand sidebar, the Waivers or Extensions screen displays. This screen provides a drop-down selection option for a line of business. After a line is selected, available states to request a waiver or extension appears. Multiple states may be selected at one time.

The status of a request is displayed in the respective Waiver or Extension column under each state and line of business as previously described in the Filing Matrix section. The request status options are:

Status	**Description**
Pending	Company submitted a request to the state and is awaiting a response.
Approved	State granted the request.
Denied	State rejected the request.

Access to an existing request is available by selecting the request status under the respective column. For example, if an extension for Health in Missouri says PENDING, select the word PENDING. The request previously submitted will appear with options to update or delete the request. It is the company's responsibility to check the waivers or extensions status in the Filing Matrix periodically to see if the state has taken action.

Attestation

The Attestation screen is located as the last section in each individual filing for each line of business. It includes fields to record the names and titles of the company representatives serving as attesters. By completing the attestation, the company's representatives are attesting to the accuracy of the MCAS data for the original filings as well as any re-filings necessary for the selected data year and line of business. The Attestation screen must be completed before the filings can be submitted.

The Company Comments field is located on this screen, as well. This field is available for the company to proactively communicate circumstances or conditions that might affect the company's MCAS numbers for a particular line of business as a whole.

Company Ratios

The Company Ratios screen provides a post-filing report by state of the statistics associated with the company's submission. This information is available for review immediately following a successful submission where filing status is Filed. As filings are completed in additional states, additional data is displayed on this screen. Once a company completes all of its filings, it is beneficial to print a final copy of this report. When the states' Scorecards become available, the company can use this report to compare their ratios to the Scorecard ratios of those states in which they do business.

User Administration

Administration of access to the MCAS application is controlled by way of the User Administration screen. Through this screen the company's MCAS Administrator has the authority to add and remove users to the MCAS application on behalf of the company. In addition, the Administrator may designate a specific MCAS contact to serve as the point person for MCAS filing issues and regulator questions. All users, including the Administrator and Contact, must obtain an MCAS user ID from the NAIC help desk prior to being added to the User Administration screen.

Administrator

The Administrator has the authority to add and remove MCAS system access for other users on behalf of the company and the authority to assign the Contact. NAIC staff can assign the Administrator role to the Market Conduct Contact, or Financial Statement Contact, as identified on the latest financial annual statement filing. This role may be assigned or reassigned to another company user, but only by special request of a company officer to the NAIC.

After an initial Administrator has been assigned by the NAIC, any subsequent changes may be made by the current Administrator by selecting the Administrator bubble for a secondary user.

Contact

The Contact person is the company's designated "go to" person for any questions from state insurance regulators and/or the NAIC related to the company's MCAS filing. Only one individual may have this role at a time, although it may be reassigned by the Administrator any time the company wishes to make a change.

Users

Users under the selected company will display in two sections on this screen: Administrator and Secondary Users. View and edit capabilities are available to all individuals associated with the company code. An Administrator or Contact role assignment is indicated with a filled bubble button in the Administrator and/or Contact column next to an individual's name.

MCAS Messages

Message Basics

Error messages are displayed in red and warning messages are displayed in yellow on the screen. The types of messages have different levels of severity, as shown below. If a validation fails, the message displays the validation rule ID in ( ) following the message. Many messages include column name and question number (Q##) to assist in identifying which cells contain an error. To correct the error, the data involved in the validation must be changed. For example, if Q47 = 0, Q48 = 5, and Q49 = 7 and the message **Life LTC Hybrid: Q47 + Q48 must be => Q49** appears, it is indicating that 0 + 5 => 7 is **not** accurate. To make the equation correct, the value of Q47 or Q48 needs to increase, or Q49 needs to decrease.

Severity	Meaning
Error	Corrective action required before submission can occur.
Warning	No corrective action required in order to proceed; however, there is some anomaly that warrants a second look before submission. If a filing is submitted with Warnings, comments should be added to the interrogatories section to address why the data is correct despite the warning.

The following pages contain a comprehensive set of MCAS messages listed by line of business and the last 5 characters of the rule ID. For example, message **(LZABN020001)** is associated with Life coverage and the rule ID is 20001. The column name is represented with the coverage type and the question number is replaced with the data element in these descriptions.

Messages by line of business

Annuity

Coverage ID	Description of Coverage Identifiers
IIFA	**Individual Indexed Fixed Annuities**
IOFA	**Individual Other Fixed Annuities**
IIVA	**Individual Indexed Variable Annuities**
IOVA	**Individual Other Variable Annuities**

Rule ID	Type	Description
10001	W	Total considerations for IIFA and IIVA should be >= $50,000.
10002	E	If there is no data to report for IIFA and IIVA, then an Annuity filing is not needed.
10007	E	If company does use TPAs, a list of the names of TPAs is required.
10008	E	If company does not use TPAs, a list of the names of the TPAs is not required.
10009	B	MCAS state Annuity Considerations (Fixed + Variable) are expected to be within 20% (+/-) of the Financial Annual Statement State Page Part 1, Annuity Considerations (Ordinary + Industrial).
10010	E	Attestor information must include first name, last name, & title.
10102	E	If there is no Individual Indexed or Individual Other Fixed Annuities (IIFA or IOFA) data to report, the outlier question response for IFA must be "N".
10103	E	If there are Individual Fixed Annuities (IFA) irregularities to report, the IFA explanation field must not be blank.
10104	E	If there are no Individual Fixed Annuities (IFA) irregularities to report, the IFA explanation field must be blank.
10105	E	If you reported having Individual Indexed Fixed Annuities (IIFA) product data to report, then all corresponding IIFA data must be reported.
10106	E	If you reported not having any Individual Indexed Fixed Annuities (IIFA) product data to report, then all corresponding IIFA data must be blank.
10120	E	If there is IIFA data to report, some IIFA data elements must contain non-zero data.
10129	E	All IIFA data elements must be >= 0 except dollar amount of annuity considerations during the period.
10161	E	IIFA Number of internal + external replacement contracts issued must be >= Number of replacement contracts issued.
10162	E	IIFA number of new deferred contracts issued for all annuitant ages must be >= number of all deferred contracts issued.
10163	E	IIFA number of contracts surrendered during the period must = the number of contracts surrendered for all insured ages during the period.
10164	E	IIFA number of contracts replaced for all insured ages must be >= number of contracts replaced.
10165	W	IIFA number of contracts applied for during period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10166	W	IIFA number of contracts in force at end of period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10167	W	Individual Indexed Fixed Annuities (IIFA) Total number of contracts surrendered with a surrender fee should be equal to or less than IIFA total number of contracted surrendered during the period.
10168	E	Individual Indexed Fixed Annuities (IIFA) lawsuits open + number of IIFA lawsuits opened during the period - number of IIFA lawsuits closed during the period must be = number of IIFA lawsuits open at end of period.
10169	W	Individual Indexed Fixed Annuities (IIFA) lawsuits closed during the period should be => number of IIFA lawsuits closed during the period with consideration for the consumer.
10205	E	If you reported having Individual Other Fixed Annuities (IOFA) product data to report, then all corresponding IOFA data must be reported.
10206	E	If you reported not having any Individual Other Fixed Annuities (IOFA) product data to report, then all corresponding IOFA data must be blank.
10220	E	If there is IOFA data to report, some IOFA data elements must contain non-zero data.
10229	E	All IOFA data elements must be >= 0 except dollar amount of annuity considerations during the period.

10261	E	IOFA Number of internal + external replacement contracts issued must be >= Number of replacement contracts issued.
10262	E	IOFA number of new deferred contracts issued for all annuitant ages must be >= number of all deferred contracts issued.

10263	E	IOFA number of contracts surrendered during the period must = the number of contracts surrendered for all insured ages during the period.
10264	E	IOFA number of contracts replaced for all insured ages must be >= number of contracts replaced.
10265	W	IOFA number of contracts applied for during period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10266	W	IOFA number of contracts in force at end of period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10267	W	Individual Other Fixed Annuities (IOFA) Total number of contracts surrendered with a surrender fee should be equal to or less than IOFA total number of contracted surrendered during the period.
10268	E	Individual Other Fixed Annuities (IOFA) lawsuits open + number of IOFA lawsuits opened during the period - number of IOFA lawsuits closed during the period must be = number of IOFA lawsuits open at end of period.
10269	W	Individual Other Fixed Annuities (IOFA) lawsuits closed during the period should be => number of IOFA lawsuits closed during the period with consideration for the consumer.
10302	E	If there is no Individual Indexed or Individual Other Variable Annuities (IIVA or IOVA) data to report, the outlier question response for IVA must be "N".
10303	E	If there are Individual Variable Annuities (IVA) irregularities to report, then the IVA explanation field must be completed.
10304	E	If there are no Individual Variable Annuities (IVA) irregularities to report, then no IVA explanation field is allowed.
10305	E	If you reported having Individual Indexed Variable Annuities (IIVA) product data to report, then all corresponding IIVA data must be reported.
10306	E	If you reported not having any Individual Indexed Variable Annuities (IIVA) product data to report, then all corresponding IIVA data must be blank.
10320	E	If there is IIVA data to report, some IIVA data elements must contain non-zero data.
10321	E	If there is no IIVA data to report, no IIVA data elements may be entered.
10329	E	All IIVA data elements must be >= 0 except dollar amount of annuity considerations during the period.
10361	E	IIVA Number of internal + external replacement contracts issued must be >= Number of replacement contracts issued.
10362	E	IIVA number of new deferred contracts issued for all annuitant ages must be >= number of all deferred contracts issued.
10363	E	IIVA number of contracts surrendered during the period must = the number of contracts surrendered for all insured ages during the period.
10364	E	IIVA number of contracts replaced for all insured ages must be >= number of contracts replaced.
10365	W	IIVA number of contracts applied for during period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10366	W	IIVA number of contracts in force at end of period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10367	W	Individual Indexed Variable Annuities (IIVA) Total number of contracts surrendered with a surrender fee should be equal to or less than IIVA total number of contracted surrendered during the period.
10368	E	Individual Indexed Variable Annuities (IIVA) lawsuits open + number of IIVA lawsuits opened during the period - number of IIVA lawsuits closed during the period must be = number of IIVA lawsuits open at end of period.
10369	W	Individual Indexed Variable Annuities (IIVA) lawsuits closed during the period should be => number of IIVA lawsuits closed during the period with consideration for the consumer.
10405	E	If you reported having Individual Other Variable Annuities (IOVA) product data to report, then all corresponding IOVA data must be reported.
10406	E	If you reported not having any Individual Other Variable Annuities (IOVA) product data to report, then all corresponding IOVA data must be blank.
10420	E	If there is IOVA data to report, some IOVA data elements must contain non-zero data.

10421	E	If there is no IOVA data to report, no IOVA data elements may be entered.
10429	E	All IOVA data elements must be >= 0 except dollar amount of annuity considerations during the period.
10461	E	IOVA number of internal + external replacement contracts issued must be >= number of replacement contracts issued.
10462	E	IOVA number of new deferred contracts issued for all annuitant ages must be >= number of all deferred contracts issued.

10463	E	IOVA number of contracts surrendered during the period must = the number of contracts surrendered for all insured ages during the period.
10464	E	IOVA number of contracts replaced for all insured ages must be >= number of contracts replaced.
10465	W	IOVA number of contracts applied for during period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10466	W	IOVA number of contracts in force at end of period should be >= number of immediate contracts issued + number of deferred contracts issued during period.
10467	W	Individual Other Variable Annuities (IOVA) Total number of contracts surrendered with a surrender fee should be equal to or less than IOVA total number of contracted surrendered during the period.
10468	E	Individual Other Variable Annuities (IOVA) lawsuits open + number of IOVA lawsuits opened during the period - number of IOVA lawsuits closed during the period must be = number of IOVA lawsuits open at end of period.
10469	W	Individual Other Variable Annuities (IOVA) lawsuits closed during the period should be => number of IOVA lawsuits closed during the period with consideration for the consumer.

Life

Coverage ID	Description of Coverage Identifiers
ICVP	**Individual Life Cash Value**
INCVP	**Individual Life Non-Cash Value**

Rule ID	Type	Description
20001	W	Total direct written premium amount for ICVP and INCVP should be => $50,000.
20002	E	If there is no data to report for ICVP and INCVP, then a Life filing is not needed.
20003	E	Attestor information must include first name, last name, & title.
20102	E	If there is no ICVP data to report, the ICVP outlier question response must be "N".
20103	E	If there are ICVP irregularities to report, the ICVP explanation field must be completed.
20104	E	If there are no ICVP irregularities to report, the ICVP explanation field must be blank.
20105	E	If you reported having Individual Life Cash Value (ICV) product data to report, then all corresponding ICV data must be reported.
20106	E	If you reported not having Individual Life Cash Value (ICV) product data to report, then all corresponding ICV data must be blank.
20120	E	If there is ICVP data to report, some ICVP data elements must contain non-zero data.
20121	E	If there is no ICVP data to report, no ICVP data elements may be entered.
20129	E	All ICVP data elements must be >= 0 except dollar amount of direct written premium and face amount of insurance issued during the period.
20161	E	ICVP internal + external replacement policies must be >= replacement policies issued.
20162	E	ICVP number of policies replaced for all insured ages must be >= number of replacement policies issued.
20163	E	ICVP number of policies surrendered during the period must = the number of policies surrendered for all insured ages.
20164	E	ICVP number of new policies issued for all insured ages must be >= number of new policies issued.
20165	W	ICVP number of policies in force at end of period should be >= number of new policies issued during period.
20166	E	ICVP number of new policies issues > 0, then ICVP face amount issued must be > 0
20167	W	If ICVP number of new policies issued + ICVP number of policies in force at end of period > 0 then ICVP dollar amount of written premium should be > 0
20168	W	ICVP face amount of policies in force at end of period should be >= ICVP face amount of new policies issued.
20169	W	If ICVP dollar amount of premium > 0, then ICVP number of policies in force at end of period + ICVP number of new policies issued during period should be > 0.
20170	E	If ICVP face amount of insurance in force at end of period > 0, then ICVP number of policies in force at end of period must be > 0.
20171	E	If ICVP number of policies in force at end of period > 0, then ICVP face amount of insurance in force at end of period > 0.
20172	W	ICVP death claims closed within 60 days + death claims closed beyond 60 days should be > death claims denied, resisted, or compromised.
20173	W	ICVP number of policies applied for during period should be >= number of new policies issued during period.
20174	E	Individual Life Cash Value (ICVP) Number of lawsuits open at the beginning of the period + ICVP Number of lawsuits opened during the period - ICVP Number of lawsuits closed during the period = ICVP Number of lawsuits open at the end of the period.
20175	W	Individual Life Cash Value (ICVP) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to ICVP number of lawsuits closed during the period.
20176	W	Individual Life Cash Value (ICVP) Total number of contracts surrendered with a surrender fee should be equal to or less than ICVP total number of contracted surrendered during the period.
20202	E	If there is no INCVP data to report, the INCVP outlier question response must be "N".
20203	E	If there are INCVP irregularities to report, the INCVP explanation field must be completed.
20204	E	If there are no INCVP irregularities to report, the INCVP explanation field must be blank.

20205	E	If you reported having Individual Non-Life Cash Value (INCV) product data to report, then all corresponding INCV data must be reported.

20206	E	If you reported not having Individual Non-Life Cash Value (INCV) product data to report, then all corresponding INCV data must be blank.
20207	E	If company does use TPAs, a list of the names of TPAs is required.
20208	E	If company does not use TPAs, a list of the names of the TPAs is not required.
20220	E	If there is INCVP data to report, some INCVP data elements must contain non-zero data.
20221	E	If there is no INCVP data to report, no INCVP data elements may be entered.
20229	E	All INCVP data elements must be >= 0 except dollar amount of direct written premium and face amount of insurance issued during the period.
20261	E	INCVP internal + external replacement policies must be >= replacement policies issued.
20265	W	INCVP number of policies in force at end of period should be >= number of new policies issued during period.
20266	E	INCVP number of new policies issues > 0, then INCVP face amount issued must be > 0
20267	W	If INCVP number of new policies issued + INCVP number of policies in force at end of period > 0 then INCVP dollar amount of written premium should be > 0.
20268	W	INCVP face amount of policies in force at end of period should be >= INCVP face amount of new policies issued during period.
20269	W	If INCVP dollar amount of premium > 0, then INCVP number of policies in force at end of period + INCVP number of new policies issued during period should be > 0.
20270	E	If INCVP face amount of insurance in force at end of period > 0, then INCVP number of policies in force at end of period must be > 0.
20271	E	If INCVP number of policies in force at end of period > 0, then INCVP face amount of insurance in force at end of period > 0.
20272	W	INCVP death claims closed within 60 days + INCVP death claims closed beyond 60 days should be > INCVP death claims denied, resisted, or compromised.
20273	W	INCVP number of policies applied for during period should be >= number of new policies issued during period.
20274	E	Individual Life Non-Cash Value (INCVP) Number of lawsuits open at the beginning of the period + INCVP Number of lawsuits opened during the period - INCVP Number of lawsuits closed during the period = INCVP Number of lawsuits open at the end of the period.
20275	W	Individual Life Non-Cash Value (INCVP) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to INCVP number of lawsuits closed during the period.

Private Passenger Auto

Coverage ID	Description of Coverage Identifiers
COL	Collision
COMP	Comprehensive
BI	Bodily Injury
PD	Property Damage
UMBI & UIMBI	Uninsured Motorists and Underinsured Motorists (UMBI)
UMPD & UIMPD	Uninsured Motorists and Underinsured Motorists (UMPD)
MP	Medical Payments
CSL	Combined Single Limits
PIP	Personal Injury Protection

Rule ID	Type	Description
30001	E	Attestor information must include first name, last name, & title.
30002	E	Since all PPA data-to-report indicators = N, do not submit PPA for this state.
30009	B	The reported MCAS state Private Passenger Auto direct written premium is expected to be within 20% (+/-) of the Financial Annual Statement State Page Direct Written Premium (Line nos. 19.1 + 19.2 + 21.1).
30101	E	If significant event or business strategy change = Y, an explanation is required.
30102	E	If significant event or business strategy change = N, then no explanation is allowed.
30103	E	If any of this business was sold, closed, or moved to another company, an explanation is required.
30104	E	If none of this business was sold, closed, or moved to another company, then no explanation is allowed.
30105	E	An answer is required regarding treatment of supplemental or additional payments on previously reported claims.
30106	E	If the Company writes in the non-standard market = Y, a percent is required.
30107	E	If the Company writes in the non-standard market = N, then no percent is allowed.
30108	E	If company does use MGAs, a list of the names of the MGAs is required.
30109	E	If company does not use MGAs, a list of the names of the MGAs is not required.
30110	E	If company does use TPAs, a list of the names of TPAs is required.
30111	E	If company does not use TPAs, a list of the names of the TPAs is not required.
30112	E	An answer is required regarding the company's use of telemetric or usage-based data.
30140	E	All Underwriting data elements are required.
30141	E	Number of autos with policies in force at the end of the period must be >= number of policies in force at end of period.
30142	E	If number of autos with policies in force at the end of the period > 0, then number of policies in force at end of period must be > 0.
30143	E	If number of policies in force at end of period > 0, then number of autos with policies in force at the end of the period must be > 0.
30144	W	Number of policies in force at end of period should be >= number of new policies written during the period.
30145	W	If number of new policies written during the period > 0, then direct premium written during the period should be > 0.
30146	W	Direct written premium during the period should be => 50000.
30149	E	All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
30150	E	Underwriting data elements must be provided for the Private Passenger Auto coverages you indicated your company wrote or had in-force.
30151	E	You indicated not having any PPA coverage data to report, and therefore, all corresponding underwriting activity data must be blank.
30160	E	Collision (Coll) claims closed with payment during the period = sum of Coll claims closed with payment by day range categories.
30161	E	Collision (Coll) claims closed without payment during the period = sum of Coll claims without payment by day range categories.

30162	E	Collision (Coll) suits open at the beginning of the period + Coll suits opened during the period - Coll suits closed during the period = Coll suits open at the end of the period.

30163	E	Collision (Coll) claims open at the beginning of the period + Coll claims opened during the period - Coll claims closed with payment during the period - Coll claims closed without payment during the period = Coll claims open at the end of the period.
30164	W	Collision (Coll) claims closed with payment during the period should be >= Coll claims closed without payment during the period.
30165	W	Collision claims median days reported on question 32 should correspond to the date range of median claims reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30166	E	All corresponding Collision claims and suits data must not be blank.
30167	E	All corresponding Collision claims and suits data must be blank.
30168	W	Collision (Coll) claims closed without payment during the period should be >= Coll claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30169	W	Collision (Coll) lawsuits closed during the period should be >= Coll lawsuits closed with consideration for the consumer.
30221	E	If there is no Comprehensive (Comp) data to report, no Comprehensive data elements may be entered.
30260	E	Comprehensive (Comp) claims closed with payment during the period = sum of Comp claims closed with payment by day range categories.
30261	E	Comprehensive (Comp) claims closed without payment during the period = sum of Comp claims without payment by day range categories.
30262	E	Comprehensive (Comp) suits open at the beginning of the period + Comp suits opened during the period - Comp suits closed during the period = Comp suits open at the end of the period.
30263	E	Comprehensive (Comp) claims open at the beginning of the period + Comp claims opened during the period - Comp claims closed with payment during the period - Comp claims closed without payment during the period = Comp claims open at the end of the period.
30264	W	Comprehensive (Comp) claims closed with payment during the period should be >= Comp claims closed without payment during the period.
30265	W	Comprehensive claims median days reported on question 32 should correspond to the date range of median claims reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30266	E	All corresponding Comprehensive claims and suits data must not be blank!
30267	E	All corresponding Comprehensive claims and suits data must be blank!
30268	W	Comprehensive (Comp) claims closed without payment during the period should be >= Comp claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30269	W	Comprehensive (Comp) lawsuits closed during the period should be >= Comp lawsuits closed with consideration for the consumer.
30321	E	If there is no Bodily Injury (BI) data to report, no BI data elements may be entered.
30360	E	Bodily Injury (BI) claims closed with payment during the period = sum of BI claims closed with payment by day range categories.
30361	E	Bodily Injury (BI) claims closed without payment during the period = sum of BI claims without payment by day range categories.
30362	E	Bodily Injury (BI) suits open at the beginning of the period + BI suits opened during the period - BI suits closed during the period = BI suits open at the end of the period.
30363	E	Bodily Injury (BI) claims open at the beginning of the period + BI claims opened during the period - BI claims closed with payment during the period - BI claims closed without payment during the period = BI claims open at the end of the period.
30364	W	Bodily Injury (BI) claims closed with payment during the period should be >= BI claims closed without payment during the period.
30365	W	Bodily Injury claims median days reported on question 32 should correspond to the date range of median claim reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30366	E	All corresponding Bodily Injury claims and suits data must not be blank!
30367	E	All corresponding Bodily Injury claims and suits data must be blank!
30368	W	Bodily Injury (BI) claims closed without payment during the period should be >= BI claims closed during the period, without payment, because the amount claimed is below the insured deductible.

30369	W	Bodily Injury (BI) lawsuits closed during the period should be >= BI lawsuits closed with consideration for the consumer.
30421	E	If there is no Property Damage (PD) data to report, no PD data elements may be entered.
30460	E	Property Damage (PD) claims closed with payment during the period = sum of PD claims closed with payment by day range categories.
30461	E	Property Damage (PD) claims closed without payment during the period = sum of PD claims without payment by day range categories.
30462	E	Property Damage (PD) suits open at the beginning of the period + PD suits opened during the period - PD suits closed during the period = PD suits open at the end of the period.
30463	E	Property Damage (PD) claims open at the beginning of the period + PD claims opened during the period - PD claims closed with payment during the period- PD claims closed without payment during the period = PD claims open at the end of the period.
30464	W	Property Damage (PD) claims closed with payment during the period should be >= PD claims closed without payment during the period.
30465	W	Property Damage claims median days reported on question 32 should correspond to the date range of median claim reported on question 33-38. For additional information, please reference the MCAS User Guide.
30466	E	All corresponding Property Damage claims and suits data must not be blank!
30467	E	All corresponding Property Damage claims and suits data must be blank!
30468	W	Property Damage (PD) claims closed without payment during the period should be >= PD claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30469	W	Property Damage (PD) lawsuits closed during the period should be >= PD lawsuits closed with consideration for the consumer.
30521	E	If there is no UMBI data to report, no UMBI data elements may be entered.
30560	E	UMBI claims closed with payment during the period = sum of UMBI claims closed with payment by day range categories.
30561	E	UMBI claims closed without payment during the period = sum of UMBI claims without payment by day range categories.
30562	E	UMBI suits open at the beginning of the period + UMBI suits opened during the period - UMBI suits closed during the period = UMBI suits open at the end of the period.
30563	E	UMBI claims open at the beginning of the period + UMBI claims opened during the period - UMBI claims closed with payment during the period - UMBI claims closed without payment during the period = UMBI claims open at the end of the period.
30564	W	UMBI claims closed with payment during the period should be >= UMBI claims closed without payment during the period.
30565	W	UMBI claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS User Guide.
30566	E	All corresponding UMBI & UIMBI claims and suits data must not be blank!
30567	E	All corresponding UMBI & UIMBI claims and suits data must be blank!
30568	W	UMBI and UIMBI (UMBI) claims closed without payment during the period should be >= UMBI claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30569	W	UMBI and UIMBI (UMBI) lawsuits closed during the period should be >= UMBI lawsuits closed with consideration for the consumer.
30621	E	If there is no UMPD data to report, no UMPD data elements may be entered.
30660	E	UMPD claims closed with payment during the period = sum of UMPD claims closed with payment by day range categories.
30661	E	UMPD claims closed without payment during the period = sum of UMPD claims without payment by day range categories.
30662	E	UMPD suits open at the beginning of the period + UMPD suits opened during the period - UMPD suits closed during the period = UMPD suits open at the end of the period.
30663	E	UMPD claims open at the beginning of the period + UMPD claims opened during the period - UMPD claims closed with payment during the period - UMPD claims closed without payment during the period = UMPD claims open at the end of the period.

30664	W	UMPD claims closed with payment during the period should be >= UMPD claims closed without payment during the period.
30665	W	UMPD claims median days reported on question 32 should correspond to the date range of median claims reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30666	E	All corresponding UMPD & UIMPD claims and suits data must not be blank!
30667	E	All corresponding UMPD & UIMPD claims and suits data must be blank!
30668	W	UMPD and UIMPD (UMPD) claims closed without payment during the period should be >= UMPD claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30669	W	UMPD and UIMPD (UMPD) lawsuits closed during the period should be >= UMPD lawsuits closed with consideration for the consumer.
30721	E	If there is no PPA Medical Payments (MP) data to report, no PPA MP data elements may be entered.
30760	E	PPA Medical Payments (MP) claims closed with payment during the period = sum of PPA MP claims closed with payment by day range categories.
30761	E	PPA Medical Payments (MP) claims closed without payment during the period = sum of PPA MP claims without payment by day range categories.
30762	E	PPA Medical Payments (MP) suits open at the beginning of the period + PPA MP suits opened during the period - PPA MP suits closed during the period = PPA MP suits open at the end of the period.
30763	E	PPA Medical Payments (MP) claims open at the beginning of the period + PPA MP claims opened during the period - PPA MP claims closed with payment during the period = PPA MP claims open at the end of the period.
30764	W	PPA Medical Payments (MP) claims closed with payment during the period should be >= PPA MP claims closed without payment during the period.
30765	W	PPA Medical Payments claims median days reported on question 32 should correspond to the date range of median claim reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30766	E	All corresponding Medical Payments claims and suits data must not be blank!
30767	E	All corresponding Medical Payments claims and suits data must be blank!
30768	W	Medical Payments (PPA MP) claims closed without payment during the period should be >= PPA MP claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30769	W	Medical Payments (PPA MP) lawsuits closed during the period should be >= PPA MP lawsuits closed with consideration for the consumer.
30821	E	If there is no Combined Single Limits (CSL) data to report, no CSL data elements may be entered.
30860	E	Combined Single Limits (CSL) claims closed with payment during the period = sum of CSL claims closed with payment by day range categories.
30861	E	Combined Single Limits (CSL) claims closed without payment during the period = sum of CSL claims without payment by day range categories.
30862	E	Combined Single Limits (CSL) suits open at the beginning of the period + CSL suits opened during the period - CSL suits closed during the period = CSL suits open at the end of the period.
30863	E	Combined Single Limits (CSL) claims open at the beginning of the period + CSL claims opened during the period - CSL claims closed with payment during the period - CSL claims closed without payment during the period = CSL claims open at the end of the period.
30864	W	Combined Single Limits (CSL) claims closed with payment during the period should be >= CSL claims closed without payment during the period.
30865	W	Combined Single Limits (CSL) claims median days reported on question 32 should correspond to the date range of median claim reported on questions 33-38. For additional information, please reference the MCAS User Guide.
30866	E	All corresponding Combined Single Limits claims and suits data must not be blank!
30867	E	All corresponding Combined Single Limits claims and suits data must be blank!
30868	W	Combined Single Limits (CSL) claims closed without payment during the period should be >= CSL claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30869	W	Combined Single Limits (CSL) lawsuits closed during the period should be >= CSL lawsuits closed with consideration for the consumer.
30921	E	If there is no Personal Injury Protection (PIP) data to report, no PIP data elements may be entered.

30960	E	Personal Injury Protection (PIP) claims closed with payment during the period = sum of PIP claims closed with payment by day range categories.
30961	E	Personal Injury Protection (PIP) claims closed without payment during the period = sum of PIP claims without payment by day range categories.
30962	E	Personal Injury Protection (PIP) suits open at the beginning of the period + PIP suits opened during the period - PIP suits closed during the period = PIP suits open at the end of the period.
30963	E	Personal Injury Protection (PIP) claims open at the beginning of the period + PIP claims opened during the period -
30964	W	Personal Injury Protection (PIP) claims closed with payment during the period should be >= PIP claims closed without payment during the period.
30965	W	Personal Injury Protection claims median days reported on question 32 should correspond to the date range of median claim reported on questions 33-38. For additional information, please reference the MCAS User Guide.

30966	E	All corresponding Personal Injury Protection claims and suits data must not be blank!
30967	E	All corresponding Personal Injury Protection claims and suits data must be blank!
30968	W	Personal Injury Protection (PIP) claims closed without payment during the period should be >= PIP claims closed during the period, without payment, because the amount claimed is below the insured deductible.
30969	W	Personal Injury Protection (PIP) lawsuits closed during the period should be >= PIP lawsuits closed with consideration for the consumer.

Homeowners

Coverage ID	Description of Coverage Identifiers
DWEL	Dwelling
PP	Personal Property
LIAB	Liability
MP	Medical Payments
LoU	Loss of Use

Rule ID	Type	Description
40002	E	Since all HO data-to-report indicators = N, do not submit HO for this state.
40003	E	Attestor information must include first name, last name, & title.
40009	B	MCAS state Homeowners direct written premium reported is expected to be within 20% (+/-) of the Financial Annual Statement (FAS) State Page Direct Written Premium (Line no. 4).
40101	E	If company writes business in the non-standard market = Y, then a percent of business is required.
40102	E	If company writes business in the non-standard market = N, then no percent is allowed.
40103	E	If significant event or business strategy change = Y, an explanation is required.
40104	E	If significant event or business strategy change = N, then no explanation is allowed.
40105	E	An answer is required regarding treatment of supplemental or additional payments on previously reported claims.
40106	E	If any of this business was sold, closed, or moved to another company, an explanation is required.
40107	E	If none of this business was sold, closed, or moved to another company, then no explanation is allowed.
40108	E	If company does use MGAs, a list of the names of the MGAs is required.
40109	E	If company does not use MGAs, a list of the names of the MGAs is not required.
40110	E	If company does use TPAs, a list of the names of TPAs is required.
40111	E	If company does not use TPAs, a list of the names of the TPAs is not required.
40121	E	If there is no Dwelling (Dwell) data to report, then no Dwelling data elements may be entered.
40140	E	All Underwriting data elements are required.
40141	W	Number of dwellings with policies in force at the end of the period should be >= number of dwelling policies in force at end of period.
40142	E	If number of dwellings which have policies in force at the end of the period > 0, then number of policies in force at end of period must be > 0.
40143	E	If number of policies in force at end of period > 0, then number of dwellings which have policies in force at the end of the period must be > 0.
40144	W	Number of policies in force at end of period should be >= number of new business policies written during the period.
40145	W	If number of new policies written during the period > 0, then direct premium written during the period should be > 0.
40146	W	Direct written premium during the period should be => $50,000.
40149	E	All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
40150	E	Underwriting data elements must be provided for the homeowners coverages you indicated your company wrote or had in-force.
40151	E	Number of dwellings which have policies in force at the end of the period must equal the sum of all types of residential property policies in force at the end of the period.
40160	E	Dwelling (Dwell) claims closed with payment during the period must be = sum of Dwelling claims closed with payment by day range categories.
40161	E	Dwelling (Dwell) claims closed without payment during the period must be = sum of Dwelling claims without payment by day range categories.
40162	W	Dwelling (Dwell) suits open at the beginning of the period + Dwell suits opened during the period - Dwell suits closed during the period should be = Dwell suits open at the end of the period.

40163	E	Dwelling (Dwell) claims open at the beginning of the period + Dwell claims opened during the period - Dwell claims closed with payment during the period - Dwell claims closed without payment during the period must be = Dwell claims open at the end of the period.
40164	W	Dwelling (Dwell) claims closed with payment during the period should be >= Dwell claims closed without payment during the period.

40165	W	Dwelling claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS User Guide.
40166	E	All corresponding Dwelling claims and suits data must not be blank.
40167	E	All corresponding Dwelling claims and suits data must be blank.
40170	W	Dwelling (DWELL) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to DWELL number of lawsuits closed during the period.
40221	E	If there is no Personal Property (PP) data to report, no PP data elements may be entered.
40260	E	Personal Property (PP) claims closed with payment during the period must be = sum of PP claims closed with payment by day range categories.
40261	E	Personal Property (PP) claims closed without payment during the period must be = sum of PP claims without payment by day range categories.
40262	W	Personal Property (PP) suits open at the beginning of the period + PP suits opened during the period - PP suits closed during the period should be = PP suits open at the end of the period.
40263	E	Personal Property (PP) claims open at the beginning of the period + PP claims opened during the period - PP claims closed with payment during the period - PP claims closed without payment during the period must be = PP claims open at the end of the period.
40264	W	Personal Property (PP) claims closed with payment during the period should be >= PP claims closed without payment during the period.
40265	W	Personal Property claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS Industry User Guide.
40266	E	All corresponding Personal Property claims and suits data must not be blank!
40267	E	All corresponding Personal Property claims and suits data must be blank!
40270	W	Dwelling (DWELL) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to DWELL number of lawsuits closed during the period.
40321	E	If there is no Liability data to report, no Liability data elements may be entered.
40360	E	Liab claims closed with payment during the period = sum of Liab claims closed with payment by day range categories.
40361	E	Liab claims closed without payment during the period must be = sum of Liab claims without payment by day range categories.
40362	W	Liab suits open at the beginning of the period + Liab suits opened during the period - Liab suits closed during the period should be = Liab suits open at the end of the period.
40363	E	Liab claims open at the beginning of the period + Liab claims opened during the period - Liab claims closed with payment during the period - Liab claims closed without payment during the period must be = Liab claims open at the end of the period.
40364	W	Liab claims closed with payment during the period should be >= Liab claims closed without payment during the period.
40365	W	Liab claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS Industry User Guide.
40366	E	All corresponding Liability claims and suits data must not be blank!
40367	E	All corresponding Liability claims and suits data must be blank!
40370	W	Liability (LIAB) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to LIAB number of lawsuits closed during the period.
40421	E	If there is no HO Medical Payments (MP) data to report, no HO MP data elements may be entered.
40460	E	HO Medical Payments (MP) claims closed with payment during the period must be = sum of HO MP claims closed with payment by day range categories.

40461	E	HO Medical Payments (MP) claims closed without payment during the period must be = sum of HO MP claims without payment by day range categories.
40462	W	HO Medical Payments (MP) suits open at the beginning of the period + HO MP suits opened during the period - HO MP suits closed during the period should be = HO MP suits open at the end of the period.
40463	E	HO Medical Payments (MP) claims open at the beginning of the period + HO MP claims opened during the period - HO MP claims closed with payment during the period - HO MP claims closed without payment during the period must be = HO MP claims open at the end of the period.
40464	W	HO Medical Payments (MP) claims closed with payment during the period should be >= HO MP claims closed without payment during the period.
40465	W	HO Medical Payments claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS User Guide.
40466	E	All corresponding Medical Payments claims and suits data must not be blank!
40467	E	All corresponding Medical Payments claims and suits data must be blank!
40470	W	HO Medical Payments (HO MP) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to HO MP number of lawsuits closed during the period.
40521	E	HO Loss of Use (LOU) claims closed with payment during the period must be = sum of HO LOU claims closed with payment by day range categories.
40560	E	HO Loss of Use (LOU) claims closed with payment during the period must be = sum of HO LOU claims closed with payment by day range categories.
40561	E	HO Loss of Use (LOU) claims closed without payment during the period must be = sum of HO LOU claims without payment by day range categories.
40562	W	HO Loss of Use (LOU) suits open at the beginning of the period + HO LOU suits opened during the period - HO LOU suits closed during the period should be = HO LOU suits open at the end of the period.
40563	E	HO Loss of Use (LOU) claims open at the beginning of the period + HO LOU claims opened during the period - HO LOU claims closed with payment during the period - HO LOU claims closed without payment during the period = HO LOU claims open at the end of the period.
40564	W	HO Loss of Use (LOU) claims closed with payment during the period should be >= HO LOU claims closed without payment during the period.
40565	W	HO Loss of Use claims median days reported on question 26 should correspond to the date range of median claims reported on questions 27-32. For additional information, please reference the MCAS User Guide.
40568	E	All corresponding Loss of Use claims and suits data must not be blank!
40569	E	All corresponding Loss of Use claims and suits data must be blank!
40570	W	HO Loss of Use (LOU) Number of lawsuits closed during the period with consideration for the customer should be less than or equal to LOU number of lawsuits closed during the period.

Long-Term Care

Coverage ID	Description of Coverage Identifiers
SLTC	**Stand-Alone LTC**
LHLTC	**Life LTC Hybrid**
AHLTC	**Annuity LTC Hybrid**

Rule ID	Type	Description
50002	E	Since all LTC data-to-report indicators = N, do not submit LTC for this state.
50003	E	Attestor information must include first name, last name, & title.
50102	E	If there is no Stand-Alone LTC (SLTC) data to report, the response whether the company had any significant event or business strategy change question for SLTC must also be 'No'.
50103	E	If the company had a significant event or business strategy change that would affect the Stand-Alone LTC (SLTC) data for this reporting period, then comments are required on the explanation field.
50104	E	If the company did not have any significant event or business strategy change that would affect the Stand-Alone LTC (SLTC) data for this reporting period, then the explanation field must be blank.
50105	E	The explanation field must not be blank if you had any Stand-Alone LTC business that was sold, closed, or moved to another company.
50106	E	The explanation field must be blank if you did not have any Stand-Alone LTC business that was sold, closed, or moved to another company.
50121	E	If there is no Stand-Alone LTC (SLTC) data to report, all corresponding SLTC data elements must be blank!
50122	E	All corresponding Stand-Alone LTC data must not be blank!
50140	W	Stand-Alone LTC (SLTC) policies in force at beginning of the period + SLTC policies issued during the period - SLTC cancellations, lapses & rescissions during the period should be within 20% of SLTC policies in force at end of period.
50150	E	Number of Stand-Alone LTC pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50151	W	The number of Stand-Alone LTC claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.
50160	E	Number of Stand-Alone LTC (SLTC) benefit payment requests pending at beginning of period + number of SLTC benefit payment requests received during the period must be => number of SLTC benefit payment requests denied or not paid during the period.
50161	E	Number of Stand-Alone LTC (SLTC) benefit payment requests pending at beginning of period + number of SLTC benefit payment requests received during the period - number of SLTC denied or not paid benefit payment requests during the period must be => number of SLTC pending benefit payment requests at end of period.
50162	E	Number of Stand-Alone LTC (SLTC) benefit payment requests denied or not paid within 30, 60, 90 and beyond 90 days must be = number of SLTC benefit payment requests denied or not paid during the period.
50170	E	Number of Stand-Alone LTC (SLTC) lawsuits open + number of SLTC lawsuits opened during the period - number of SLTC lawsuits closed during the period must be = number of SLTC lawsuits open at end of period.
50171	W	Number of Stand-Alone LTC (SLTC) lawsuits closed during the period should be => number of SLTC lawsuits closed during the period with consideration for the consumer.
50202	E	If there is no Life LTC Hybrid (LHLTC) data to report, the significant event or business strategy change question for LHLTC must be 'N'.
50203	E	If the company had a significant event or business strategy change that would affect the Life LTC Hybrid (LHLTC) data for this reporting period, then comments are required on the explanation field.
50204	E	If the company did not have any significant event or business strategy change that would affect the Life LTC Hybrid (LHLTC) data for this reporting period, then the explanation field must be blank.
50205	E	The explanation field must not be blank if you had any Life Hybrid LTC business that was sold, closed, or moved to another company.

50206	E	The explanation field must be blank if you did not have any Life Hybrid LTC business that was sold, closed, or moved to another company.
50221	E	If there is no Life LTC Hybrid (LHLTC) data to report, all LHLTC data elements must be blank.
50222	E	All corresponding Life Hybrid LTC data must not be blank!

50240	W	Life LTC Hybrid (LHLTC) policies in force at beginning of the period + LHLTC policies issued during the period - LHLTC cancellations, lapses & rescissions during the period should be within 20% of LHLTC policies in force at end of period.
50241	E	Life LTC Hybrid (LHLTC) internal + external replacements must be = sum of LHLTC replacements by age group.
50250	E	Number of Life LTC Hybrid pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50251	W	The number of Life LTC Hybrid claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.
50260	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests pending at beginning of period + number of LHLTC benefit payment requests received during the period must be => number of LHLTC benefit payment requests denied or not paid during the period.
50261	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests pending at beginning of period + number of LHLTC benefit payment requests received during the period - number of LHLTC denied or not paid benefit payment requests during the period must be => number of LHLTC pending benefit payment requests at end of period.
50262	E	Number of Life LTC Hybrid (LHLTC) benefit payment requests denied or not paid within 30, 60, 90 and beyond 90 days must be = number of LHLTC benefit payment requests denied or not paid during the period.
50270	E	Number of Life LTC Hybrid (LHLTC) lawsuits open + number of LHLTC lawsuits opened during the period - number of LHLTC lawsuits closed during the period must be = number of LHLTC lawsuits open at end of period.
50271	W	Number of Life LTC Hybrid (LHLTC) lawsuits closed during the period should be => number of LHLTC lawsuits closed during the period with consideration for the consumer.
50302	E	If there is no Annuity LTC Hybrid (AHLTC) data to report, the significant event or business strategy change question for AHLTC must be N.
50303	E	If the company had a significant event or business strategy change that would affect the Annuity LTC Hybrid (AHLTC) data for this reporting period, then comments are required on the explanation field.
50304	E	If the company did not have any significant event or business strategy change that would affect the Annuity LTC Hybrid (AHLTC) data for this reporting period, then the explanation field must be blank.
50305	E	The explanation field must not be blank if you had any Annuity LTC Hybrid business that was sold, closed, or moved to another company.
50306	E	The explanation field must be blank if you did not have any Annuity Hybrid LTC business that was sold, closed, or moved to another company.
50321	E	If there is no Annuity LTC Hybrid (AHLTC) data to report, all AHLTC data elements must be blank.
50322	E	All corresponding Annuity LTC Hybrid data must not be blank!
50340	W	Annuity LTC Hybrid (AHLTC) policies in force at beginning of the period + AHLTC policies issued during the period - AHLTC cancellations, lapses & rescissions during the period should be within 20% of AHLTC policies in force at end of period.
50341	E	Annuity LTC Hybrid (AHLTC) internal + external replacements must be = sum of AHLTC replacements by age group.
50350	E	Number of Annuity LTC Hybrid pending claimant request determinations at beginning of period + number of new claimants during the period - all claimant requests denied, not paid, or closed without payment during the period must be => number of pending claimant requests determinations at end of period.
50351	W	The number of Annuity LTC Hybrid claimant requests denied, not paid, or closed without payment during the period should be less than half of the total determinations.
50360	E	Number of Annuity LTC Hybrid (AHLTC) benefit payment requests pending at beginning of period + number of AHLTC benefit payment requests received during the period must be => number of AHLTC benefit payment requests denied or not paid during the period.

50361	E	Number of Annuity LTC Hybrid (AHLTC) benefit payment requests pending at beginning of period + number of AHLTC benefit payment requests received during the period - number of AHLTC denied or not paid benefit payment requests during the period must be => number of AHLTC pending benefit payment requests at end of period.
50362	E	Number of Annuity LTC Hybrid (AHLTC) benefit payment requests denied or not paid within 30, 60, 90 and beyond 90 days must be = number of AHLTC benefit payment requests denied or not paid during the period.

50370	E	Number of Annuity LTC Hybrid (AHLTC) lawsuits open + number of AHLTC lawsuits opened during the period - number of AHLTC lawsuits closed during the period must be = number of AHLTC lawsuits open at end of period.
50371	W	Number of Annuity LTC Hybrid (AHLTC) lawsuits closed during the period should be => number of AHLTC lawsuits closed during the period with consideration for the consumer.

Health

Coverage ID	Description of Coverage Identifiers
IEX	In-Exchange
IEIH	In-Exchange: Individual Health
IESG	In-Exchange: Small Group Health
IECA	In-Exchange: Catastrophic
IEMI	In-Exchange: Multi-State - Individual
IEMS	In-Exchange: Multi-State - Small Group
OEX	Out-of-Exchange
OEIH	Out-of-Exchange: Individual Health
OESG	Out-of-Exchange: Small Group Health
OEGT	Out-of-Exchange: Grandfathered/Transitional Plans
OECA	Out-of-Exchange: Catastrophic
OELG	Out-of-Exchange: Large Group
OESP	Out-of-Exchange: Student Plans

Rule ID	Type	Description
60001	E	Responses to all MCAS Interrogatory questions must not be blank!
60002	E	If you indicated that your company does not have any health insurance data to report, then no MCAS Health Filing is required.
60003	E	If the company has Small Group or Multi-State Small Group data to report, then the number of small groups (Item 6) in-force at the end of the reporting period must not be blank!
60004	E	If the company does not have Small Group or Multi-State Small Group data to report, then the number of small groups (Item 6) in-force at the end of the reporting period must be blank!
60007	E	OESG: If the company has any Small Group Health insurance coverage other than transitional, grandfathered, or multi-state policies data to report, then the number of small groups must not be blank.
60008	E	OESG: If the company does not have any Small Group Health insurance coverage, then the number of small groups must be blank.
60009	E	OELG: If the company has any Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then the number of large groups must not be blank.
60010	E	OELG: If the company does not have any Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) or Grandfathered or Traditional plan data to report, then the number of large groups must be blank.
60013	E	No Health MCAS filing is required if the total earned premiums for the reporting year is less than $50,000.
60014	B	The reported state MCAS Health premium earned is expected to be within 20% (+/-) of the Financial Annual Statement (FAS) Supplemental Healthcare Exhibit Part 1 (Line no. 1.1) for Comprehensive (Individual, Small Group and Large Group) and Student Health Insurance coverages.
60015	E	Attestor information must include first name, last name, & title.
61101	E	IEIH-Bronze: If the company has In-Exchange Individual Health insurance (IEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Bronze data elements must be reported.
61102	E	IEIH-Bronze: If the company does not have In-Exchange Individual Health insurance (IEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Bronze data elements.
61104	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61105	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61106	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

61107	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61108	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61110	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the total policies issued and policies renewed for IEIH-Bronze should be greater than zero.
61111	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the member months for policies issued for IEIH-Bronze should be greater than zero.
61112	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the member months for policies renewed for IEIH-Bronze should be greater than zero.
61113	W	IEIH-Bronze: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Individual Health Bronze health plans, the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Bronze should be greater than zero.
61114	W	IEIH-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Bronze health plans, the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Bronze should be greater than zero.
61117	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, if the number of claims paid for IEIH-Bronze is greater than zero then the number of claims paid for IEIH-Bronze should be greater than the number of claims denied.
61119	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the number of claims submitted by network providers for IEIH-Bronze should be greater than the number of claims submitted by out-of-network providers.
61121	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the total amount of claims paid for IEIH-Bronze should be less than the reported Earned Premiums.
61122	W	IEIH-Bronze: For In-Exchange Individual Health Bronze health plans, the number of adverse determinations upheld for IEIH-Bronze should be greater than the number of adverse determinations overturned for grievances involving adverse determinations (excluding voluntary levels of reviews).
61129	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61130	E	IEIH-Bronze: For In-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61201	E	IEIH-Silver: If the company has In-Exchange Individual Health insurance (IEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Silver data elements must be reported.
61202	E	IEIH-Silver: If the company does not have In-Exchange Individual Health insurance (IEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Silver data elements.
61204	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61205	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

61206	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61207	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61208	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61210	W	IEIH-Silver: For In-Exchange Individual Health Silver health plans, the total policies issued, and policies renewed for IEIH-Silver should be greater than zero.
61211	W	IEIH-Silver: For In-Exchange Individual Health Silver health plans, the member months for policies issued for IEIH-Silver should be greater than zero.
61212	W	IEIH-Silver: If the company reported policies renewed greater than zero for In-Exchange Individual Health Silver health plans, then the member months for policies renewed for IEIH-Silver should be greater than zero.
61213	W	IEIH-Silver: For In-Exchange Individual Health Silver health plans, the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Silver should be greater than zero for terminations and cancellations initiated by consumer greater than zero.
61214	W	IEIH-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Silver should be greater than zero.
61217	W	IEIH-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Silver health plans, then the number of claims paid for IEIH-Silver should be greater than the number of claims denied.
61219	W	IEIH-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Silver health plans, then the number of claims submitted by network providers for IEIH-Silver should be greater than the number of claims submitted by out-of-network providers.
61221	W	IEIH-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Silver health plans, then the total amount of claims paid for IEIH-Silver should be less than the reported Earned Premiums.
61222	W	IEIH-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Silver health plans, then the number of adverse determinations upheld for IEIH-Silver should be greater than the number of adverse determinations overturned.
61229	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61230	E	IEIH-Silver: For In-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61301	E	IEIH-Gold: If the company has In-Exchange Individual Health insurance (IEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Gold data elements must be reported.
61302	E	IEIH-Gold: If the company does not have In-Exchange Individual Health insurance (IEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Gold data elements.
61304	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.

61305	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61306	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61307	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61308	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61310	W	IEIH-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Gold health plans, then the total policies issued and policies renewed for IEIH-Gold should be greater than zero.
61311	W	IEIH-Gold: If the company reported new policies issued greater than zero for In-Exchange Individual Health Gold health plans, then the member months for policies issued for IEIH-Gold should be greater than zero.
61312	W	IEIH-Gold: If the company reported policies renewed greater than zero for In-Exchange Individual Health Gold health plans, then the member months for policies renewed for IEIH-Gold should be greater than zero.
61313	W	IEIH-Gold: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Gold should be greater than zero.
61314	W	IEIH-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Gold should be greater than zero.
61317	W	IEIH-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Gold health plans, then the number of claims paid for IEIH-Gold should be greater than the number of claims denied.
61319	W	IEIH-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Gold health plans, then the number of claims submitted by network providers for IEIH-Gold should be greater than the number of claims submitted by out-of-network providers.
61321	W	IEIH-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Gold health plans, then the total amount of claims paid for IEIH-Gold should be less than the reported Earned Premiums.
61322	W	IEIH-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Gold health plans, then the number of adverse determinations upheld for IEIH-Gold should be greater than the number of adverse determinations overturned.
61329	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
61330	E	IEIH-Gold: For In-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61401	E	IEIH-Platinum: If the company has In-Exchange Individual Health insurance (IEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Platinum data elements must be reported.

61402	E	IEIH-Platinum: If the company does not have In-Exchange Individual Health insurance (IEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Platinum data elements.
61404	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61405	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61406	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

61407	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61408	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61410	W	IEIH-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Platinum health plans, then the total policies issued and policies renewed for IEIH-Platinum should be greater than zero.
61411	W	IEIH-Platinum: If the company reported new policies issued greater than zero for In-Exchange Individual Health Platinum health plans, then the member months for policies issued for IEIH-Platinum should be greater than zero.
61412	W	IEIH-Platinum: If the company reported policies renewed greater than zero for In-Exchange Individual Health Platinum health plans, then the member months for policies renewed for IEIH-Platinum should be greater than zero.
61413	W	IEIH-Platinum: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Platinum should be greater than zero.
61414	W	IEIH-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Platinum should be greater than zero.
61417	W	IEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Platinum health plans, then the number of claims paid for IEIH-Platinum should be greater than the number of claims denied.
61419	W	IEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Platinum health plans, then the number of claims submitted by network providers for IEIH-Platinum should be greater than the number of claims submitted by out-of-network providers.
61421	W	IEIH-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Platinum health plans, then the total amount of claims paid for IEIH-Platinum should be less than the reported Earned Premiums.
61422	W	IEIH-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Platinum health plans, then the number of adverse determinations upheld for IEIH-Platinum should be greater than the number of adverse determinations overturned.
61429	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.

61430	E	IEIH-Platinum: For In-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61501	E	IEIH-Total: If the company has In-Exchange Individual Health insurance (IEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all IEIH-Total data elements must be reported.
61502	E	IEIH-Total: If the company does not have In-Exchange Individual Health insurance (IEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all IEIH-Total data elements.
61504	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
61505	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61506	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61507	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61508	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
61510	W	IEIH-Total: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Total health plans, then the total policies issued and policies renewed for IEIH-Total should be greater than zero.
61511	W	IEIH-Total: If the company reported new policies issued greater than zero for In-Exchange Individual Health Total health plans, then the member months for policies issued for IEIH-Total should be greater than zero.
61512	W	IEIH-Total: If the company reported policies renewed greater than zero for In-Exchange Individual Health Total health plans, then the member months for policies renewed for IEIH-Total should be greater than zero.
61513	W	IEIH-Total: If the company reported terminations and cancellations initiated by consumer greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEIH-Total should be greater than zero.
61514	W	IEIH-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEIH-Total should be greater than zero.
61515	W	IEIH-Total: If the company reported rescissions greater than zero for In-Exchange Individual Health Total health plans, then the number of lives impacted by rescissions for IEIH-Total should be greater than zero.
61516	W	IEIH-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Individual Health Total health plans, then the number of prior authorizations approved for IEIH-Total should be greater than the number of prior authorizations denied.
61517	W	IEIH-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for IEIH-Total should be greater than the number of claims denied.
61518	W	IEIH-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for IEIH-Total should be greater than the number of claims denied.

61519	W	IEIH-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims submitted by network providers for IEIH-Total should be greater than the number of claims submitted by out-of-network providers.
61520	W	IEIH-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Individual Health Total health plans, then the number of claims paid for in-network services for IEIH-Total should be greater than the number of claims paid for out-of-network services.
61521	W	IEIH-Total: If the company reported Earned Premiums greater than zero for In-Exchange Individual Health Total health plans, then the total amount of claims paid for IEIH-Total should be less than the reported Earned Premiums.
61522	W	IEIH-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Individual Health Total health plans, then the number of adverse determinations upheld for IEIH-Total should be greater than the number of adverse determinations overturned.
61524	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
61525	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
61526	W	IEIH-Total: For In-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
61529	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61530	E	IEIH-Total: For In-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
61601	E	IEIH: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange individual health insurance coverage for reporting year.
61602	E	IEIH: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for in-exchange individual health insurance coverage during the period.
61603	E	IEIH: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for in-exchange individual health insurance coverage during the period.
61604	E	IEIH: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange individual health insurance coverage during the period.
61605	E	IEIH: The sum of member months for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies renewed for in-exchange individual health insurance coverage during the period.
61606	E	IEIH: The sum of number of policy terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by the policyholder reported for in-exchange individual health insurance coverage during the period.

61607	E	IEIH: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for in-exchange individual health insurance coverage during the period.
61608	E	IEIH: The sum of number of insured lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on terminations and cancellations initiated by the policyholder for in-exchange individual health insurance coverage during the period.
61609	E	IEIH: The sum of number of insured lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange individual health insurance coverage during the period.
61611	E	IEIH: The sum of number of insured lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted by rescissions reported for in-exchange individual health insurance coverage during the period.
61615	E	IEIH: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange individual health insurance coverage during the period.
61616	E	IEIH: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange individual health insurance coverage during the period.
61617	E	IEIH: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange individual health insurance coverage during the period.

61618	E	IEIH: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange individual health insurance coverage during the period.
61619	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61620	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61621	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange individual health insurance coverage during the period.
61622	E	IEIH: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61623	E	IEIH: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange individual health insurance coverage during the period.
61624	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61625	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61626	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange individual health insurance coverage during the period.

61627	E	IEIH: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61628	E	IEIH: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange individual health insurance coverage during the period.
61629	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61630	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61631	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange individual health insurance coverage during the period.
61632	E	IEIH: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61633	E	IEIH: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of- network services reported for in-exchange individual health insurance coverage during the period.
61634	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange individual health insurance coverage during the period.
61635	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange individual health insurance coverage during the period.
61636	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange individual health insurance coverage during the period.
61637	E	IEIH: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange individual health insurance coverage during the period.
61638	E	IEIH: The sum of claims paid reported for bronze, silver, gold and platinum coverages must equal the total claims paid (excluding pharmacy claims) reported for in-exchange individual health insurance coverage during the period.
61639	E	IEIH: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange individual health insurance coverage during the period.
61640	E	IEIH: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange individual health insurance coverage during the period.
61641	E	IEIH: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange individual health insurance coverage during the period.
61642	E	IEIH: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange individual health insurance coverage during the period.
61643	E	IEIH: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange individual health insurance coverage during the period.

61644	E	IEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
61645	E	IEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange individual health insurance coverage during the period.
61646	E	IEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange individual health insurance coverage during the period.
61647	E	IEIH: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange individual health insurance coverage during the period.
61648	E	IEIH: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange individual health insurance coverage during the period.
61649	E	IEIH: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
61650	E	IEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange individual health insurance coverage during the period.
61651	E	IEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange individual health insurance coverage during the period.

61652	E	IEIH: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange individual health insurance coverage during the period.
61653	E	IEIH: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange individual health insurance coverage during the period.
61654	E	IEIH: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange individual health insurance coverage during the period.
61655	E	IEIH: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange individual health insurance coverage during the period.
62101	E	IESG-Bronze: If the company has In-Exchange Small Group Health insurance (IESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Bronze data elements must be reported.
62102	E	IESG-Bronze: If the company does not have In-Exchange Small Group Health insurance (IESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Bronze data elements.

62104	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62105	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62106	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62107	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62108	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62117	W	IESG-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of claims paid for IESG-Bronze should be greater than the number of claims denied.
62119	W	IESG-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of claims submitted by network providers for IESG-Bronze should be greater than the number of claims submitted by out-of-network providers.
62121	W	IESG-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Bronze health plans, then the total amount of claims paid for IESG-Bronze should be less than the reported Earned Premiums.
62122	W	IESG-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Bronze health plans, then the number of adverse determinations upheld for IESG-Bronze should be greater than the number of adverse determinations overturned.
62129	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62130	E	IESG-Bronze: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62201	E	IESG-Silver: If the company has In-Exchange Small Group Health insurance (IESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Silver data elements must be reported.
62202	E	IESG-Silver: If the company does not have In-Exchange Small Group Health insurance (IESG) Silver coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Silver data elements.
62204	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62205	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62206	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

62207	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62208	E	IESG-Silver: For In-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62217	W	IESG-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Silver health plans, then the number of claims paid for IESG-Silver should be greater than the number of claims denied.
62219	W	IESG-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Silver health plans, then the number of claims submitted by network providers for IESG-Silver should be greater than the number of claims submitted by out-of-network providers.
62221	W	IESG-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Silver health plans, then the total amount of claims paid for IESG-Silver should be less than the reported Earned Premiums.
62222	W	IESG-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Silver health plans, then the number of adverse determinations upheld for IESG-Silver should be greater than the number of adverse determinations overturned.
62229	E	IESG-Silver: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62230	E	IESG-Silver: For In-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62301	E	IESG-Gold: If the company has In-Exchange Small Group Health insurance (IESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Gold data elements must be reported.
62302	E	IESG-Gold: If the company does not have In-Exchange Small Group Health insurance (IESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Gold data elements.

62304	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62305	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62306	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62307	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62308	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62317	W	IESG-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Gold health plans, then the number of claims paid for IESG-Gold should be greater than the number of claims denied.

62319	W	IESG-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Gold health plans, then the number of claims submitted by network providers for IESG-Gold should be greater than the number of claims submitted by out-of-network providers.
62321	W	IESG-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Gold health plans, then the total amount of claims paid for IESG-Gold should be less than the reported Earned Premiums.
62322	W	IESG-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Gold health plans, then the number of adverse determinations upheld for IESG-Gold should be greater than the number of adverse determinations overturned.
62329	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62330	E	IESG-Gold: For In-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62401	E	IESG-Platinum: If the company has In-Exchange Small Group Health insurance (IESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Platinum data elements must be reported.
62402	E	IESG-Platinum: If the company does not have In-Exchange Small Group Health insurance (IESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Platinum data elements.
62404	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62405	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62406	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62407	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62408	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62417	W	IESG-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of claims paid for IESG-Platinum should be greater than the number of claims denied.
62419	W	IESG-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of claims submitted by network providers for IESG-Platinum should be greater than the number of claims submitted by out-of-network providers.
62421	W	IESG-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Platinum health plans, then the total amount of claims paid for IESG-Platinum should be less than the reported Earned Premiums.
62422	W	IESG-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Platinum health plans, then the number of adverse determinations upheld for IESG-Platinum should be greater than the number of adverse determinations overturned.

62429	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62430	E	IESG-Platinum: For In-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62501	E	IESG-Total: If the company has In-Exchange Small Group Health insurance (IESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all IESG-Total data elements must be reported.
62502	E	IESG-Total: If the company does not have In-Exchange Small Group Health insurance (IESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all IESG-Total data elements.
62504	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
62505	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62506	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62507	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62508	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
62515	W	IESG-Total: If the company reported rescissions greater than zero for In-Exchange Small Group Health Total health plans, then the number of lives impacted by rescissions for IESG-Total should be greater than zero.
62516	W	IESG-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Small Group Health Total health plans, then the number of prior authorizations approved for IESG-Total should be greater than the number of prior authorizations denied.
62517	W	IESG-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for IESG-Total should be greater than the number of claims denied.
62518	W	IESG-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for IESG-Total should be greater than the number of claims denied.
62519	W	IESG-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims submitted by network providers for IESG-Total should be greater than the number of claims submitted by out-of-network providers.
62520	W	IESG-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Small Group Health Total health plans, then the number of claims paid for in-network services for IESG-Total should be greater than the number of claims paid for out-of-network services.
62521	W	IESG-Total: If the company reported Earned Premiums greater than zero for In-Exchange Small Group Health Total health plans, then the total amount of claims paid for IESG-Total should be less than the reported Earned Premiums.

62522	W	IESG-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Small Group Health Total health plans, then the number of adverse determinations upheld for IESG-Total should be greater than the number of adverse determinations overturned.
62529	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62530	E	IESG-Total: For In-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
62601	E	IESG: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Small Group Health insurance coverage for reporting year.
62604	E	IESG: The sum of member months for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months for policies issued for in-exchange Small Group Health insurance coverage during the period.
62605	E	IESG: The sum of member months for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of member months and cancellations for policies renewed for in-exchange Small Group Health insurance coverage during the period.
62608	E	IESG: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Small Group Health insurance coverage during the period.
62609	E	IESG: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Small Group Health insurance coverage during the period.
62611	E	IESG: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for in-exchange Small Group Health insurance coverage during the period.
62615	E	IESG: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Small Group Health insurance coverage during the period.
62616	E	IESG: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Small Group Health insurance coverage during the period.
62617	E	IESG: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Small Group Health insurance coverage during the period.

62618	E	IESG: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Small Group Health insurance coverage during the period.
62619	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62620	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.

62621	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62622	E	IESG: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.
62623	E	IESG: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Small Group Health insurance coverage during the period.
62624	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62625	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62626	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62627	E	IESG: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.
62628	E	IESG: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Small Group Health insurance coverage during the period.
62629	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62630	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62631	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62632	E	IESG: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.
62633	E	IESG: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of number of paid claims for out-of-network services reported for in-exchange Small Group Health insurance coverage during the period.
62634	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Small Group Health insurance coverage during the period.
62635	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Small Group Health insurance coverage during the period.
62636	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Small Group Health insurance coverage during the period.
62637	E	IESG: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Small Group Health insurance coverage during the period.

62638	E	IESG: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Small Group Health insurance coverage during the period.
62639	E	IESG: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Small Group Health insurance coverage during the period.
62640	E	IESG: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Small Group Health insurance coverage during the period.
62641	E	IESG: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Small Group Health insurance coverage during the period.
62642	E	IESG: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange small group health insurance coverage during the period.
62643	E	IESG: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange small group health insurance coverage during the period.
62644	E	IESG: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange small group health insurance coverage during the period.
62645	E	IESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange small group health insurance coverage during the period.
62646	E	IESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange small group health insurance coverage during the period.
62647	E	IESG: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange small group health insurance coverage during the period.
62648	E	IESG: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange small group health insurance coverage during the period.
62649	E	IESG: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange individual health insurance coverage during the period.
62650	E	IESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange small group health insurance coverage during the period.
62651	E	IESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange small group health insurance coverage during the period.

62652	E	IESG: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange small group health insurance coverage during the period.
62653	E	IESG: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange small group health insurance coverage during the period.
62654	E	IESG: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange small group health insurance coverage during the period.
62655	E	IESG: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange small group health insurance coverage during the period.
63101	E	IEMI-Bronze: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Bronze plan coverage data to report, then all IEMI-Bronze data elements must be reported.
63102	E	IEMI-Bronze: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Bronze plan coverage data to report, then no data is allowed for all IEMI-Bronze data elements.
63104	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63105	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63106	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63107	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63108	E	IEMI-Bronze: For In-Exchange Bronze Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63110	W	IEMI-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the total policies issued, and policies renewed for IEMI-Bronze should be greater than zero.
63111	W	IEMI-Bronze: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the member months for policies issued for IEMI-Bronze should be greater than zero.
63112	W	IEMI-Bronze: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the member months for policies renewed for IEMI-Bronze should be greater than zero.
63113	W	IEMI-Bronze: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Bronze should be greater than zero.
63114	W	IEMI-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Bronze should be greater than zero.

63117	W	IEMI-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of claims paid for IEMI-Bronze should be greater than the number of claims denied.
63119	W	IEMI-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of claims submitted by network providers for IEMI-Bronze should be greater than the number of claims submitted by out-of-network providers.
63121	W	IEMI-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the total amount of claims paid for IEMI-Bronze should be less than the reported Earned Premiums.
63122	W	IEMI-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Bronze health plans, then the number of adverse determinations upheld for IEMI-Bronze should be greater than the number of adverse determinations overturned.
63129	E	IEMI-Bronze: For In-Exchange Multi-State Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63130	E	IEMI-Bronze: For In-Exchange Multi-State Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63201	E	IEMI-Silver: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Silver plan coverage data to report, then all IEMI-Silver data elements must be reported.
63202	E	IEMI-Silver: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Silver plan coverage data to report, then no data is allowed for all IEMI-Silver data elements.
63204	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63205	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63206	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63207	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63208	E	IEMI-Silver: For In-Exchange Silver Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63210	W	IEMI-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the total policies issued and policies renewed for IEMI-Silver should be greater than zero.
63211	W	IEMI-Silver: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the member months for policies issued for IEMI-Silver should be greater than zero.
63212	W	IEMI-Silver: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the member months for policies renewed for IEMI-Silver should be greater than zero.
63213	W	IEMI-Silver: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Silver should be greater than zero.

63214	W	IEMI-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Silver should be greater than zero.
63217	W	IEMI-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of claims paid for IEMI-Silver should be greater than the number of claims denied.
63219	W	IEMI-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of claims submitted by network providers for IEMI-Silver should be greater than the number of claims submitted by out-of-network providers.
63221	W	IEMI-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the total amount of claims paid for IEMI-Silver should be less than the reported Earned Premiums.
63222	W	IEMI-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Silver health plans, then the number of adverse determinations upheld for IEMI-Silver should be greater than the number of adverse determinations overturned.
63229	E	IEMI-Silver: For In-Exchange Multi-State Silver Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63230	E	IEMI-Silver: For In-Exchange Multi-State Silver Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63301	E	IEMI-Gold: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Gold plan coverage data to report, then all IEMI-Gold data elements must be reported.
63302	E	IEMI-Gold: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Gold plan coverage data to report, then no data is allowed for all IEMI-Gold data elements.
63304	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63305	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63306	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63307	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63308	E	IEMI-Gold: For In-Exchange Gold Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63310	W	IEMI-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the total policies issued and policies renewed for IEMI-Gold should be greater than zero.
63311	W	IEMI-Gold: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the member months for policies issued for IEMI-Gold should be greater than zero.
63312	W	IEMI-Gold: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the member months for policies renewed for IEMI-Gold should be greater than zero.

63313	W	IEMI-Gold: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Gold should be greater than zero.
63314	W	IEMI-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Gold should be greater than zero.
63317	W	IEMI-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of claims paid for IEMI-Gold should be greater than the number of claims denied.
63319	W	IEMI-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of claims submitted by network providers for IEMI-Gold should be greater than the number of claims submitted by out-of-network providers.
63321	W	IEMI-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the total amount of claims paid for IEMI-Gold should be less than the reported Earned Premiums.
63322	W	IEMI-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Gold health plans, then the number of adverse determinations upheld for IEMI-Gold should be greater than the number of adverse determinations overturned.
63329	E	IEMI-Gold: For In-Exchange Multi-State Gold Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63330	E	IEMI-Gold: For In-Exchange Multi-State Gold Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63401	E	IEMI-Platinum: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) Platinum plan coverage data to report, then all IEMI-Platinum data elements must be reported.
63402	E	IEMI-Platinum: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) Platinum plan coverage data to report, then no data is allowed for all IEMI-Platinum data elements.
63404	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63405	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63406	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63407	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63408	E	IEMI-Platinum: For In-Exchange Platinum Multi-State (Individual) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63410	W	IEMI-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the total policies issued, and policies renewed for IEMI-Platinum should be greater than zero.
63411	W	IEMI-Platinum: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the member months for policies issued for IEMI-Platinum should be greater than zero.

63412	W	IEMI-Platinum: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the member months for policies renewed for IEMI-Platinum should be greater than zero.
63413	W	IEMI-Platinum: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Platinum should be greater than zero.
63414	W	IEMI-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Platinum should be greater than zero.
63417	W	IEMI-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of claims paid for IEMI-Platinum should be greater than the number of claims denied.
63419	W	IEMI-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of claims submitted by network providers for IEMI-Platinum should be greater than the number of claims submitted by out-of-network providers.
63421	W	IEMI-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the total amount of claims paid for IEMI-Platinum should be less than the reported Earned Premiums.
63422	W	IEMI-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Platinum health plans, then the number of adverse determinations upheld for IEMI-Platinum should be greater than the number of adverse determinations overturned.
63429	E	IEMI-Platinum: For In-Exchange Multi-State Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63430	E	IEMI-Platinum: For In-Exchange Multi-State Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63501	E	IEMI-Total: If the company has In-Exchange Multi-State (Individual) Health insurance (IEMI) plan coverage data to report, then all IEMI-Total data elements must be reported.
63502	E	IEMI-Total: If the company does not have In-Exchange Multi-State (Individual) Health insurance (IEMI) plan coverage data to report, then no data is allowed for all IEMI-Total data elements.
63504	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
63505	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63506	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63507	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
63508	E	IEMI-Total: For In-Exchange Multi-State (Individual) Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

63510	W	IEMI-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the total policies issued and policies renewed for IEMI-Total should be greater than zero.
63511	W	IEMI-Total: If the company reported new policies issued greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the member months for policies issued for IEMI-Total should be greater than zero.
63512	W	IEMI-Total: If the company reported policies renewed greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the member months for policies renewed for IEMI-Total should be greater than zero.
63513	W	IEMI-Total: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for IEMI-Total should be greater than zero.
63514	W	IEMI-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for IEMI-Total should be greater than zero.
63515	W	IEMI-Total: If the company reported rescissions greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of insured lives impacted by rescissions for IEMI-Total should be greater than zero.
63516	W	IEMI-Total: If the company reported prior authorizations (excluding pharmacy) requested greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of prior authorizations approved for IEMI-Total should be greater than the number of prior authorizations denied.
63517	W	IEMI-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for IEMI-Total should be greater than the number of claims denied.
63518	W	IEMI-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for IEMI-Total should be greater than the number of claims denied.
63519	W	IEMI-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims submitted by network providers for IEMI-Total should be greater than the number of claims submitted by out-of-network providers.
63520	W	IEMI-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of claims paid for in-network services for IEMI-Total should be greater than the number of claims paid for out-of-network services.
63521	W	IEMI-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the total amount of claims paid for IEMI-Total should be less than the reported Earned Premiums.
63522	W	IEMI-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Individual) Total health plans, then the number of adverse determinations upheld for IEMI-Total should be greater than the number of adverse determinations overturned.
63529	E	IEMI-Total: For In-Exchange Multi- Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
63530	E	IEMI-Total: For In-Exchange Multi-State Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
63601	E	IEMI: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Multi-State (Individual) Health insurance coverage for reporting year.

63602	E	IEMI: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63603	E	IEMI: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for in-exchange Multi-State (Individual) Health insurance coverage during the period.

63604	E	IEMI: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63605	E	IEMI: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63606	E	IEMI: The sum of number of policy terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by the policyholder reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63607	E	IEMI: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63608	E	IEMI: The sum of number of insured lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63609	E	IEMI: The sum of number of insured lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63611	E	IEMI: The sum of number of insured lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted by rescissions reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63615	E	IEMI: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63616	E	IEMI: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63617	E	IEMI: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63618	E	IEMI: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63619	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63620	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

63621	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63622	E	IEMI: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

63623	E	IEMI: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63624	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63625	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63626	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63627	E	IEMI: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63628	E	IEMI: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63629	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63630	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63631	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63632	E	IEMI: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63633	E	IEMI: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of number of paid claims for out-of-network services reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63634	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

63635	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63636	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63637	E	IEMI: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.

63638	E	IEMI: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63639	E	IEMI: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63640	E	IEMI: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63641	E	IEMI: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Multi-State (Individual) Health insurance coverage during the period.
63642	E	IEMI: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state health insurance coverage during the period.
63643	E	IEMI: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange multi-state health insurance coverage during the period.
63644	E	IEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state health insurance coverage during the period.
63645	E	IEMI: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state health insurance coverage during the period.
63646	E	IEMI: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state health insurance coverage during the period.
63647	E	IEMI: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state health insurance coverage during the period.
63648	E	IEMI: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state health insurance coverage during the period.

63649	E	IEMI: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state health insurance coverage during the period.
63650	E	IEMI: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state health insurance coverage during the period.
63651	E	IEMI: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state health insurance coverage during the period.
63652	E	IEMI: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange multi-state health insurance coverage during the period.
63653	E	IEMI: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange multi-state health insurance coverage during the period.
63654	E	IEMI: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange multi-state health insurance coverage during the period.
63655	E	IEMI: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange multi-state health insurance coverage during the period.
64101	E	IEMS-Bronze: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Bronze plan coverage data to report, then all IEMS-Bronze data elements must be reported.
64102	E	IEMS-Bronze: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Bronze plan coverage data to report, then no data is allowed for all IEMS-Bronze data elements.
64104	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64105	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64106	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of claim denials for out-of-network claims (excluding pharmacy claims) must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64107	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64108	E	IEMS-Bronze: For In-Exchange Bronze Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64117	W	IEMS-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of claims paid for IEMS-Bronze should be greater than the number of claims denied.
64119	W	IEMS-Bronze: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of claims submitted by network providers for IEMS-Bronze should be greater than the number of claims submitted by out-of-network providers.

64121	W	IEMS-Bronze: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the total amount of claims paid for IEMS-Bronze should be less than the reported Earned Premiums.
64122	W	IEMS-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Bronze health plans, then the number of adverse determinations upheld for IEMS-Bronze should be greater than the number of adverse determinations overturned.
64129	E	IEMS-Bronze: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64130	E	IEMS-Bronze: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64201	E	IEMS-Silver: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Silver plan coverage data to report, then all IEMS-Silver data elements must be reported.
64202	E	IEMS-Silver: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Silver plan coverage data to report, then no data elements are allowed for all IEMS-Silver data elements.
64204	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64205	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64206	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64207	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64208	E	IEMS-Silver: For In-Exchange Silver Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64217	W	IEMS-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of claims paid for IEMS-Silver should be greater than the number of claims denied.
64219	W	IEMS-Silver: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of claims submitted by network providers for IEMS-Silver should be greater than the number of claims submitted by out-of-network providers.
64221	W	IEMS-Silver: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the total amount of claims paid for IEMS-Silver should be less than the reported Earned Premiums.
64222	W	IEMS-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Silver health plans, then the number of adverse determinations upheld for IEMS-Silver should be greater than the number of adverse determinations overturned.
64229	E	IEMS-Silver: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.

64230	E	IEMS-Silver: For In-Exchange Bronze Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64301	E	IEMS-Gold: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Gold plan coverage data to report, then all IEMS-Gold data elements must be reported.
64302	E	IEMS-Gold: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Gold plan coverage data to report, then no data is allowed for all IEMS-Gold data elements.
64304	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64305	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64306	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64307	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64308	E	IEMS-Gold: For In-Exchange Gold Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64317	W	IEMS-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of claims paid for IEMS-Gold should be greater than the number of claims denied.
64319	W	IEMS-Gold: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of claims submitted by network providers for IEMS-Gold should be greater than the number of claims submitted by out-of-network providers.
64321	W	IEMS-Gold: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the total amount of claims paid for IEMS-Gold should be less than the reported Earned Premiums.
64322	W	IEMS-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Gold health plans, then the number of adverse determinations upheld for IEMS-Gold should be greater than the number of adverse determinations overturned.
64329	E	IEMS-Gold: For In-Exchange Gold Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64330	E	IEMS-Gold: For In-Exchange Gold Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64401	E	IEMS-Platinum: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) Platinum plan coverage data to report, then all IEMS-Platinum data elements must be reported.
64402	E	IEMS-Platinum: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) Platinum plan coverage data to report, then no data is allowed for all IEMS-Platinum data elements.
64404	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.

64405	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64406	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64407	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64408	E	IEMS-Platinum: For In-Exchange Platinum Multi-State (Small Group) Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64417	W	IEMS-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of claims paid for IEMS-Platinum should be greater than the number of claims denied.
64419	W	IEMS-Platinum: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of claims submitted by network providers for IEMS-Platinum should be greater than the number of claims submitted by out-of-network providers.
64421	W	IEMS-Platinum: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the total amount of claims paid for IEMS-Platinum should be less than the reported Earned Premiums.
64422	W	IEMS-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Platinum health plans, then the number of adverse determinations upheld for IEMS-Platinum should be greater than the number of adverse determinations overturned.
64429	E	IEMS-Platinum: For In-Exchange Platinum Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64430	E	IEMS-Platinum: For In-Exchange Platinum Multi-State Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64501	E	IEMS-Total: If the company has In-Exchange Multi-State (Small Group) Health insurance (IEMS) plan coverage data to report, then all IEMS-Total data elements must be reported.
64502	E	IEMS-Total: If the company does not have In-Exchange Multi-State (Small Group) Health insurance (IEMS) plan coverage data to report, then no data is allowed for all IEMS-Total data elements.
64504	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claims (excluding pharmacy claims) received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
64505	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64506	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64507	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

64508	E	IEMS-Total: For In-Exchange Multi-State (Small Group) Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
64515	W	IEMS-Total: If the company reported rescissions greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of insured lives impacted by rescissions for IEMS-Total should be greater than zero.
64516	W	IEMS-Total: If the company reported prior authorizations requested greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of prior authorizations approved for IEMS-Total should be greater than the number of prior authorizations denied.
64517	W	IEMS-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for IEMS-Total should be greater than the number of claims denied.
64518	W	IEMS-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for IEMS-Total should be greater than the number of claims denied.
64519	W	IEMS-Total: If the company reported non-pharmacy claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims submitted by network providers for IEMS-Total should be greater than the number of claims submitted by out-of-network providers.
64520	W	IEMS-Total: If the company reported pharmacy-only claims received greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of claims paid for in-network services for IEMS-Total should be greater than the number of claims paid for out-of-network services.
64521	W	IEMS-Total: If the company reported Earned Premiums greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the total amount of claims paid for IEMS-Total should be less than the reported Earned Premiums.
64522	W	IEMS-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Multi-State (Small Group) Total health plans, then the number of adverse determinations upheld for IEMS-Total should be greater than the number of adverse determinations overturned.
64529	E	IEMS-Total: For In-Exchange Multi-State Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64530	E	IEMS-Total: For In-Exchange Multi-State Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
64601	E	IEMS: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for in-exchange Multi-State (Small Group) Health insurance coverage for reporting year.
64604	E	IEMS: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64605	E	IEMS: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64608	E	IEMS: The sum of number of insured lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on terminations and cancellations initiated by the policyholder for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

64609	E	IEMS: The sum of number of insured lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted on policies terminated and cancelled due to non-payment reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64611	E	IEMS: The sum of number of insured lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of insured lives impacted by rescissions reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64615	E	IEMS: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64616	E	IEMS: The sum of number of claims submitted by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64617	E	IEMS: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64618	E	IEMS: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64619	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64620	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64621	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64622	E	IEMS: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64623	E	IEMS: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64624	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64625	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64626	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

64627	E	IEMS: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64628	E	IEMS: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64629	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64630	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64631	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64632	E	IEMS: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64633	E	IEMS: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of number of paid claims for out-of-network services reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64634	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64635	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64636	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64637	E	IEMS: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64638	E	IEMS: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64639	E	IEMS: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64640	E	IEMS: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.
64641	E	IEMS: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for in-exchange Multi-State (Small Group) Health insurance coverage during the period.

64642	E	IEMS: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state small group health insurance coverage during the period.
64643	E	IEMS: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for in-exchange multi-state small group health insurance coverage during the period.
64644	E	IEMS: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state small group health insurance coverage during the period.
64645	E	IEMS: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state small group health insurance coverage during the period.
64646	E	IEMS: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state small group health insurance coverage during the period.
64647	E	IEMS: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state small group health insurance coverage during the period.
64648	E	IEMS: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for in-exchange multi-state small group health insurance coverage during the period.
64649	E	IEMS: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for in-exchange multi-state small group health insurance coverage during the period.
64650	E	IEMS: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for in-exchange multi-state small group health insurance coverage during the period.
64651	E	IEMS: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for in-exchange multi-state small group health insurance coverage during the period.
64652	E	IEMS: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for in-exchange multi-state small group health insurance coverage during the period.
64653	E	IEMS: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for in-exchange multi-state small group health insurance coverage during the period.

64654	E	IEMS: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for in-exchange multi-state small group health insurance coverage during the period.
64655	E	IEMS: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for in-exchange multi-state small group health insurance coverage during the period.
65001	E	IECA: If the company has In-Exchange Catastrophic Health insurance (IECA) plan coverage data to report, then all IECA data elements must be reported.
65002	E	IECA: If the company does not have In-Exchange Catastrophic Health insurance (IECA) plan coverage data to report, then no data is allowed for all IECA data elements.
65003	W	IECA: For In-Exchange Catastrophic Health Plans, the total number of prior authorizations received should be less than or equal to the number of prior authorizations approved and the number of prior authorizations denied.
65004	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65005	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claim denials for in-network claims (excluding pharmacy claims) must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, and 61-90 days and beyond 90 days.
65006	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65007	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65008	E	IECA: For In-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65010	W	IECA: If the company reported Earned Premiums greater than zero for In-Exchange Catastrophic health plans, then the total policies issued and policies renewed for IECA should be greater than zero.
65011	W	IECA: If the company reported new policies issued greater than zero for In-Exchange Catastrophic health plans, then the member months for policies issued for IECA should be greater than zero.
65012	W	IECA: If the company reported policies renewed greater than zero for In-Exchange Catastrophic health plans, then the member months for policies renewed for IECA should be greater than zero.
65013	W	IECA: If the company reported terminations and cancellations initiated by the policyholder greater than zero for In-Exchange Catastrophic health plans, then the number of insured lives impacted on terminations and cancellations initiated by the policyholder for IECA should be greater than zero.
65014	W	IECA: If the company reported terminations and cancellations due to non-payment of premium greater than zero for In-Exchange Catastrophic health plans, then the number of insured lives impacted on terminations and cancellations due to non-payment of premium for IECA should be greater than zero.
65015	W	IECA: If the company reported rescissions greater than zero for In-Exchange Catastrophic health plans, then the number of insured lives impacted by rescissions for IECA should be greater than zero.
65016	W	IECA: If the company reported prior authorizations requested greater than zero for In-Exchange Catastrophic health plans, then the number of prior authorizations approved for IECA should be greater than the number of prior authorizations denied.
65017	W	IECA: If the company reported non-pharmacy claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for IECA should be greater than the number of claims denied.
65018	W	IECA: If the company reported pharmacy-only claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for IECA should be greater than the number of claims denied.

65019	W	IECA: If the company reported non-pharmacy claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims submitted by network providers for IECA should be greater than the number of claims submitted by out-of-network providers.
65020	W	IECA: If the company reported pharmacy-only claims received greater than zero for In-Exchange Catastrophic health plans, then the number of claims paid for in-network services for IECA should be greater than the number of claims paid for out-of-network services.
65021	W	IECA: If the company reported Earned Premiums greater than zero for In-Exchange Catastrophic health plans, then the total amount of claims paid for IECA should be less than the reported Earned Premiums.
65022	W	IECA: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for In-Exchange Catastrophic health plans, then the number of adverse determinations upheld for IECA should be greater than the number of adverse determinations overturned.
65029	E	IECA: For In-Exchange Catastrophic Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
65030	E	IECA: For In-Exchange Catastrophic Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
65101	E	OEIH-Bronze: If the company has Out-of-Exchange Individual Health insurance (OEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Bronze data elements must be reported.
65102	E	OEIH-Bronze: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Bronze plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Bronze data elements.
65104	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65105	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65106	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65107	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65108	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

65110	W	OEIH-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the total policies issued and policies renewed for OEIH-Bronze should be greater than zero.
65111	W	OEIH-Bronze: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the member months for policies issued for OEIH-Bronze should be greater than zero.
65112	W	OEIH-Bronze: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the member months for policies renewed for OEIH-Bronze should be greater than zero.
65113	W	OEIH-Bronze: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Bronze should be greater than zero.

65114	W	OEIH-Bronze: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Bronze should be greater than zero.
65117	W	OEIH-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of claims paid for OEIH-Bronze should be greater than the number of claims denied.
65119	W	OEIH-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of claims submitted by network providers for OEIH-Bronze should be greater than the number of claims submitted by out-of-network providers.
65121	W	OEIH-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the total amount of claims paid for OEIH-Bronze should be less than the reported Earned Premiums.
65122	W	OEIH-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Bronze health plans, then the number of adverse determinations upheld for OEIH-Bronze should be greater than the number of adverse determinations overturned.
65129	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65130	E	OEIH-Bronze: For Out-of-Exchange Bronze Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65201	E	OEIH-Silver: If the company has Out-of-Exchange Individual Health insurance (OEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Silver data elements must be reported.
65202	E	OEIH-Silver: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Silver plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Silver data elements.
65204	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65205	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65206	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65207	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65208	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65210	W	OEIH-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Silver health plans, then the total policies issued and policies renewed for OEIH-Silver should be greater than zero.

65211	W	OEIH-Silver: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Silver health plans, then the member months for policies issued for OEIH-Silver should be greater than zero.
65212	W	OEIH-Silver: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Silver health plans, then the member months for policies renewed for OEIH-Silver should be greater than zero.
65213	W	OEIH-Silver: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Silver should be greater than zero.
65214	W	OEIH-Silver: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Silver should be greater than zero.
65217	W	OEIH-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of claims paid for OEIH-Silver should be greater than the number of claims denied.
65219	W	OEIH-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of claims submitted by network providers for OEIH-Silver should be greater than the number of claims submitted by out-of-network providers.
65221	W	OEIH-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Silver health plans, then the total amount of claims paid for OEIH-Silver should be less than the reported Earned Premiums.
65222	W	OEIH-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Silver health plans, then the number of adverse determinations upheld for OEIH-Silver should be greater than the number of adverse determinations overturned.
65229	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65230	E	OEIH-Silver: For Out-of-Exchange Silver Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65301	E	OEIH-Gold: If the company has Out-of-Exchange Individual Health insurance (OEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Gold data elements must be reported.
65302	E	OEIH-Gold: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Gold plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Gold data elements.
65304	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65305	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65306	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65307	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

65308	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65310	W	OEIH-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Gold health plans, then the total policies issued and policies renewed for OEIH-Gold should be greater than zero.
65311	W	OEIH-Gold: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Gold health plans, then the member months for policies issued for OEIH-Gold should be greater than zero.
65312	W	OEIH-Gold: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Gold health plans, then the member months for policies renewed for OEIH-Gold should be greater than zero.
65313	W	OEIH-Gold: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Gold should be greater than zero.
65314	W	OEIH-Gold: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Gold should be greater than zero.
65317	W	OEIH-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of claims paid for OEIH-Gold should be greater than the number of claims denied.
65319	W	OEIH-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of claims submitted by network providers for OEIH-Gold should be greater than the number of claims submitted by out-of-network providers.
65321	W	OEIH-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Gold health plans, then the total amount of claims paid for OEIH-Gold should be less than the reported Earned Premiums.
65322	W	OEIH-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Gold health plans, then the number of adverse determinations upheld for OEIH-Gold should be greater than the number of adverse determinations overturned.
65329	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65330	E	OEIH-Gold: For Out-of-Exchange Gold Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65401	E	OEIH-Platinum: If the company has Out-of-Exchange Individual Health insurance (OEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Platinum data elements must be reported.
65402	E	OEIH-Platinum: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) Platinum plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Platinum data elements.
65404	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65405	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

65406	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65407	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65408	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65410	W	OEIH-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the total policies issued and policies renewed for OEIH-Platinum should be greater than zero.
65411	W	OEIH-Platinum: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the health plans, then the member months for policies issued for OEIH-Platinum should be greater than zero.
65412	W	OEIH-Platinum: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the member months for policies renewed for OEIH-Platinum should be greater than zero.
65413	W	OEIH-Platinum: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Platinum should be greater than zero.
65414	W	OEIH-Platinum: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Platinum should be greater than zero.
65417	W	OEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of claims paid for OEIH-Platinum should be greater than the number of claims denied.
65419	W	OEIH-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of claims submitted by network providers for OEIH-Platinum should be greater than the number of claims submitted by out-of-network providers.
65421	W	OEIH-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the total amount of claims paid for OEIH-Platinum should be less than the reported Earned Premiums.
65422	W	OEIH-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Platinum health plans, then the number of adverse determinations upheld for OEIH-Platinum should be greater than the number of adverse determinations overturned.
65429	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65430	E	OEIH-Platinum: For Out-of-Exchange Platinum Individual Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65501	E	OEIH-Total: If the company has Out-of-Exchange Individual Health insurance (OEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then all OEIH-Total data elements must be reported.

65502	E	OEIH-Total: If the company does not have Out-of-Exchange Individual Health insurance (OEIH) plan coverage other than transitional, grandfathered, multi-state, catastrophic, or student data to report, then no data is allowed for all OEIH-Total data elements.
65504	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
65505	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65506	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65507	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65508	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
65510	W	OEIH-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Total health plans, then the total policies issued and policies renewed for OEIH-Total should be greater than zero.
65511	W	OEIH-Total: If the company reported new policies issued greater than zero for Out-of-Exchange Individual Health Total health plans, then the health plans, then the member months for policies issued for OEIH-Total should be greater than zero.
65512	W	OEIH-Total: If the company reported policies renewed greater than zero for Out-of-Exchange Individual Health Total health plans, then the member months for policies renewed for OEIH-Total should be greater than zero.
65513	W	OEIH-Total: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEIH-Total should be greater than zero.
65514	W	OEIH-Total: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEIH-Total should be greater than zero.
65515	W	OEIH-Total: If the company reported rescissions greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of lives impacted by rescissions for OEIH-Total should be greater than zero.
65516	W	OEIH-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of prior authorizations approved for OEIH-Total should be greater than the number of prior authorizations denied.
65517	W	OEIH-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims paid for OEIH-Total should be greater than the number of claims denied.
65518	W	OEIH-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims paid for OEIH-Total should be greater than the number of claims denied.
65519	W	OEIH-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of claims submitted by network providers for OEIH-Total should be greater than the number of claims submitted by out-of-network providers.
65520	W	OEIH-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Individual Health Total health plans, then the health plans, then the number of claims paid for in-network services for OEIH-Total should be greater than the number of claims paid for out-of-network services.
65521	W	OEIH-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Individual Health Total health plans, then the total amount of claims paid for OEIH-Total should be less than the reported Earned Premiums.

65522	W	OEIH-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Individual Health Total health plans, then the number of adverse determinations upheld for OEIH-Total should be greater than the number of adverse determinations overturned.
65524	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
65525	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
65526	W	OEIH-Total: For Out-of-Exchange Individual Health plans, the number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
65529	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65530	E	OEIH-Total: For Out-of-Exchange Individual Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
65601	E	OEIH: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for out-of-exchange Individual Health insurance coverage for reporting year.
65602	E	OEIH: The sum of number of new policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of new policies issued for out-of-exchange Individual Health insurance coverage during the period.
65603	E	OEIH: The sum of number of policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policies renewed for out-of-exchange Individual Health insurance coverage during the period.
65604	E	OEIH: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Individual Health insurance coverage during the period.
65605	E	OEIH: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Individual Health insurance coverage during the period.
65606	E	OEIH: The sum of number of policy terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations initiated by the policyholder reported for out-of-exchange Individual Health insurance coverage during the period.
65607	E	OEIH: The sum of number of policy terminations and cancellations due to non-payment of premium reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations due to non-payment of premium for out-of-exchange Individual Health insurance coverage during the period.
65608	E	OEIH: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Individual Health insurance coverage during the period.

65609	E	OEIH: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Individual Health insurance coverage during the period.
65611	E	OEIH: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for out-of-exchange Individual Health insurance coverage during the period.
65615	E	OEIH: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for out-of-exchange Individual Health insurance coverage during the period.
65616	E	OEIH: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for out-of-exchange Individual Health insurance coverage during the period.
65617	E	OEIH: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Individual Health insurance coverage during the period.
65618	E	OEIH: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for out-of-exchange Individual Health insurance coverage during the period.
65619	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65620	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65621	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65622	E	OEIH: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65623	E	OEIH: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Individual Health insurance coverage during the period.
65624	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65625	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65626	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65627	E	OEIH: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65628	E	OEIH: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for out-of-exchange Individual Health insurance coverage during the period.
65629	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.

65630	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65631	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65632	E	OEIH: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65633	E	OEIH: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of number of paid claims for out-of-network services reported for out-of-exchange Individual Health insurance coverage during the period.
65634	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Individual Health insurance coverage during the period.
65635	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Individual Health insurance coverage during the period.
65636	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65637	E	OEIH: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Individual Health insurance coverage during the period.
65638	E	OEIH: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for out-of-exchange Individual Health insurance coverage during the period.
65639	E	OEIH: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Individual Health insurance coverage during the period.
65640	E	OEIH: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for out-of-exchange Individual Health insurance coverage during the period.
65641	E	OEIH: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for out-of-exchange Individual Health insurance coverage during the period.
65642	E	OEIH: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange individual health insurance coverage during the period.
65643	E	OEIH: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual health insurance coverage during the period.
65644	E	OEIH: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange individual health insurance coverage during the period.
65645	E	OEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange individual health insurance coverage during the period.

65646	E	OEIH: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange individual health insurance coverage during the period.
65647	E	OEIH: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange individual health insurance coverage during the period.
65648	E	OEIH: The sum of out-of-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual health insurance coverage during the period.
65649	E	OEIH: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange individual health insurance coverage during the period.
65650	E	OEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange individual health insurance coverage during the period.
65651	E	OEIH: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange individual health insurance coverage during the period.
65652	E	OEIH: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange individual health insurance coverage during the period.
65653	E	OEIH: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange individual health insurance coverage during the period.
65654	E	OEIH: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange individual health insurance coverage during the period.
65655	E	OEIH: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange individual health insurance coverage during the period.
66101	E	OESG-Bronze: If the company has Out-of-Exchange Small Group Health insurance (OESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Bronze data elements must be reported.
66102	E	OESG-Bronze: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Bronze plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Bronze data elements.
66104	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66105	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

66106	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66107	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66108	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66117	W	OESG-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of claims paid for OESG-Bronze should be greater than the number of claims denied.
66119	W	OESG-Bronze: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of claims submitted by network providers for OESG-Bronze should be greater than the number of claims submitted by out-of-network providers.
66121	W	OESG-Bronze: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the total amount of claims paid for OESG-Bronze should be less than the reported Earned Premiums.
66122	W	OESG-Bronze: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Bronze health plans, then the number of adverse determinations upheld for OESG-Bronze should be greater than the number of adverse determinations overturned.
66129	E	OESG-Bronze: For Out-of-Exchange Bronze Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be less or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66130	E	OESG-Bronze: For Out-of-Exchange Small Group Bronze Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be less or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66201	E	OESG-Silver: If the company has Out-of-Exchange Small Group Health insurance (OESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Silver data elements must be reported.
66202	E	OESG-Silver: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Silver plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Silver data elements.
66204	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66205	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66206	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66207	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66208	E	OESG-Silver: For Out-of-Exchange Silver Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

66217	W	OESG-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of claims paid for OESG-Silver should be greater than the number of claims denied.
66219	W	OESG-Silver: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of claims submitted by network providers for OESG-Silver should be greater than the number of claims submitted by out-of-network providers.
66221	W	OESG-Silver: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the total amount of claims paid for OESG-Silver should be less than the reported Earned Premiums.
66222	W	OESG-Silver: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Silver health plans, then the number of adverse determinations upheld for OESG-Silver should be greater than the number of adverse determinations overturned.
66229	E	OESG-Silver: For Out-of-Exchange Small Group Silver Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66230	E	OESG-Silver: For Out-of-Exchange Small Group Silver Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66301	E	OESG-Gold: If the company has Out-of-Exchange Small Group Health insurance (OESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Gold data elements must be reported.
66302	E	OESG-Gold: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Gold plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Gold data elements.
66304	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66305	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66306	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66307	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66308	E	OESG-Gold: For Out-of-Exchange Gold Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66317	W	OESG-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of claims paid for OESG-Gold should be greater than the number of claims denied.
66319	W	OESG-Gold: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of claims submitted by network providers for OESG-Gold should be greater than the number of claims submitted by out-of-network providers.
66321	W	OESG-Gold: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the total amount of claims paid for OESG-Gold should be less than the reported Earned Premiums.

66322	W	OESG-Gold: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Gold health plans, then the number of adverse determinations upheld for OESG-Gold should be greater than the number of adverse determinations overturned.
66329	E	OESG-Gold: For Out-of-Exchange Small Group Gold Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66330	E	OESG-Gold: For Out-of-Exchange Small Group Gold Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66401	E	OESG-Platinum: If the company has Out-of-Exchange Small Group Health insurance (OESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Platinum data elements must be reported.
66402	E	OESG-Platinum: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) Platinum plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Platinum data elements.
66404	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66405	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66406	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66407	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66408	E	OESG-Platinum: For Out-of-Exchange Platinum Small Group Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66417	W	OESG-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of claims paid for OESG-Platinum should be greater than the number of claims denied.
66419	W	OESG-Platinum: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of claims submitted by network providers for OESG-Platinum should be greater than the number of claims submitted by out-of-network providers.
66421	W	OESG-Platinum: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the total amount of claims paid for OESG-Platinum should be less than the reported Earned Premiums.
66422	W	OESG-Platinum: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Platinum health plans, then the number of adverse determinations upheld for OESG-Platinum should be greater than the number of adverse determinations overturned.
66429	E	OESG-Platinum: For Out-of-Exchange Small Group Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be greater or equal to the sum of in-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

66430	E	OESG-Platinum: For Out-of-Exchange Small Group Platinum Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
66501	E	OESG-Total: If the company has Out-of-Exchange Small Group Health insurance (OESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then all OESG-Total data elements must be reported.
66502	E	OESG-Total: If the company does not have Out-of-Exchange Small Group Health insurance (OESG) plan coverage other than transitional, grandfathered, or multi-state policies data to report, then no data is allowed for all OESG-Total data elements.

66504	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
66505	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66506	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66507	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of paid claims for (excluding pharmacy claims) in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66508	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
66515	W	OESG-Total: If the company reported rescissions greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of lives impacted by rescissions for OESG-Total should be greater than zero.
66516	W	OESG-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of prior authorizations approved for OESG-Total should be greater than the number of prior authorizations denied.
66517	W	OESG-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for OESG-Total should be greater than the number of claims denied.
66518	W	OESG-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for OESG-Total should be greater than the number of claims denied.
66519	W	OESG-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims submitted by network providers for OESG-Total should be greater than the number of claims submitted by out-of-network providers.
66520	W	OESG-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of claims paid for in-network services for OESG-Total should be greater than the number of claims paid for out-of-network services.
66521	W	OESG-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Small Group Health Total health plans, then the total amount of claims paid for OESG-Total should be less than the reported Earned Premiums.
66522	W	OESG-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Small Group Health Total health plans, then the number of adverse determinations upheld for OESG-Total should be greater than the number of adverse determinations overturned.
66524	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders should be less than or equal to the total number of prior authorizations (excluding pharmacy) requested.

66525	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
66526	W	OESG-Total: For Out-of-Exchange Small Group Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
66529	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66530	E	OESG-Total: For Out-of-Exchange Small Group Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
66601	E	OESG: The sum of earned premiums reported for bronze, silver, gold and platinum coverages must equal the total earned premiums for out-of-exchange Small Group Health insurance coverage for reporting year.
66604	E	OESG: The sum of policy terminations and cancellations for policies issued during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Small Group Health insurance coverage during the period.
66605	E	OESG: The sum of policy terminations and cancellations for policies renewed during the period reported for bronze, silver, gold and platinum coverages must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Small Group Health insurance coverage during the period.
66608	E	OESG: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Small Group Health insurance coverage during the period.
66609	E	OESG: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Small Group Health insurance coverage during the period.
66611	E	OESG: The sum of number of lives impacted by rescissions reported for bronze, silver, gold and platinum coverages must equal the total number of lives impacted by rescissions reported for out-of-exchange Small Group Health insurance coverage during the period.
66615	E	OESG: The sum of number of claims received (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total number of claims received reported for out-of-exchange Small Group Health insurance coverage during the period.
66616	E	OESG: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted by network providers reported for out-of-exchange Small Group Health insurance coverage during the period.
66617	E	OESG: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for bronze, silver, gold and platinum coverages must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Small Group Health insurance coverage during the period.
66618	E	OESG: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for in-network claims reported for out-of-exchange Small Group Health insurance coverage during the period.
66619	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.

66620	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66621	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66622	E	OESG: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66623	E	OESG: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for bronze, silver, gold and platinum coverages must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Small Group Health insurance coverage during the period.
66624	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66625	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66626	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66627	E	OESG: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66628	E	OESG: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for in-network services reported for out-of-exchange Small Group Health insurance coverage during the period.
66629	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66630	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66631	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66632	E	OESG: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66633	E	OESG: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for bronze, silver, gold and platinum coverages must equal the total number of paid claims for out-of-network services reported for out-of-exchange Small Group Health insurance coverage during the period.
66634	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66635	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66636	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Small Group Health insurance coverage during the period.

66637	E	OESG: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for bronze, silver, gold and platinum coverages must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Small Group Health insurance coverage during the period.
66638	E	OESG: The sum of claims paid (excluding pharmacy claims) reported for bronze, silver, gold and platinum coverages must equal the total claims paid reported for out-of-exchange Small Group Health insurance coverage during the period.
66639	E	OESG: The sum of insured/beneficiary co-payment responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Small Group Health insurance coverage during the period.
66640	E	OESG: The sum of insured coinsurance responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured coinsurance responsibility reported for out-of-exchange Small Group Health insurance coverage during the period.
66641	E	OESG: The sum of insured deductible responsibility reported for bronze, silver, gold and platinum coverages must equal the total insured deductible responsibility reported for out-of-exchange Small Group Health insurance coverage during the period.
66642	E	OESG: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
66643	E	OESG: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange small group health insurance coverage during the period.
66644	E	OESG: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
66645	E	OESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
66646	E	OESG: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
66647	E	OESG: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
66648	E	OESG: The sum of out-of-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual small group insurance coverage during the period.
66649	E	OESG: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
66650	E	OESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.

66651	E	OESG: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
66652	E	OESG: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
66653	E	OESG: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange small group health insurance coverage during the period.
66654	E	OESG: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange small group health insurance coverage during the period.
66655	E	OESG: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67101	E	OEGT-Large Group: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Large Group data elements must be reported.
67102	E	OEGT-Large Group: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Large Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Large Group data elements.
67104	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67105	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67106	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67107	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67108	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67110	W	OEGT-Large Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the total policies issued and policies renewed for OEGT-Large Group should be greater than zero.
67111	W	OEGT-Large Group: If the company reported new policies issued greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the member months for policies issued for OEGT-Large Group should be greater than zero.
67112	W	OEGT-Large Group: If the company reported policies renewed greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the member months for policies renewed for OEGT-Large Group should be greater than zero.

67113	W	OEGT-Large Group: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEGT-Large Group should be greater than zero.
67114	W	OEGT-Large Group: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEGT-Large Group should be greater than zero.
67115	W	OEGT-Large Group: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of lives impacted by rescissions for OEGT-Large Group should be greater than zero.
67116	W	OEGT-Large Group: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of prior authorizations approved for OEGT-Large Group should be greater than the number of prior authorizations denied.
67117	W	OEGT-Large Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for OEGT-Large Group should be greater than the number of claims denied.
67118	W	OEGT-Large Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for OEGT-Large Group should be greater than the number of claims denied.
67119	W	OEGT-Large Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims submitted by network providers for OEGT-Large Group should be greater than the number of claims submitted by out-of-network providers.
67120	W	OEGT-Large Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of claims paid for in-network services for OEGT-Large Group should be greater than the number of claims paid for out-of-network services.

67121	W	OEGT-Large Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the total amount of claims paid for OEGT-Large Group should be less than the reported Earned Premiums.
67122	W	OEGT-Large Group: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Large Group health plans, then the number of adverse determinations upheld for OEGT-Large Group should be greater than the number of adverse determinations overturned.
67124	W	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67125	W	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67126	W	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67129	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.

67130	E	OEGT-Large Group: For Out-of-Exchange Large Group Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
67201	E	OEGT-Small Group: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Small Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Small Group data elements must be reported.
67202	E	OEGT-Small Group: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Small Group comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Small Group data elements.
67204	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claims received must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67205	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claim denials for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67206	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of claim denials for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67207	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of paid claims for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67208	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the number of paid claims for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67215	W	OEGT-Small Group: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of lives impacted by rescissions for OEGT-Small Group should be greater than zero.
67216	W	OEGT-Small Group: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of prior authorizations approved for OEGT-Small Group should be greater than the number of prior authorizations denied.
67217	W	OEGT-Small Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for OEGT-Small Group should be greater than the number of claims denied.
67218	W	OEGT-Small Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for OEGT-Small Group should be greater than the number of claims denied.
67219	W	OEGT-Small Group: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims submitted by network providers for OEGT-Small Group should be greater than the number of claims submitted by out-of-network providers.
67220	W	OEGT-Small Group: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of claims paid for in-network services for OEGT-Small Group should be greater than the number of claims paid for out-of-network services.
67221	W	OEGT-Small Group: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the total amount of claims paid for OEGT-Small Group should be less than the reported Earned Premiums.
67222	W	OEGT-Small Group: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Small Group health plans, then the number of adverse determinations upheld for OEGT-Small Group should be greater than the number of adverse determinations overturned.

67224	W	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67225	W	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67226	W	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67229	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
67230	E	OEGT-Small Group: For Out-of-Exchange Small Group Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary(excluding behavioral health benefits) or behavioral benefits only.
67301	E	OEGT-Individual: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Individual data elements must be reported.
67302	E	OEGT-Individual: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Individual data elements.
67304	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67305	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67306	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67307	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67308	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67310	W	OEGT-Individual: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the total policies issued and policies renewed for OEGT-Individual should be greater than zero.
67311	W	OEGT-Individual: If the company reported new policies issued greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the member months for policies issued for OEGT-Individual should be greater than zero.
67312	W	OEGT-Individual: If the company reported policies renewed greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the member months for policies renewed for OEGT-Individual should be greater than zero.

67313	W	OEGT-Individual: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OEGT-Individual should be greater than zero.
67314	W	OEGT-Individual: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OEGT-Individual should be greater than zero.
67315	W	OEGT-Individual: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of lives impacted by rescissions for OEGT-Individual should be greater than zero.
67316	W	OEGT-Individual: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of prior authorizations approved for OEGT-Individual should be greater than the number of prior authorizations denied.
67317	W	OEGT-Individual: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for OEGT-Individual should be greater than the number of claims denied.
67318	W	OEGT-Individual: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for OEGT-Individual should be greater than the number of claims denied.
67319	W	OEGT-Individual: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims submitted by network providers for OEGT-Individual should be greater than the number of claims submitted by out-of-network providers.
67320	W	OEGT-Individual: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of claims paid for in-network services for OEGT-Individual should be greater than the number of claims paid for out-of-network services.
67321	W	OEGT-Individual: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the total amount of claims paid for OEGT-Individual should be less than the reported Earned Premiums.
67322	W	OEGT-Individual: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Individual health plans, then the number of adverse determinations upheld for OEGT-Individual should be greater than the number of adverse determinations overturned.
67324	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67325	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67326	W	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health plans, the number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67329	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.

67330	E	OEGT-Individual: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67401	E	OEGT-Total: If the company has Out-of-Exchange Grandfathered/Transitional Health insurance (OESG) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then all OEGT-Total data elements must be reported.
67402	E	OEGT-Total: If the company does not have Out-of-Exchange Grandfathered/Transitional Health insurance (OEGT) Individual comprehensive major medical and managed care (Minimum Essential Coverage policies) data to report, then no data is allowed for all OEGT-Total data elements.
67404	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
67405	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67406	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67407	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67408	E	OEGT-Total: For Out-of-Exchange Individual Grandfathered/Transitional Health Plans, the number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
67415	W	OEGT-Total: If the company reported rescissions greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of lives impacted by rescissions for OEGT-Total should be greater than zero.
67416	W	OEGT-Total: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of prior authorizations approved for OEGT-Total should be greater than the number of prior authorizations denied.
67417	W	OEGT-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for OEGT-Total should be greater than the number of claims denied.
67418	W	OEGT-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for OEGT-Total should be greater than the number of claims denied.
67419	W	OEGT-Total: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims submitted by network providers for OEGT-Total should be greater than the number of claims submitted by out-of-network providers.
67420	W	OEGT-Total: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of claims paid for in-network services for OEGT-Total should be greater than the number of claims paid for out-of-network services.
67421	W	OEGT-Total: If the company reported Earned Premiums greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the total amount of claims paid for OEGT-Total should be less than the reported Earned Premiums.
67422	W	OEGT-Total: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Grandfathered/Transitional Total health plans, then the number of adverse determinations upheld for OEGT-Total should be greater than the number of adverse determinations overturned.

67424	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) requested.
67425	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) denied.
67426	W	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health plans, the total number of prior authorizations (excluding pharmacy) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy) approved.
67429	E	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67430	E	OEGT-Total: For Out-of-Exchange Grandfathered/Transitional Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be greater or equal to the sum of out-of-network claims denied, rejected or returned for Claim Submission Coding errors, needing prior authorizations, non-covered benefits/benefit limitation, not-medically necessary (excluding behavioral health benefits) or behavioral benefits only.
67601	E	OEGT: The sum of earned premiums reported for large group, small group and individual plans must equal the total earned premiums for out-of-exchange Grandfathered/Transitional Health insurance plans for reporting year.
67604	E	OEGT: The sum of policy terminations and cancellations for policies issued during the period reported for large group, small group and individual plans must equal the total number of policy terminations and cancellations for policies issued for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67605	E	OEGT: The sum of policy terminations and cancellations for policies renewed during the period reported for large group, small group and individual plans must equal the total number of policy terminations and cancellations for policies renewed for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67608	E	OEGT: The sum of number of lives impacted on terminations and cancellations initiated by the policyholder reported for large group, small group and individual plans must equal the total number of lives impacted on terminations and cancellations initiated by the policyholder for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67609	E	OEGT: The sum of number of lives impacted on policies terminated and cancelled due to non-payment reported for large group, small group and individual plans must equal the total number of lives impacted on policies terminated and cancelled due to non-payment reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67610	E	OEGT: The sum of number of rescissions reported for large group, small group and individual plans must equal the total number of rescissions reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67611	E	OEGT: The sum of number of lives impacted by rescissions reported for large group, small group and individual plans must equal the total number of lives impacted by rescissions reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67612	E	OEGT: The sum of number of prior authorizations requested reported for large group, small group and individual plans must equal the total number of prior authorizations requested reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67613	E	OEGT: The sum of number of prior authorizations approved reported for large group, small group and individual plans must equal the total number of prior authorizations approved reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

67614	E	OEGT: The sum of number of prior authorizations denied reported for large group, small group and individual plans must equal the total number of prior authorizations denied reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67615	E	OEGT: The sum of number of claims received (excluding pharmacy claims) reported for large group, small group and individual plans must equal the total number of claims received reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67616	E	OEGT: The sum of number of claims submitted (excluding pharmacy claims) by network providers reported for large group, small group and individual plans must equal the total number of claims submitted by network providers reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67617	E	OEGT: The sum of number of claims submitted (excluding pharmacy claims) for by out-of-network providers reported for large group, small group and individual plans must equal the total number of claims submitted for by out-of-network providers reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67618	E	OEGT: The sum of number of claim denials (excluding pharmacy claims) for in-network claims reported for large group, small group and individual plans must equal the total number of claim denials for in-network claims reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67619	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number in-network claims denied within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67620	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of in-network claims denied within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67621	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of in-network claims denied within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67622	E	OEGT: The sum of in-network claims denied (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of in-network claims denied beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67623	E	OEGT: The sum of number of claim denials (excluding pharmacy claims) for out-of-network claims reported for large group, small group and individual plans must equal the total number of claim denials for out-of-network claims reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67624	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67625	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67626	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67627	E	OEGT: The sum of out-of-network claims denied (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims denied beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

67628	E	OEGT: The sum of number of paid claims (excluding pharmacy claims) for in-network services reported for large group, small group and individual plans must equal the total number of paid claims for in-network services reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67629	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67630	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67631	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of in-network claims paid within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67632	E	OEGT: The sum of in-network claims paid (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of in-network claims paid beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67633	E	OEGT: The sum of number of paid claims (excluding pharmacy claims) for out-of-network services reported for large group, small group and individual plans must equal the total number of number of paid claims for out-of-network services reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67634	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 0-30 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 0-30 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67635	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 31-60 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 31-60 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67636	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) within 61-90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid within 61-90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67637	E	OEGT: The sum of out-of-network claims paid (excluding pharmacy claims) beyond 90 days reported for large group, small group and individual plans must equal the total number of out-of-network claims paid beyond 90 days reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67638	E	OEGT: The sum of claims paid (excluding pharmacy claims) reported for large group, small group and individual plans must equal the total claims paid reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67639	E	OEGT: The sum of insured/beneficiary co-payment responsibility reported for large group, small group and individual plans must equal the total insured/beneficiary co-payment responsibility amount reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67640	E	OEGT: The sum of insured coinsurance responsibility reported for large group, small group and individual plans must equal the total insured coinsurance responsibility reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67641	E	OEGT: The sum of insured deductible responsibility reported for large group, small group and individual plans must equal the total insured deductible responsibility reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67642	E	OEGT: The sum of number of claims received reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67643	E	OEGT: The sum of number of claim denials for in-network claims reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

67644	E	OEGT: The sum of number of claim denials for out-of-network claims reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.

67645	E	OEGT: The sum of number of paid claims for in-network services reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67646	E	OEGT: The sum of number of paid claims for out-of-network services reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67647	E	OEGT: The sum of claims paid reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67648	E	OEGT: The sum of Insured/beneficiary co-payment responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67649	E	OEGT: The sum of Insured coinsurance responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67650	E	OEGT: The sum of Insured deductible responsibility reported for large group, small group and individual plans must equal the total number reported for out-of-exchange Grandfathered/Transitional Health insurance plans during the period.
67651	E	OEGT: The sum of in-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for large group, small group and individual coverages must equal the total in-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67652	E	OEGT: The sum of in-network claims denied, rejected or returned for missing Prior Authorizations reported for large group, small group and individual coverages must equal the total in-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67653	E	OEGT: The sum of in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.
67654	E	OEGT: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
67655	E	OEGT: The sum of in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total in-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
67656	E	OEGT: The sum of out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Claims Submission Coding Error(s) for out-of-exchange small group health insurance coverage during the period.
67657	E	OEGT: The sum of out-of-network claims denied, rejected or returned for missing Prior Authorizations reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for needing Prior Authorizations for out-of-exchange individual small group insurance coverage during the period.
67658	E	OEGT: The sum of out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for Non-Covered Benefit or Benefit Limitation for out-of-exchange small group health insurance coverage during the period.

67659	E	OEGT: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Excluding Behavioral Health Benefits) for out-of-exchange small group health insurance coverage during the period.
67660	E	OEGT: The sum of out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) reported for bronze, silver, gold and platinum coverages must equal the total out-of-network claims denied, rejected or returned for being Not Medically Necessary (Behavioral Health Benefits Only) for out-of-exchange small group health insurance coverage during the period.
67661	E	OEGT: The number of customer requests for internal reviews of grievances involving adverse determinations (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67662	E	OEGT: The number of adverse determinations upheld upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations upheld upon request for internal review for out-of-exchange small group health insurance coverage during the period.
67663	E	OEGT: The number of adverse determinations overturned upon request for internal review (excluding additional voluntary levels of reviews) reported for bronze, silver, gold and platinum coverages must equal the total number of adverse determinations overturned upon request for internal review for out-of-exchange small group health insurance coverage during the period.
67664	E	OEGT: The number of customer requests for internal reviews of grievances not involving adverse determinations reported for bronze, silver, gold and platinum coverages must equal the total number of customer requests for internal reviews of grievances not involving adverse determinations for out-of-exchange small group health insurance coverage during the period.
67665	E	OEGT: The number of customer requested appeals on final adverse determinations to external review organizations reported for large group, small group and individual coverages must equal the total number of customer requested appeals on final adverse determinations to external review organizations for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67666	E	OEGT: The number of final adverse determinations upheld upon request for external reviews reported for large group, small group and individual coverages must equal the total number of final adverse determinations upheld for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
67667	E	OEGT: The number of final adverse determinations overturned upon request for external reviews reported for large group, small group and individual coverages must equal the total number of final adverse determinations overturned for out-of-exchange Grandfathered/Transitional health insurance coverage during the period.
68001	E	OECA: If the company has Out-of-Exchange Catastrophic Health insurance (OECA) plan coverage data to report, then all corresponding OECA Policy Administration, Prior Authorizations, Claims and Consumer Requested Review data elements must be reported.
68002	E	OECA: If the company does not have Out-of-Exchange Catastrophic Health insurance (OECA) plan coverage data to report, then no data is allowed for all OECA data elements.
68004	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68005	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68006	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68007	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.

68008	E	OECA: For Out-of-Exchange Catastrophic Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68010	W	OECA: If the company reported Earned Premiums greater than zero for Out-of-Exchange Catastrophic health plans, then the total policies issued and policies renewed for OECA should be greater than zero.
68011	W	OECA: If the company reported new policies issued greater than zero for Out-of-Exchange Catastrophic health plans, then the member months for policies issued for OECA should be greater than zero.
68012	W	OECA: If the company reported policies renewed greater than zero for Out-of-Exchange Catastrophic health plans, then the member months for policies renewed for OECA should be greater than zero.
68013	W	OECA: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OECA should be greater than zero.
68014	W	OECA: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OECA should be greater than zero.
68015	W	OECA: If the company reported rescissions greater than zero for Out-of-Exchange Catastrophic health plans, then the number of lives impacted by rescissions for OECA should be greater than zero.
68016	W	OECA: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Catastrophic health plans, then the number of prior authorizations approved for OECA should be greater than the number of prior authorizations denied.
68017	W	OECA: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for OECA should be greater than the number of claims denied.
68018	W	OECA: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for OECA should be greater than the number of claims denied.
68019	W	OECA: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims submitted by network providers for OECA should be greater than the number of claims submitted by out-of-network providers.
68020	W	OECA: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Catastrophic health plans, then the number of claims paid for in-network services for OECA should be greater than the number of claims paid for out-of-network services.
68021	W	OECA: If the company reported Earned Premiums greater than zero for Out-of-Exchange Catastrophic health plans, then the total amount of claims paid for OECA should be less than the reported Earned Premiums.
68022	W	OECA: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Catastrophic health plans, then the number of adverse determinations upheld for OECA should be greater than the number of adverse determinations overturned.
68024	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
68025	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
68026	W	OECA: For Out-of-Exchange Catastrophic Health plans, the total number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
68101	E	OELG: If the company has Out-of-Exchange Large Group Comprehensive Health insurance (OELG) plan coverage other than transitional, grandfathered, multi-state, Large Group Comprehensive, or student data to report, then all OELG data elements must be reported.

68102	E	OELG: If the company does not have Out-of-Exchange Large Group Comprehensive Health insurance (OELG) plan coverage other than transitional, grandfathered, multi-state, Large Group Comprehensive, or student data to report, then no data is allowed for all OELG data elements.
68104	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68105	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claim denials (excluding pharmacy claims) for in-network claims must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68106	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of claim denials (excluding pharmacy claims) for out-of-network claims must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68107	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68108	E	OELG: For Out-of-Exchange Large Group Comprehensive Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68109	W	OELG: For Out-of-Exchange Large Group Health Plans, the total number of pharmacy-only claims received should be greater or equal to the sum of in-network claims paid, in-network claims denied, out-of-network claims paid and out-of-network claims denied for pharmacy-only claims.
68110	W	OELG: If the company reported Earned Premiums greater than zero for Out-of-Exchange Large Group health plans, then the total policies issued and policies renewed for OELG should be greater than zero.
68111	W	OELG: If the company reported new policies issued greater than zero for Out-of-Exchange Large Group health plans, then the member months for policies issued for OELG should be greater than zero.
68112	W	OELG: If the company reported policies renewed greater than zero for Out-of-Exchange Large Group health plans, then the member months for policies renewed for OELG should be greater than zero.
68113	W	OELG: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OELG should be greater than zero.
68114	W	OELG: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OELG should be greater than zero.
68115	W	OELG: If the company reported rescissions greater than zero for Out-of-Exchange Large Group health plans, then the number of lives impacted by rescissions for OELG should be greater than zero.
68116	W	OELG: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Large Group health plans, then the number of prior authorizations approved for OELG should be greater than the number of prior authorizations denied.
68117	W	OELG: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for OELG should be greater than the number of claims denied.
68118	W	OELG: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for OELG should be greater than the number of claims denied.
68119	W	OELG: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims submitted by network providers for OELG should be greater than the number of claims submitted by out-of-network providers.
68120	W	OELG: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Large Group health plans, then the number of claims paid for in-network services for OELG should be greater than the number of claims paid for out-of-network services.
68121	W	OELG: If the company reported Earned Premiums greater than zero for Out-of-Exchange Large Group health plans, then the total amount of claims paid for OELG should be less than the reported Earned Premiums.

68122	W	OELG: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Large Group health plans, then the number of adverse determinations upheld for OELG should be greater than the number of adverse determinations overturned.
68124	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
68125	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
68126	W	OELG: For Out-of-Exchange Large Group Health plans, the total number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.
68201	E	OESP: If the company has Out-of-Exchange Student Health insurance (OESP) plan coverage data to report, then all OESP data elements must be reported.
68202	E	OESP: If the company does not have Out-of-Exchange Student Health insurance (OESP) plan coverage to report, then no data is allowed for all OESP data elements.
68204	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claims received (excluding pharmacy claims) must be equal to the number of claims submitted by network providers and claims submitted by out-of-network providers.
68205	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claim denials for in-network claims (excluding pharmacy claims) must be equal to the number of in-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68206	E	OESP: For Out-of-Exchange Student Health Plans, the total number of claim denials for out-of-network claims (excluding pharmacy claims) must be equal to the number of out-of-network claims denied within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68207	E	OESP: For Out-of-Exchange Student Health Plans, the total number of paid claims (excluding pharmacy claims) for in-network services must be equal to the number of in-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68208	E	OESP: For Out-of-Exchange Student Health Plans, the total number of paid claims (excluding pharmacy claims) for out-of-network services must be equal to the number of out-of-network claims paid within 0-30 days, 31-60 days, 61-90 days and beyond 90 days.
68209	W	OESP: For Out-of-Exchange Student Coverage health plans, the total number of pharmacy-only claims received should be greater or equal to the sum of in-network claims paid, in-network claims denied, out-of-network claims paid and out-of-network claims denied for pharmacy-only claims.
68210	W	OESP: If the company reported Earned Premiums greater than zero for Out-of-Exchange Student Coverage health plans, then the total policies issued and policies renewed for OESP should be greater than zero.
68211	W	OESP: If the company reported new policies issued greater than zero for Out-of-Exchange Student Coverage health plans, then the member months for policies issued for OESP should be greater than zero.
68212	W	OESP: If the company reported policies renewed greater than zero for Out-of-Exchange Student Coverage health plans, then the member months for policies renewed for OESP should be greater than zero.
68213	W	OESP: If the company reported terminations and cancellations initiated by consumer greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted on terminations and cancellations initiated by the policyholder for OESP should be greater than zero.
68214	W	OESP: If the company reported terminations and cancellations due to non-payment of premium greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted on terminations and cancellations due to non-payment of premium for OESP should be greater than zero.
68215	W	OESP: If the company reported rescissions greater than zero for Out-of-Exchange Student Coverage health plans, then the number of lives impacted by rescissions for OESP should be greater than zero.

68216	W	OESP: If the company reported prior authorizations requested greater than zero for Out-of-Exchange Student Coverage health plans, then the number of prior authorizations approved for OESP should be greater than the number of prior authorizations denied.
68217	W	OESP: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for OESP should be greater than the number of claims denied.
68218	W	OESP: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for OESP should be greater than the number of claims denied.
68219	W	OESP: If the company reported non-pharmacy claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims submitted by network providers for OESP should be greater than the number of claims submitted by out-of-network providers.
68220	W	OESP: If the company reported pharmacy-only claims received greater than zero for Out-of-Exchange Student Coverage health plans, then the number of claims paid for in-network services for OESP should be greater than the number of claims paid for out-of-network services.

68221	W	OESP: If the company reported Earned Premiums greater than zero for Out-of-Exchange Student Coverage health plans, then the total amount of claims paid for OESP should be less than the reported Earned Premiums.
68222	W	OESP: If the company reported numbers of customer requests for internal reviews of grievances involving adverse determinations (excluding voluntary levels of reviews) greater than zero for Out-of-Exchange Student Coverage health plans, then the number of adverse determinations upheld for OESP should be greater than the number of adverse determinations overturned.
68224	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy-only) requested for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) requested.
68225	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy-only) denied for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) denied.
68226	W	OESP: For Out-of-Exchange Student Health plans, the total number of prior authorizations (excluding pharmacy-only) approved for mental health benefits, behavioral health benefits, and substance use disorders requested should be less or equal to the total number of prior authorizations (excluding pharmacy-only) approved.

Lender-Placed Insurance (LPI)

Coverage ID	Description of Coverage Identifiers
SIA	Single-Interest Auto
DIA	Dual Interest Auto
SIHH	Single-Interest Home Hazard
DIHH	Dual Interest Home Hazard
SIHF	Single-Interest Home Flood
DIHF	Dual Interest Home Flood
SIHWO	Single-Interest Home Wind-Only
DIHWO	Dual Interest Home Wind-Only
BVSIA	Blanket Value Single-Interest Auto
BVSIH	Blanket Value Single-Interest Home

Rule ID	Type	Description
70001	E	Responses must be provided to all Interrogatories in the 'Yes/No Response' column.
70002	E	You are not required to submit a MCAS Filing for this state since you answered 'No' to Interrogatory questions regarding having in-force lender-placed insurance coverage.
70003	E	You indicated having significant event/business strategy changes potentially affecting data for the reporting period; however, you did not provide additional comments.
70004	E	You reported that all or part of the block of business has been sold, closed or moved to another company during the year; however, you did not provide additional comments.
70005	E	Attestor information must include first name, last name, & title.
70006	W	Total considerations for all LPI coverage types should be => $50,000.
70101	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Auto (SIA) Insurance Coverage policies/certificates issued during the period.
70102	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage in Question 1; however, you did not provide responses to all corresponding Single-Interest Auto (SIA) Coverage data in the Claims section.
70103	E	For Single-Interest Auto (SIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70104	E	For Single-Interest Auto (SIA) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70105	E	For Single-Interest Auto (SIA) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70106	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70107	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70108	W	For Single-Interest Auto (SIA) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70109	E	You indicated that you did not have in-force Single-Interest Auto (SIA) Insurance Coverage; therefore, responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Claims Activity section must be blank.
70111	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.

70112	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.

70113	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70114	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70115	E	For Single-Interest Auto (SIA) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70116	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70117	W	For Single-Interest Auto (SIA) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70118	W	For Single-Interest Auto (SIA) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70119	E	You indicated that you have in-force Single-Interest Auto (SIA) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Underwriting Activity section.
70120	E	You indicated that you did not have in-force Single-Interest Auto (SIA) Insurance Coverage; therefore, responses to all corresponding Single-Interest Auto (SIA) Insurance Coverage data in the Underwriting Activity section must be blank.
70201	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Auto (DIA) Insurance Coverage policies/certificates issued during the period.
70202	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage in Question 3; however, you did not provide responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Claims section.
70203	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70204	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70205	E	For Dual-Interest Auto (DIA) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70206	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70207	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70208	W	For Dual-Interest Auto (DIA) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70209	E	You indicated that you did not have in-force Dual-Interest Auto (DIA) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Claims Activity section must be blank.

70211	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70212	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.

70213	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70214	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70215	E	For Dual-Interest Auto (DIA) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70216	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70217	W	For Dual-Interest Auto (DIA) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70218	W	For Dual-Interest Auto (DIA) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70219	E	You indicated that you have in-force Dual-Interest Auto (DIA) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Underwriting Activity section.
70220	E	You indicated that you did not have in-force Dual-Interest Auto (DIA) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Auto (DIA) Insurance Coverage data in the Underwriting Activity section must be blank.
70301	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Hazard (SIHH) Insurance Coverage policies/certificates issued during the period.
70302	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage in Question 5; however, you did not provide responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Claims section.
70303	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70304	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70305	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70306	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70307	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70308	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.

70309	E	You indicated that you did not have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Claims Activity section must be blank.
70311	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70312	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.

70313	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70314	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70315	E	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70316	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70317	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70318	W	For Single-Interest Home Hazard (SIHH) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70319	E	You indicated that you have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Underwriting Activity section.
70320	E	You indicated that you did not have in-force Single-Interest Home Hazard (SIHH) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Hazard (SIHH) Insurance Coverage data in the Underwriting Activity section must be blank.
70401	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Home Hazard (DIHH) Insurance Coverage policies/certificates issued during the period.
70402	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage in Question 7; however, you did not provide responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Claims section.
70403	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70404	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70405	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70406	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70407	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.

70408	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70409	E	You indicated that you did not have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Claims Activity section must be blank.
70411	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70412	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.

70413	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70414	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70415	E	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70416	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70417	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70418	W	For Dual-Interest Home Hazard (DIHH) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70419	E	You indicated that you have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Underwriting Activity section.
70420	E	You indicated that you did not have in-force Dual-Interest Home Hazard (DIHH) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Hazard (DIHH) Insurance Coverage data in the Underwriting Activity section must be blank.
70501	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Flood (SIHF) Insurance Coverage policies/certificates issued during the period.
70502	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Claims section.
70503	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70504	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70505	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.

70506	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70507	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70508	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70509	E	You indicated that you did not have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Claims Activity section must be blank.
70511	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70512	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70513	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70514	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70515	E	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70516	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70517	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70518	W	For Single-Interest Home Flood (SIHF) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70519	E	You indicated that you have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Underwriting Activity section.
70520	E	You indicated that you did not have in-force Single-Interest Home Flood (SIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Single-Interest Home Flood (SIHF) Insurance Coverage data in the Underwriting Activity section must be blank.
70601	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage; however, you did not provide a response for the percentage of Dual-Interest Home Flood (DIHF) Insurance Coverage policies/certificates issued during the period.
70602	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Claims section.
70603	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70604	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.

70605	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70606	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70607	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70608	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70609	E	You indicated that you did not have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Claims Activity section must be blank.
70611	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70612	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70613	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70614	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70615	E	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70616	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70617	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70618	W	For Dual-Interest Home Flood (DIHF) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70619	E	You indicated that you have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; however, you did not provide responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Underwriting Activity section.
70620	E	You indicated that you did not have in-force Dual-Interest Home Flood (DIHF) Insurance Coverage in Question 9; therefore, responses to all corresponding Dual-Interest Home Flood (DIHF) Insurance Coverage data in the Underwriting Activity section must be blank.
70701	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; however, you did not provide a response for the percentage of Single-Interest Home Wind-Only (SIHWO) Insurance Coverage policies/certificates issued during the period.
70702	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Claims section.
70703	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.

70704	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70705	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70706	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70707	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70708	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70709	E	You indicated that you did not have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Claims Activity section must be blank.
70711	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70712	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70713	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70714	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70715	E	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70716	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70717	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70718	W	For Single-Interest Home Wind-Only (SIHWO) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70719	E	You indicated that you have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; however, you did not provide responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Underwriting Activity section.
70720	E	You indicated that you did not have in-force Single-Interest Home Wind-Only (SIHWO) Insurance Coverage; therefore, responses to all corresponding Single-Interest Home Wind-Only (SIHWO) Insurance Coverage data in the Underwriting Activity section must be blank.
70801	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage ; however, you did not provide a response for the percentage of Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage policies/certificates issued during the period.
70802	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage in Question 11; however, you did not provide responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Claims section.

70803	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70804	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70805	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70806	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70807	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70808	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70809	E	You indicated that you did not have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Claims Activity section must be blank.
70811	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70812	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates in-force at the end of the period must equal the number of certificates in-force at the beginning the period, certificates written during the period less certificates flat-cancelled or cancelled for any other reason during the period.
70813	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of flat cancellations on certificates during the period must equal the number of all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70814	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of individual policies in-force at the end of the period must equal the number of individual policies in-force at the beginning the period, individual policies written during the period less individual policies flat-cancelled or cancelled for any other reason during the period.
70815	E	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of flat cancellations on individual policies during the period must equal the all flat cancellations within 45 days, between 45-90 days and beyond 90 days from placement.
70816	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates in-force at the beginning of the period should be more than or equal to the number of master policies in-force at the start of the reporting period.
70817	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the number of certificates written during the period should be more than or equal to the number of master policies added during the period.
70818	W	For Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70819	E	You indicated that you have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; however, you did not provide responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Underwriting Activity section.
70820	E	You indicated that you did not have in-force Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage; therefore, responses to all corresponding Dual-Interest Home Wind-Only (DIHWO) Insurance Coverage data in the Underwriting Activity section must be blank.
70902	E	You indicated that you have in-force Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage in Question 17; however, you did not provide responses to all corresponding Blanket Value Single-Interest Auto (BVSIA) Coverage data in the Claims section.

70903	E	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70904	E	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
70905	E	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
70906	E	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
70907	W	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
70908	W	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.
70909	E	You indicated that you did not have in-force Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage; therefore, responses to all corresponding Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage data in the Claims Activity section must be blank.
70911	E	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
70918	W	For Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
70919	E	You indicated that you have in-force Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage; however, you did not provide responses to all corresponding Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage data in the Underwriting Activity section.
70920	E	You indicated that you did not have in-force Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage; therefore, responses to all corresponding Blanket Value Single-Interest Auto (BVSIA) Insurance Coverage data in the Underwriting Activity section must be blank.
71002	E	You indicated that you have in-force Blanket Value Single-Interest Home (BVSIH) Insurance Coverage in Question 18; however, you did not provide responses to all corresponding Blanket Value Single-Interest Home (BVSIH) Insurance Coverage data in the Claims section.
71003	E	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, claims open at the end of the period must equal claims opened at the beginning the period, claims opened during the period less claims closed with payment and claims closed without payment during the same period.
71004	E	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, claims closed WITH payment during period must equal all claims closed with payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
71005	E	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, claims closed WITHOUT payment during period must equal all claims closed without payment within 30 days, between 31-60 days, 61-90 days, 91-180 days, 181-365 days and beyond 365 days.
71006	E	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, the number of suits open at the end of the period must equal the number of suits opened at the beginning the period, suits opened during the period less suits closed during the same period.
71007	W	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, the number of suits closed during the period with consideration for the borrower should be less than all suits closed during the same period.
71008	W	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, the median days to final claims settlement should correspond to the median date range for claims closed with payment. For additional information, please refer to the MCAS User Guide.

71009	E	You indicated that you did not have in-force Blanket Value Single-Interest Home (BVSIH) Insurance Coverage; therefore, responses to all corresponding Blanket Value Single-Interest Home (BVSIH) Insurance Coverage data in the Claims Activity section must be blank.
71011	E	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, the number of master policies in-force at the end of the period must equal the number of master policies in-force at the beginning the period, master policies added during the period less master policies cancelled for any reason during the period.
71018	W	For Blanket Value Single-Interest Home (BVSIH) Insurance Coverage, the net written premium during the period for policies/certificates for which no separate charge is made to the borrower should be less than the dollar amount of net written premium during the period.
71019	E	You indicated that you have in-force Blanket Value Single-Interest Home (BVSIH): Insurance Coverage; however, you did not provide responses to all corresponding Blanket Value Single-Interest Auto (BVSIH) Insurance Coverage data in the Underwriting Activity section.
71020	E	You indicated that you did not have in-force Blanket Value Single-Interest Home (BVSIH) Insurance Coverage; therefore, responses to all corresponding Blanket Value Single-Interest Auto (BVSIH) Insurance Coverage data in the Underwriting Activity section must be blank.

Disability Income (DI)

Coverage ID	Description of Coverage Identifiers
IVST	**Individual Voluntary Short-Term**
IVLT	**Individual Voluntary Long-Term**
IEPST	**Individual Employer-Paid Short-Term**
IEPLT	**Individual Employer-Paid Long-Term**
GVST	**Group Voluntary Short-Term**
GVLT	**Group Voluntary Long-Term**
GEPST	**Group Employer-Paid Short-Term**
GEPLT	**Group Employer-Paid Long-Term**

Rule ID	Type	Description
80001	E	Responses to all 'Yes/No' response questions must not be blank!
80002	E	Since all MCAS Disability Income (DI) data-to-report indicators = N, do not submit a DI Filing for this state.
80003	E	If a significant event or business strategy change would affect the data for this reporting period = N, the explanation field must be blank.
80004	E	If a significant event or business strategy change would affect the data for this reporting period = Y, an explanation is required.
80005	E	If business sold, closed or moved to another insurer during the reporting period = N, the explanation field must be blank.
80006	E	If business sold, closed or moved to another insurer during the reporting period = Y, an explanation is required.
80007	E	Attestor information must include first name, last name, & title.
80120	E	IVST: If the company does not have Individual Voluntary Short-Term (IVST) data to report, all IVST data elements must be blank.
80122	E	IVST: If the company has Individual Voluntary Short-Term (IVST) data to report, all corresponding IVST data elements must not be blank.
80124	E	If the total direct written premium (Q69) (IVST + IVLT + IEPST + IEPLT + GVST + GVLT + GEPST + GEPLT) < $50,000, then Disability Income filing is not needed.
80140	W	IVST: Individual Voluntary Short-Term (IVST) Number of Policies In Force at the end of the reporting period should = IVST Number of Policies In Force at the beginning of the reporting period + IVST Number of New Policies Issued during the reporting period - IVST Number of Policyholder Cancellations and Non Renewals - IVST Number of Insurer Non Renewals - IVST Number of Insurer Cancellations - IVST Number of Rescissions Within Two Years from Policy Issue - IVST Number of Rescissions After Two Years from Policy Issue.
80149	E	IVST: Individual Voluntary Short-Term (IVST) Number of Lawsuits Open at the end of the period must = IVST Number of Lawsuits Open at the beginning of the period + IVST Number of New Lawsuits Opened during the period - IVST Number of Lawsuits Closed during the period.
80150	W	IVST: Individual Voluntary Short-Term (IVST) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= IVST Number of Lawsuits Closed during the period.
80160	W	IVST: Individual Voluntary Short-Term (IVST) Active Paid Claims at the beginning of the reporting period + IVST New Paid Claims during the reporting period - IVST Paid Claims Closed during the reporting period should be >= IVST Active Paid Claims at the end of the reporting period.
80161	W	IVST: Individual Voluntary Short-Term (IVST) Pending Benefit Determinations at the beginning of the reporting period + IVST Claims Received during the reporting period - IVST New Paid Claim Determinations during the reporting period - IVST Claim Denials during the reporting period should be >= IVST Pending Benefit Determinations at the end of the reporting period.
80162	W	IVST: Individual Voluntary Short-Term (IVST) Initial Claims Decision Median Days reported on Q29 should correspond to the date range of median days reported on Q25-Q28. For additional information please reference the MCAS User Guide.
80166	W	IVST: Individual Voluntary Short-Term (IVST) Median Processing Time in Days for Claims Closed without Payment reported on Q39 should correspond to the date range of median days reported on Q35-Q38. For additional information please reference the MCAS User Guide.

80168	W	IVST: Individual Voluntary Short-Term (IVST) All Other Denials should be < IVST Claimant Not Covered at Onset Date + IVST Claimant Returned to Work during Elimination Period + IVST Pre-existing Condition + IVST Claimant not Disabled Under Policy Definition + IVST Lack of Documentation + IVST Diagnosis Excluded under Policy + IVST Disability Work-Related or Condition Excluded Under Policy + IVST Disability Excluded Circumstances not Work-Related + IVST Misrepresentation.
80169	E	IVST: Individual Voluntary Short-Term (IVST) claim denials during the reporting period must = the sum of IVST claims denied on Q45-Q54.
80170	W	IVST: Individual Voluntary Short-Term (IVST) Other Claims Closed After Payment should be < IVST Claimant Returned to Work Own Occupation + IVST Claimant Returned to Work Any Occupation + IVST Lack of Documentation + IVST Evaluation Non Participation + IVST Death of Claimant + IVST Failure to Participate in Rehabilitation + IVST Misrepresentation + IVST Offsetting Compensation + IVST Maximum Benefit Reached + IVST No longer Own Occupation Disabled but has not Returned to Work + IVST No longer Any Occupation Disabled but has not Returned to Work.
80171	E	IVST: Individual Voluntary Short-Term (IVST) paid claims closed during the reporting period must = the sum of IVST claims closed after initial payment on Q55-Q66.
80221	E	IVLT: If the company does not have Individual Voluntary Long-Term (IVLT) data to report, all IVLT data elements must be blank.
80223	E	IVLT: If the company has Individual Voluntary Long-Term (IVLT) data to report, all corresponding IVLT data elements may not all equal zero and must not be blank.
80240	W	IVLT: Individual Voluntary Long-Term (IVLT) Number of Policies In Force at the end of the reporting period should = IVLT Number of Policies In Force at the beginning of the reporting period + IVLT Number of New Policies Issued during the reporting period - IVLT Number of Policyholder Cancellations and Non Renewals - IVLT Number of Insurer Non Renewals - IVLT Number of Insurer Cancellations - IVLT Number of Rescissions Within Two Years from Policy Issue - IVLT Number of Rescissions After Two Years from Policy Issue.
80249	E	IVLT: Individual Voluntary Long-Term (IVLT) Number of Lawsuits Open at the end of the period must = IVLT Number of Lawsuits Open at the beginning of the period + IVLT Number of New Lawsuits Opened during the period - IVLT Number of Lawsuits Closed during the period.
80250	W	IVLT: Individual Voluntary Long-Term (IVLT) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= IVLT Number of Lawsuits Closed during the period.
80260	W	IVLT: Individual Voluntary Long-Term (IVLT) Active Paid Claims at the beginning of the reporting period + IVLT New Paid Claims during the reporting period - IVLT Paid Claims Closed during the reporting period should be >= IVLT Active Paid Claims at the end of the reporting period.
80261	W	IVLT: Individual Voluntary Long-Term (IVLT) Pending Benefit Determinations at the beginning of the reporting period + IVLT Claims Received during the reporting period - IVLT New Paid Claim Determinations during the reporting period - IVLT Claim Denials during the reporting period should be >= IVLT Pending Benefit Determinations at the end of the reporting period.
80263	W	IVLT: Individual Voluntary Long-Term (IVLT) Initial Claims Decision Median Days reported on Q34 should correspond to the date range of median days reported on Q30-Q33. For additional information please reference the MCAS User Guide.
80267	W	IVLT: Individual Voluntary Long-Term (IVLT) Median Processing Time in Days for Claims Closed without Payment reported on Q44 should correspond to the date range of median days reported on Q40-Q43. For additional information please reference the MCAS User Guide.
80268	W	IVLT: Individual Voluntary Long-Term (IVLT) All Other Denials should be < IVLT Claimant Not Covered at Onset Date + IVLT Claimant Returned to Work during Elimination Period + IVLT Pre-existing Condition + IVLT Claimant not Disabled Under Policy Definition + IVLT Lack of Documentation + IVLT Diagnosis Excluded under Policy + IVLT Disability Work-Related or Condition Excluded Under Policy + IVLT Disability Excluded Circumstances not Work-Related + IVLT Misrepresentation.
80269	E	IVLT: Individual Voluntary Long-Term (IVLT) claim denials during the reporting period must = the sum of IVLT claims denied on Q45-Q54.
80270	W	IVLT: Individual Voluntary Long-Term (IVLT) Other Claims Closed After Payment should be < IVLT Claimant Returned to Work Own Occupation + IVLT Claimant Returned to Work Any Occupation + IVLT Lack of Documentation + IVLT Evaluation Non Participation + IVLT Death of Claimant + IVLT Failure to Participate in Rehabilitation + IVLT Misrepresentation + IVLT Offsetting Compensation + IVLT Maximum Benefit Reached + IVLT No longer Own Occupation Disabled but has not Returned to Work + IVLT No longer Any Occupation Disabled but has not Returned to Work.

80271	E	IVLT: Individual Voluntary Long-Term (IVLT) paid claims closed during the reporting period must = the sum of IVLT claims closed after initial payment on Q55-Q66.

80320	E	IEPST: If the company does not have Individual Employer-Paid Short-Term (IEPST) data to report, all IEPST data elements must be blank.
80322	E	IEPST: If the company has Individual Employer-Paid Short-Term (IEPST) data to report, all corresponding IEPST data elements may not all equal zero and must not be blank.
80340	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Number of Policies In Force at the end of the reporting period should = IEPST Number of Policies In Force at the beginning of the reporting period + IEPST Number of New Policies Issued during the reporting period - IEPST Number of Policyholder Cancellations and Non Renewals - IEPST Number of Insurer Non Renewals - IEPST Number of Insurer Cancellations - IEPST Number of Rescissions Within Two Years from Policy Issue - IEPST Number of Rescissions After Two Years from Policy Issue.
80349	E	IEPST: Individual Employer-Paid Short-Term (IEPST) Number of Lawsuits Open at the end of the period must = IEPST Number of Lawsuits Open at the beginning of the period + IEPST Number of New Lawsuits Opened during the period - IEPST Number of Lawsuits Closed during the period.
80350	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= IEPST Number of Lawsuits Closed during the period.
80360	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Active Paid Claims at the beginning of the reporting period + IEPST New Paid Claims during the reporting period - IEPST Paid Claims Closed during the reporting period should be >= IEPST Active Paid Claims at the end of the reporting period.
80361	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Pending Benefit Determinations at the beginning of the reporting period + IEPST Claims Received during the reporting period- IEPST New Paid Claim Determinations during the reporting period- IEPST Claim Denials during the reporting period should be >= IEPST Pending Benefit Determinations at the end of the reporting period.
80362	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Initial Claims Decision Median Days reported on Q29 should correspond to the date range of median days reported on Q25-Q28. For additional information please reference the MCAS User Guide.
80366	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Median Processing Time in Days for Claims Closed without Payment reported on Q39 should correspond to the date range of median days reported on Q35-Q38. For additional information please reference the MCAS User Guide.
80368	W	IEPST: Individual Employer-Paid Short-Term (IEPST) All Other Denials should be < IEPST Claimant Not Covered at Onset Date + IEPST Claimant Returned to Work during Elimination Period + IEPST Pre-existing Condition + IEPST Claimant not Disabled Under Policy Definition + IEPST Lack of Documentation + IEPST Diagnosis Excluded under Policy + IEPST Disability Work-Related or Condition Excluded Under Policy + IEPST Disability Excluded Circumstances not Work-Related + IEPST Misrepresentation.
80369	E	IEPST: Individual Employer-Paid Short-Term (IEPST) claim denials during the reporting period must = the sum of IEPST claims denied on Q45-Q54.
80370	W	IEPST: Individual Employer-Paid Short-Term (IEPST) Other Claims Closed After Payment should be < IEPST Claimant Returned to Work Own Occupation + IEPST Claimant Returned to Work Any Occupation + IEPST Lack of Documentation + IEPST Evaluation Non Participation + IEPST Death of Claimant + IEPST Failure to Participate in Rehabilitation + IEPST Misrepresentation + IEPST Offsetting Compensation + IEPST Maximum Benefit Reached + IEPST No longer Own Occupation Disabled but has not Returned to Work + IEPST No longer Any Occupation Disabled but has not Returned to Work.
80371	E	IEPST: Individual Employer-Paid Short-Term (IEPST) paid claims closed during the reporting period must = the sum of IEPST claims closed after initial payment on Q55-Q66.
80421	E	IEPLT: If the company does not have Individual Employer-Paid Long-Term (IEPLT) data to report, all IEPLT data elements must be blank.
80423	E	IEPLT: If the company has Individual Employer-Paid Long-Term (IEPLT) data to report, all corresponding IEPLT data elements may not all equal zero and must not be blank.

80440	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Number of Policies In Force at the end of the reporting period should = IEPLT Number of Policies In Force at the beginning of the reporting period + IEPLT Number of New Policies Issued during the reporting period - IEPLT Number of Policyholder Cancellations and Non Renewals - IEPLT Number of Insurer Non Renewals - IEPLT Number of Insurer Cancellations - IEPLT Number of Rescissions Within Two Years from Policy Issue - IEPLT Number of Rescissions After Two Years from Policy Issue.
80449	E	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Number of Lawsuits Open at the end of the period must = IEPLT Number of Lawsuits Open at the beginning of the period + IEPLT Number of New Lawsuits Opened during the period - IEPLT Number of Lawsuits Closed during the period.

80450	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= IEPLT Number of Lawsuits Closed during the period.
80460	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Active Paid Claims at the beginning of the reporting period + IEPLT New Paid Claims during the reporting period - IEPLT Paid Claims Closed during the reporting period should be >= IEPLT Active Paid Claims at the end of the reporting period.
80461	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Pending Benefit Determinations at the beginning of the reporting period + IEPLT Claims Received during the reporting period - IEPLT New Paid Claim Determinations during the reporting period - IEPLT Claim Denials during the reporting period should be >= IEPLT Pending Benefit Determinations at the end of the reporting period.
80463	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Initial Claims Decision Median Days reported on Q34 should correspond to the date range of median days reported on Q30-Q33. For additional information please reference the MCAS User Guide.
80467	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Median Processing Time in Days for Claims Closed without Payment reported on Q44 should correspond to the date range of median days reported on Q40-Q43. For additional information please reference the MCAS User Guide.
80468	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) All Other Denials should be < IEPLT Claimant Not Covered at Onset Date + IEPLT Claimant Returned to Work during Elimination Period + IEPLT Pre-existing Condition + IEPLT Claimant not Disabled Under Policy Definition + IEPLT Lack of Documentation + IEPLT Diagnosis Excluded under Policy + IEPLT Disability Work-Related or Condition Excluded Under Policy + IEPLT Disability Excluded Circumstances not Work-Related + IEPLT Misrepresentation.
80469	E	IEPLT: Individual Employer-Paid Long-Term (IEPLT) claim denials during the reporting period must = the sum of IEPLT claims denied on Q45-Q54.
80470	W	IEPLT: Individual Employer-Paid Long-Term (IEPLT) Other Claims Closed After Payment should be < IEPLT Claimant Returned to Work Own Occupation + IEPLT Claimant Returned to Work Any Occupation + IEPLT Lack of Documentation + IEPLT Evaluation Non Participation + IEPLT Death of Claimant + IEPLT Failure to Participate in Rehabilitation + IEPLT Misrepresentation + IEPLT Offsetting Compensation + IEPLT Maximum Benefit Reached + IEPLT No longer Own Occupation Disabled but has not Returned to Work + IEPLT No longer Any Occupation Disabled but has not Returned to Work.
80471	E	IEPLT: Individual Employer-Paid Long-Term (IEPLT) paid claims closed during the reporting period must = the sum of IEPLT claims closed after initial payment on Q55-Q66.
80520	E	GVST: If the company does not have Group Voluntary Short-Term (GVST) data to report, all corresponding GVST data elements must be blank.
80522	E	GVST: If the company has Group Voluntary Short-Term (GVST) data to report, all corresponding GVST data elements may not all equal zero and must not be blank.
80540	W	GVST: Group Voluntary Short-Term (GVST) Number of Policies In Force at the end of the reporting period should = GVST Number of Policies In Force at the beginning of the reporting period + GVST Number of New Policies Issued during the reporting period - GVST Number of Policyholder Cancellations and Non Renewals - GVST Number of Insurer Non Renewals - GVST Number of Insurer Cancellations - GVST Number of Rescissions Within Two Years from Policy Issue - GVST Number of Rescissions After Two Years from Policy Issue.

80541	W	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Policies In Force at the end of the reporting period should = GVST Number of Lives Covered Under Policies In Force at the beginning of the reporting period + GVST Number of Lives Covered Under New Policies Issued during the reporting period - GVST Number of Lives Covered Under Policyholder Cancellations and Non Renewals - GVST Number of Lives Covered Under Insurer Non Renewals - GVST Number of Lives Covered Under Insurer Cancellations - GVST Number of Lives Covered Under Rescinded Policies.
80542	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Policies In Force at the beginning of the reporting period must be => GVST Number of Policies In Force at the beginning of the reporting period.
80543	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under New Policies Issued during the reporting period must be => GVST Number of New Policies Issued during the reporting period.
80544	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Policyholder Cancellations and Non Renewals during the reporting period must be => GVST Number of Policyholder Cancellations and Non Renewals during the reporting period.
80545	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Insurer Non Renewals during the reporting period must be => GVST Number of Insurer Non Renewals during the reporting period.
80546	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Insurer Cancellations during the reporting period must be => GVST Number of Insurer Cancellations during the reporting period.
80547	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Rescinded Policies during the reporting period must be => (GVST Number of Rescinded Policies Within Two Years from Policy Issue during the reporting period + GVST Number of Rescinded Policies After Two Years from Policy Issue during the reporting period.)
80548	E	GVST: Group Voluntary Short-Term (GVST) Number of Lives Covered Under Policies In Force at the end of the reporting period must be => GVST Number of Policies In Force at the end of the reporting period.
80549	E	GVST: Group Voluntary Short-Term (GVST) Number of Lawsuits Open at the end of the period must = GVST Number of Lawsuits Open at the beginning of the period + GVST Number of New Lawsuits Opened during the period - GVST Number of Lawsuits Closed during the period.
80550	W	GVST: Group Voluntary Short-Term (GVST) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= GVST Number of Lawsuits Closed during the period.
80560	W	GVST: Group Voluntary Short-Term (GVST) Active Paid Claims at the beginning of the reporting period + GVST New Paid Claims during the reporting period - GVST Paid Claims Closed during the reporting period should be >= GVST Active Paid Claims at the end of the reporting period.
80561	W	GVST: Group Voluntary Short-Term (GVST) Pending Benefit Determinations at the beginning of the reporting period + GVST Claims Received during the reporting period - GVST New Paid Claim Determinations during the reporting period - GVST Claim Denials during the reporting period should be >= GVST Pending Benefit Determinations at the end of the reporting period.
80562	W	GVST: Group Voluntary Short-Term (GVST) Initial Claims Decision Median Days reported on Q29 should correspond to the date range of median days reported on Q25-Q28. For additional information please reference the MCAS User Guide.
80566	W	GVST: Group Voluntary Short-Term (GVST) Median Processing Time in Days for Claims Closed without Payment reported on Q39 should correspond to the date range of median days reported on Q35-Q38. For additional information please reference the MCAS User Guide.
80568	W	GVST: Group Voluntary Short-Term (GVST) All Other Denials should be < GVST Claimant Not Covered at Onset Date + GVST Claimant Returned to Work during Elimination Period + GVST Pre-existing Condition + GVST Claimant not Disabled Under Policy Definition + GVST Lack of Documentation + GVST Diagnosis Excluded under Policy + GVST Disability Work-Related or Condition Excluded Under Policy + GVST Disability Excluded Circumstances not Work-Related + GVST Misrepresentation.
80569	E	GVST: Group Voluntary Short-Term (GVST) claim denials during the reporting period must = the sum of GVST claims denied on Q45-Q54.

80570	W	GVST: Group Voluntary Short-Term (GVST) Other Claims Closed After Payment should be < GVST Claimant Returned to Work Own Occupation + GVST Claimant Returned to Work Any Occupation + GVST Lack of Documentation + GVST Evaluation Non Participation + GVST Death of Claimant + GVST Failure to Participate in Rehabilitation + GVST Misrepresentation + GVST Offsetting Compensation + GVST Maximum Benefit Reached + GVST No longer Own Occupation Disabled but has not Returned to Work + GVST No longer Any Occupation Disabled but has not Returned to Work.
80571	E	GVST: Group Voluntary Short-Term (GVST) paid claims closed during the reporting period must = the sum of GVST claims closed after initial payment on Q55-Q66.
80621	E	GVLT: If the company does not have Group Voluntary Long-Term (GVLT) data to report, all GVLT data elements must be blank.
80623	E	GVLT: If the company has Group Voluntary Long-Term (GVLT) data to report, all corresponding GVLT data elements may not all equal zero and must not be blank.
80640	W	GVLT: Group Voluntary Long-Term (GVLT) Number of Policies In Force at the end of the reporting period should = GVLT Number of Policies In Force at the beginning of the reporting period + GVLT Number of New Policies Issued during the reporting period - GVLT Number of Policyholder Cancellations and Non Renewals - GVLT Number of Insurer Non Renewals - GVLT Number of Insurer Cancellations - GVLT Number of Rescissions Within Two Years from Policy Issue - GVLT Number of Rescissions After Two Years from Policy Issue.
80641	W	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Policies In Force at the end of the reporting period should = GVLT Number of Lives Covered Under Policies In Force at the beginning of the reporting period + GVLT Number of Lives Covered Under New Policies Issued during the reporting period - GVLT Number of Lives Covered Under Policyholder Cancellations and Non Renewals - GVLT Number of Lives Covered Under Insurer Non Renewals - GVLT Number of Lives Covered Under Insurer Cancellations - GVLT Number of Lives Covered Under Rescinded Policies.
80642	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Policies In Force at the beginning of the reporting period must be => GVLT Number of Policies In Force at the beginning of the reporting period.
80643	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under New Policies Issued during the reporting period must be => GVLT Number of New Policies Issued during the reporting period.
80644	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Policyholder Cancellations and Non Renewals during the reporting period must be => GVLT Number of Policyholder Cancellations and Non Renewals during the reporting period.
80645	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Insurer Non Renewals during the reporting period must be => GVLT Number of Insurer Non Renewals during the reporting period.
80646	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Insurer Cancellations during the reporting period must be => GVLT Number of Insurer Cancellations during the reporting period.
80647	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Rescinded Policies during the reporting period must be => (GVLT Number of Rescinded Policies Within Two Years from Policy Issue during the reporting period + GVLT Number of Rescinded Policies After Two Years from Policy Issue during the reporting period.)
80648	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lives Covered Under Policies In Force at the end of the reporting period must be => GVLT Number of Policies In Force at the end of the reporting period.
80649	E	GVLT: Group Voluntary Long-Term (GVLT) Number of Lawsuits Open at the end of the period must = GVLT Number of Lawsuits Open at the beginning of the period + GVLT Number of New Lawsuits Opened during the period - GVLT Number of Lawsuits Closed during the period.
80650	W	GVLT: Group Voluntary Long-Term (GVLT) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= GVLT Number of Lawsuits Closed during the period.
80660	W	GVLT: Group Voluntary Long-Term (GVLT) Active Paid Claims at the beginning of the reporting period + GVLT New Paid Claims during the reporting period - GVLT Paid Claims Closed during the reporting period should be >= GVLT Active Paid Claims at the end of the reporting period.
80661	W	GVLT: Group Voluntary Long-Term (GVLT) Pending Benefit Determinations at the beginning of the reporting period + GVLT Claims Received during the reporting period - GVLT New Paid Claim Determinations during the reporting period- Claim Denials during the reporting period should be >= GVLT Pending Benefit Determinations at the end of the reporting period.

80663	W	GVLT: Group Voluntary Long-Term (GVLT) Initial Claims Decision Median Days reported on Q34 should correspond to the date range of median days reported on Q30-Q33. For additional information please reference the MCAS User Guide.
80667	W	GVLT: Group Voluntary Long-Term (GVLT) Median Processing Time in Days for Claims Closed without Payment reported on Q44 should correspond to the date range of median days reported on Q40-Q43. For additional information please reference the MCAS User Guide.
80668	W	GVLT: Group Voluntary Long-Term (GVLT) All Other Denials should be < GVLT Claimant Not Covered at Onset Date + GVLT Claimant Returned to Work during Elimination Period + GVLT Pre-existing Condition + GVLT Claimant not Disabled Under Policy Definition + GVLT Lack of Documentation + GVLT Diagnosis Excluded under Policy + GVLT Disability Work-Related or Condition Excluded Under Policy + GVLT Disability Excluded Circumstances not Work-Related + GVLT Misrepresentation.
80669	E	GVLT: Group Voluntary Long-Term (GVLT) claim denials during the reporting period must = the sum of GVLT claims denied on Q45-Q54.
80670	W	GVLT: Group Voluntary Long-Term (GVLT) Other Claims Closed After Payment should be < GVLT Claimant Returned to Work Own Occupation + GVLT Claimant Returned to Work Any Occupation + GVLT Lack of Documentation + GVLT Evaluation Non Participation + GVLT Death of Claimant + GVLT Failure to Participate in Rehabilitation + GVLT Misrepresentation + GVLT Offsetting Compensation + GVLT Maximum Benefit Reached + GVLT No longer Own Occupation Disabled but has not Returned to Work + GVLT No longer Any Occupation Disabled but has not Returned to Work.
80671	E	GVLT: Group Voluntary Long-Term (GVLT) paid claims closed during the reporting period must = the sum of GVLT claims closed after initial payment on Q55-Q66.
80720	E	GEPST: If the company does not have Group Employer-Paid Short-Term (GEPST) data to report, all GEPST data elements must be blank.
80722	E	GEPST: If the company has Group Employer-Paid Short-Term (GEPST) data to report, all corresponding GEPST data elements may not all equal zero and must not be blank.

80740	W	GEPST: Group Employer Paid Short-Term (GEPST) Number of Policies In Force at the end of the reporting period should = GEPST Number of Policies In Force at the beginning of the reporting period + GEPST Number of New Policies Issued during the reporting period - GEPST Number of Policyholder Cancellations and Non Renewals - GEPST Number of Insurer Non Renewals - GEPST Number of Insurer Cancellations - GEPST Number of Rescissions Within Two Years from Policy Issue - GEPST Number of Rescissions After Two Years from Policy Issue.
80741	W	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Policies In Force at the end of the reporting period should = GEPST Number of Lives Covered Under Policies In Force at the beginning of the reporting period + GEPST Number of Lives Covered Under New Policies Issued during the reporting period - GEPST Number of Lives Covered Under Policyholder Cancellations and Non Renewals - GEPST Number of Lives Covered Under Insurer Non Renewals - GEPST Number of Lives Covered Under Insurer Cancellations - GEPST Number of Lives Covered Under Rescinded Policies.
80742	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Policies In Force at the beginning of the reporting period must be => GEPST Number of Policies In Force at the beginning of the reporting period.
80743	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under New Policies Issued during the reporting period must be => GEPST Number of New Policies Issued during the reporting period.
80744	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Policyholder Cancellations and Non Renewals during the reporting period must be => GEPST Number of Policyholder Cancellations and Non Renewals during the reporting period.
80745	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Insurer Non Renewals during the reporting period must be => GEPST Number of Insurer Non Renewals during the reporting period.
80746	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Insurer Cancellations during the reporting period must be => GEPST Number of Insurer Cancellations during the reporting period.

80747	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Rescinded Policies during the reporting period must be => (GEPST Number of Rescinded Policies Within Two Years from Policy Issue during the reporting period + GEPST Number of Rescinded Policies After Two Years from Policy Issue during the reporting period.)
80748	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lives Covered Under Policies In Force at the end of the reporting period must be => GEPST Number of Policies In Force at the end of the reporting period.
80749	E	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lawsuits Open at the end of the period must = GEPST Number of Lawsuits Open at the beginning of the period + GEPST Number of New Lawsuits Opened during the period - GEPST Number of Lawsuits Closed during the period.
80750	W	GEPST: Group Employer Paid Short-Term (GEPST) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= GEPST Number of Lawsuits Closed during the period.
80760	W	GEPST: Group Employer Paid Short-Term (GEPST) Active Paid Claims at the beginning of the reporting period + GEPST New Paid Claims during the reporting period - GEPST Paid Claims Closed during the reporting period should be >= GEPST Active Paid Claims at the end of the reporting period.
80761	W	GEPST: Group Employer Paid Short-Term (GEPST) Pending Benefit Determinations at the beginning of the reporting period + GEPST Claims Received during the reporting period - GEPST New Paid Claim Determinations during the reporting period - GEPST Claim Denials during the reporting period should be >= GEPST Pending Benefit Determinations at the end of the reporting period.
80762	W	GEPST: Group Employer Paid Short-Term (GEPST) Initial Claims Decision Median Days reported on Q29 should correspond to the date range of median days reported on Q25-Q28. For additional information please reference the MCAS User Guide.
80766	W	GEPST: Group Employer Paid Short-Term (GEPST) Median Processing Time in Days for Claims Closed without Payment reported on Q39 should correspond to the date range of median days reported on Q35-Q38. For additional information please reference the MCAS User Guide.
80768	W	GEPST: Group Employer Paid Short-Term (GEPST) All Other Denials should be < GEPST Claimant Not Covered at Onset Date + GEPST Claimant Returned to Work during Elimination Period + GEPST Pre-existing Condition + GEPST Claimant not Disabled Under Policy Definition + GEPST Lack of Documentation + GEPST Diagnosis Excluded under Policy + GEPST Disability Work-Related or Condition Excluded Under Policy + GEPST Disability Excluded Circumstances not Work-Related + GEPST Misrepresentation.
80769	E	GEPST: Group Employer Paid Short-Term (GEPST) claim denials during the reporting period must = the sum of GEPST claims denied on Q45-Q54.
80770	W	GEPST: Group Employer Paid Short-Term (GEPST) Other Claims Closed After Payment should be < GEPST Claimant Returned to Work Own Occupation + GEPST Claimant Returned to Work Any Occupation + GEPST Lack of Documentation + GEPST Evaluation Non Participation + GEPST Death of Claimant + GEPST Failure to Participate in Rehabilitation + GEPST Misrepresentation + GEPST Offsetting Compensation + GEPST Maximum Benefit Reached + GEPST No longer Own Occupation Disabled but has not Returned to Work + GEPST No longer Any Occupation Disabled but has not Returned to Work.
80771	E	GEPST: Group Employer Paid Short-Term (GEPST) paid claims closed during the reporting period must = the sum of GEPST claims closed after initial payment on Q55-Q66.
80821	E	GEPLT: If the company does not have Group Employer-Paid Long-Term (GEPLT) data to report, all GEPLT data elements must be blank.
80823	E	GEPLT: If the company has Group Employer-Paid Long-Term (GEPLT) data to report, all corresponding GEPLT data elements may not all equal zero and must not be blank.
80840	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Policies In Force at the end of the reporting period should = GEPLT Number of Policies In Force at the beginning of the reporting period + GEPLT Number of New Policies Issued during the reporting period - GEPLT Number of Policyholder Cancellations and Non Renewals - GEPLT Number of Insurer Non Renewals - GEPLT Number of Insurer Cancellations - GEPLT Number of Rescissions Within Two Years from Policy Issue - GEPLT Number of Rescissions After Two Years from Policy Issue.

80841	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Policies In Force at the end of the reporting period should = GEPLT Number of Lives Covered Under Policies In Force at the beginning of the reporting period + GEPLT Number of Lives Covered Under New Policies Issued during the reporting period - GEPLT Number of Lives Covered Under Policyholder Cancellations and Non Renewals - GEPLT Number of Lives Covered Under Insurer Non Renewals - GEPLT Number of Lives Covered Under Insurer Cancellations - GEPLT Number of Lives Covered Under Rescinded Policies.
80842	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Policies In Force at the beginning of the reporting period must be => GEPLT Number of Policies In Force at the beginning of the reporting period.
80843	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under New Policies Issued during the reporting period must be => GEPLT Number of New Policies Issued during the reporting period.
80844	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Policyholder Cancellations and Non Renewals during the reporting period must be => GEPLT Number of Policyholder Cancellations and Non Renewals during the reporting period.
80845	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Insurer Non Renewals during the reporting period must be => GEPLT Number of Insurer Non Renewals during the reporting period.
80846	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Insurer Cancellations during the reporting period must be => GEPLT Number of Insurer Cancellations during the reporting period.
80847	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Rescinded Policies during the reporting period must be => (GEPLT Number of Rescinded Policies Within Two Years from Policy Issue during the reporting period + GEPLT Number of Rescinded Policies After Two Years from Policy Issue during the reporting period.)
80848	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lives Covered Under Policies In Force at the end of the reporting period must be => GEPLT Number of Policies In Force at the end of the reporting period.
80849	E	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lawsuits Open at the end of the period must = GEPLT Number of Lawsuits Open at the beginning of the period + GEPLT Number of New Lawsuits Opened during the period - GEPLT Number of Lawsuits Closed during the period.
80850	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Number of Lawsuits Closed with Consideration for the Consumer during the period should be <= GEPLT Number of Lawsuits Closed during the period.
80860	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Active Paid Claims at the beginning of the reporting period + GEPLT New Paid Claims during the reporting period - GEPLT Paid Claims Closed during the reporting period should be >= GEPLT Active Paid Claims at the end of the reporting period.
80861	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Pending Benefit Determinations at the beginning of the reporting period + GEPLT Claims Received during the reporting period - GEPLT New Paid Claim Determinations during the reporting period - GEPLT Claim Denials during the reporting period should be >= GEPLT Pending Benefit Determinations at the end of the reporting period.
80863	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Initial Claims Decision Median Days reported on Q34 should correspond to the date range of median days reported on Q30-Q33. For additional information please reference the MCAS User Guide.
80867	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Median Processing Time in Days for Claims Closed without Payment reported on Q44 should correspond to the date range of median days reported on Q40-Q43. For additional information please reference the MCAS User Guide.
80868	W	GEPLT: Group Employer Paid Long-Term (GEPLT) All Other Denials should be < GEPLT Claimant Not Covered at Onset Date + GEPLT Claimant Returned to Work during Elimination Period + GEPLT Pre-existing Condition + GEPLT Claimant not Disabled Under Policy Definition + GEPLT Lack of Documentation + GEPLT Diagnosis Excluded under Policy + GEPLT Disability Work-Related or Condition Excluded Under Policy + GEPLT Disability Excluded Circumstances not Work-Related + GEPLT Misrepresentation.
80869	E	GEPLT: Group Employer Paid Long-Term (GEPLT) claim denials during the reporting period must = the sum of GEPLT claims denied on Q45-Q54.

80870	W	GEPLT: Group Employer Paid Long-Term (GEPLT) Other Closed After Payment should be < GEPLT Claimant Returned to Work Own Occupation + GEPLT Claimant Returned to Work Any Occupation + GEPLT Lack of Documentation + GEPLT Evaluation Non Participation + GEPLT Death of Claimant + GEPLT Failure to Participate in Rehabilitation + GEPLT Misrepresentation + GEPLT Offsetting Compensation + GEPLT Maximum Benefit Reached + GEPLT No longer Own Occupation Disabled but has not Returned to Work + GEPLT No longer Any Occupation Disabled but has not Returned to Work.
80871	E	GEPLT: Group Employer Paid Long-Term (GEPLT) paid claims closed during the reporting period must = the sum of GEPLT claims closed after initial payment on Q55-Q66.

Private Flood (PF)

Coverage ID	Description of Coverage Identifiers
SAFDC	Stand-Alone Policies (First Dollar Coverage)
SAEC	Stand-Alone Policies (Excess Coverage)
EHFDC	Endorsements to a Homeowners Policy (First Dollar Coverage)
EHEC	Endorsements to a Homeowners Policy (Excess Coverage)
EOFDC	Endorsements to a Policy Other than Homeowners (First Dollar Coverage)
EOEC	Endorsements to a Policy Other than Homeowners (Excess Coverage)

Rule ID	Type	Description
90000	W	The sum of all Private Flood product coverage types direct written premiums during the period should be >= 50000.
90001	B	The reported MCAS state Private Flood direct written premium is expected to be within 20% (+/-) of the Financial Annual Statement State Page Direct Written Premium (Line no. 2.5).
90002	E	If the company does not write private flood policies or have private flood policies and endorsement in force during the reporting period, then a Private Flood filing is not needed.
90003	E	A response must be provided to General Interrogatories 'Yes/No' response questions 1, 2, 8, 15, 22, 29, 36, and 43.
90004	E	A valid response ('1', '2', or '3') must be reported as an explanation for question 7.
90005	E	The explanation field for question 3 must not be blank.
90006	W	If the company does write private flood policies or have private flood policies or endorsements in force during the reporting period, then the company should have data to report.
90007	E	Attestor information must include first name, last name, & title.
90101	E	If the company has stand-alone (first dollar coverage) to report, questions 9 and 11 must not be blank.
90102	E	If the company does not have stand-alone (first dollar coverage) to report, questions 10 and 12 must be blank.
90103	E	If the company had a significant event/business strategy that would affect stand-alone (first dollar coverage) data for this reporting period, an explanation is required.
90104	E	If the company did not have a significant event/business strategy that would affect stand-alone (first dollar coverage) data for this reporting period, no explanation is expected.
90105	E	If any part of the stand-alone (first dollar coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90106	E	If no part of the stand-alone (first dollar coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90107	E	If the number of stand-alone (first dollar coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90108	E	If the number of stand-alone (first dollar coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90120	E	If there is stand-alone (first dollar coverage) data to report, then SAFDC data elements must not be blank.
90121	E	If there is no stand-alone (first dollar coverage) data to report, then all SAFDC data elements must be blank.
90142	W	The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90143	W	SAFDC: Number of policies in force at end of period should be <= the sum of number of new policies written during the period.
90144	W	SAFDC: Number of policies in force at end of period should be >= number of new policies written during the period.
90145	W	SAFDC: If number of new policies written during the period > 0, then direct premium written during the period should be > 0.

90149	E	SAFDC: All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
90160	E	Stand-alone (first dollar coverage) claims closed with payment during the period must = sum of SAFDC claims closed with payment by day range categories.
90161	E	Stand-alone (first dollar coverage) claims closed without payment during the period must = sum of SAFDC claims without payment by day range categories.
90163	E	Stand-alone (first dollar coverage) claims open at the beginning of the period + SAFDC claims opened during the period - SAFDC claims closed with payment during the period - SAFDC claims closed without payment during the period must = SAFDC claims open at the end of the period.
90164	W	Stand-alone (first dollar coverage) claims closed with payment during the period should be >= SAFDC claims closed without payment during the period.
90165	W	Stand-alone (first dollar coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.
90170	E	Number of stand-alone (first dollar coverage) lawsuits open + number of SAFDC lawsuits opened during the period - number of SAFDC lawsuits closed during the period must = number of SAFDC lawsuits open at end of period.
90171	W	Number of stand-alone (first dollar coverage) lawsuits closed during the period should be >= number of SAFDC lawsuits closed during the period with consideration for the consumer.
90201	E	If the company has stand-alone (excess coverage) to report, questions 16 and 18 must not be blank.
90202	E	If the company does not have stand-alone (excess coverage) to report, questions 17 and 19 must be blank.
90203	E	If the company had a significant event/business strategy that would affect stand-alone (excess coverage) data for this reporting period, an explanation is required.
90204	E	If the company did not have a significant event/business strategy that would affect stand-alone (excess coverage) data for this reporting period, no explanation is expected.
90205	E	If any part of the stand-alone (excess coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90206	E	If no part of the stand-alone (excess coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90207	E	If the number of stand-alone (excess coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90208	E	If the number of stand-alone (excess coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90220	E	If there is stand-alone (excess coverage) data to report, then SAEC data elements must not be blank.
90221	E	If there is no stand-alone (excess coverage) data to report, then all SAEC data elements must be blank.
90242	W	SAEC: The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90243	W	SAEC: Number of policies in force at end of period should be <= the sum of number of new policies written during the period.
90244	W	SAEC: Number of policies in force at end of period should be >= number of new policies written during the period.
90245	W	SAEC: If number of new policies written during the period > 0, then direct premium written during the period should be > 0.
90249	E	SAEC: All Underwriting data elements must be >= 0 except the dollar amount of direct written premium during the period.
90260	E	Stand-alone (excess coverage) claims closed with payment during the period must = sum of SAEC claims closed with payment by day range categories.
90261	E	Stand-alone (excess coverage) claims closed without payment during the period must = sum of SAEC claims without payment by day range categories.

90263	E	Stand-alone (excess coverage) claims open at the beginning of the period + SAEC claims opened during the period - SAEC claims closed with payment during the period - SAEC claims closed without payment during the period must = SAEC claims open at the end of the period.
90264	W	Stand-alone (excess coverage) claims closed with payment during the period should be >= SAEC claims closed without payment during the period.
90265	W	Stand-alone (excess coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.

90270	E	Number of stand-alone (excess coverage) lawsuits open + number of SAEC lawsuits opened during the period - number of SAEC lawsuits closed during the period must = number of SAEC lawsuits open at end of period.
90271	W	Number of stand-alone (excess coverage) lawsuits closed during the period should be >= number of SAEC lawsuits closed during the period with consideration for the consumer.
90301	E	If the company has endorsements to a homeowners policy (first dollar coverage) to report, questions 23 and 25 must not be blank.
90302	E	If the company does not have endorsements to a homeowners policy (first dollar coverage) to report, questions 24 and 26 must be blank.
90303	E	If the company had a significant event/business strategy that would affect endorsements to a homeowners policy (first dollar coverage) data for this reporting period, an explanation is required.
90304	E	If the company did not have a significant event/business strategy that would affect endorsements to a homeowners policy (first dollar coverage) data for this reporting period, no explanation is expected.
90305	E	If any part of the endorsements to a homeowners policy (first dollar coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90306	E	If no part of the endorsements to a homeowners policy (first dollar coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90307	E	If the number of endorsements to a homeowners policy (first dollar coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90308	E	If the number of endorsements to a homeowners policy (first dollar coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90320	E	If there is endorsements to a homeowners policy (first dollar coverage) data to report, then EHFDC data elements must not be blank.
90321	E	If there is no endorsements to a homeowners policy (first dollar coverage) data to report, then all EHFDC data elements must be blank.
90342	W	EHFDC: The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90343	W	EHFDC: Number of endorsements in force at end of period should be <= the sum of number of new endorsements written during the period.
90344	W	EHFDC: Number of endorsements in force at end of period should be >= number of new endorsements written during the period.
90345	W	EHFDC: If number of new endorsements written during the period > 0, then direct premium written during the period for endorsements should be > 0.
90349	E	EHFDC: All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
90360	E	Endorsements to a homeowners policy (first dollar coverage) claims closed with payment during the period must = sum of EHFDC claims closed with payment by day range categories.
90361	E	Endorsements to a homeowners policy (first dollar coverage) claims closed without payment during the period must = sum of EHFDC claims without payment by day range categories.
90363	E	Endorsements to a homeowners policy (first dollar coverage) claims open at the beginning of the period + EHFDC claims opened during the period - EHFDC claims closed with payment during the period - EHFDC claims closed without payment during the period must = EHFDC claims open at the end of the period.

90364	W	Endorsements to a homeowners policy (first dollar coverage) claims closed with payment during the period should be >= EHFDC claims closed without payment during the period.
90365	W	Endorsements to a homeowners policy (first dollar coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.
90370	E	Number of endorsements to a homeowners policy (first dollar coverage) lawsuits open + number of EHFDC lawsuits opened during the period - number of EHFDC lawsuits closed during the period must = number of EHFDC lawsuits open at end of period.
90371	W	Number of endorsements to a homeowners policy (first dollar coverage) lawsuits closed during the period should be >= number of EHFDC lawsuits closed during the period with consideration for the consumer.

90401	E	If the company has endorsements to a homeowners policy (excess coverage) to report, questions 30 and 32 must not be blank.
90402	E	If the company does not have endorsements to a homeowners policy (excess coverage) to report, questions 31 and 33 must be blank.
90403	E	If the company had a significant event/business strategy that would affect endorsements to a homeowners policy (excess coverage) data for this reporting period, an explanation is required.
90404	E	If the company did not have a significant event/business strategy that would affect endorsements to a homeowners policy (excess coverage) data for this reporting period, no explanation is expected.
90405	E	If any part of the endorsements to a homeowners policy (excess coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90406	E	If no part of the endorsements to a homeowners policy (excess coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90407	E	If the number of endorsements to a homeowners policy (excess coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90408	E	If the number of endorsements to a homeowners policy (excess coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90420	E	If there is endorsements to a homeowners policy (excess coverage) data to report, then EHEC data elements must not be blank.
90421	E	If there is no endorsements to a homeowners policy (excess coverage) data to report, then all EHEC data elements must be blank.
90442	W	EHEC: The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90443	W	EHFDC: Number of endorsements in force at end of period should be <= the sum of number of new endorsements written during the period.
90444	W	EHEC: Number of endorsements in force at end of period should be >= number of new endorsements written during the period.
90445	W	EHEC: If number of new endorsements written during the period > 0, then direct premium written during the period should be > 0.
90449	E	EHEC: All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
90460	E	Endorsements to a homeowners policy (excess coverage) claims closed with payment during the period must = sum of EHEC claims closed with payment by day range categories.
90461	E	Endorsements to a homeowners policy (excess coverage) claims closed without payment during the period must = sum of EHEC claims without payment by day range categories.
90463	E	Endorsements to a homeowners policy (excess coverage) claims open at the beginning of the period + EHEC claims opened during the period - EHEC claims closed with payment during the period - EHEC claims closed without payment during the period must = EHEC claims open at the end of the period.
90464	W	Endorsements to a homeowners policy (excess coverage) claims closed with payment during the period should be >= EHEC claims closed without payment during the period.

90465	W	Endorsements to a homeowners policy (excess coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.
90470	E	Number of endorsements to a homeowners policy (excess coverage) lawsuits open + number of EHEC lawsuits opened during the period - number of EHEC lawsuits closed during the period must = number of EHEC lawsuits open at end of period.
90471	W	Number of endorsements to a homeowners policy (excess coverage) lawsuits closed during the period should be >= number of EHEC lawsuits closed during the period with consideration for the consumer.
90501	E	If the company has endorsements to a policy other than homeowners (first dollar coverage) to report, questions 37 and 39 must not be blank.
90502	E	If the company does not have endorsements to a policy other than homeowners (first dollar coverage) to report, questions 38 and 40 must be blank.
90503	E	If the company had a significant event/business strategy that would affect endorsements to a policy other than homeowners (first dollar coverage) data for this reporting period, an explanation is required.
90504	E	If the company did not have a significant event/business strategy that would affect endorsements to a policy other than homeowners (first dollar coverage) data for this reporting period, no explanation is expected.
90505	E	If any part of the endorsements to a policy other than homeowners (first dollar coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90506	E	If no part of the endorsements to a policy other than homeowners (first dollar coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90507	E	If the number of endorsements to a policy other than homeowners (first dollar coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90508	E	If the number of endorsements to a policy other than homeowners (first dollar coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90520	E	If there is endorsements to a policy other than homeowners (first dollar coverage) data to report, then EOFDC claims data elements must not be blank.
90521	E	If there is no endorsements to a policy other than homeowners (first dollar coverage) data to report, then all EOFDC data elements must be blank.
90542	W	EOFDC: The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90543	W	EOFDC: Number of endorsements in force at end of period should be <= the sum of number of new endorsements written during the period.
90544	W	EOFDC: Number of endorsements in force at end of period should be >= number of new endorsements written during the period.
90545	W	EOFDC: If number of new endorsements written during the period > 0, then direct premium written during the period should be > 0.
90549	E	EOFDC: All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
90560	E	Endorsements to a policy other than homeowners (first dollar coverage) claims closed with payment during the period must = sum of EOFDC claims closed with payment by day range categories.
90561	E	Endorsements to a policy other than homeowners (first dollar coverage) claims closed without payment during the period must = sum of EOFDC claims without payment by day range categories.
90563	E	Endorsements to a policy other than homeowners (first dollar coverage) claims open at the beginning of the period + EOFDC claims opened during the period - EOFDC claims closed with payment during the period - EOFDC claims closed without payment during the period must = EOFDC claims open at the end of the period.
90564	W	Endorsements to a policy other than homeowners (first dollar coverage) claims closed with payment during the period should be >= EOFDC claims closed without payment during the period.

90565	W	Endorsements to a policy other than homeowners (first dollar coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.
90570	E	Number of endorsements to a policy other than homeowners (first dollar coverage) lawsuits open + number of EOFDC lawsuits opened during the period - number of EOFDC lawsuits closed during the period must = number of EOFDC lawsuits open at end of period.
90571	W	Number of endorsements to a policy other than homeowners (first dollar coverage) lawsuits closed during the period should be >= number of EOFDC lawsuits closed during the period with consideration for the consumer.
90601	E	If the company has endorsements to a policy other than homeowners (excess coverage) to report, questions 44 and 46 must not be blank.
90602	E	If the company does not have endorsements to a policy other than homeowners (excess coverage) to report, questions 45 through 47 must be blank.
90603	E	If the company had a significant event/business strategy that would affect endorsements to a policy other than homeowners (excess coverage) data for this reporting period, an explanation is required.
90604	E	If the company did not have a significant event/business strategy that would affect endorsements to a policy other than homeowners (excess coverage) data for this reporting period, no explanation is expected.

90605	E	If any part of the endorsements to a policy other than homeowners (excess coverage) block of business has been sold, closed or moved to another company during the year, an explanation is required.
90606	E	If no part of the endorsements to a policy other than homeowners (excess coverage) block of business has been sold, closed or moved to another company during the year, no explanation is expected.
90607	E	If the number of endorsements to a policy other than homeowners (excess coverage) policies in force at the beginning of the reporting period in this report matches the number of policies or endorsement in force at the end of the reporting period for the first prior year report, no explanation of a difference is needed.
90608	E	If the number of endorsements to a policy other than homeowners (excess coverage) policies in force at the beginning of the reporting period in this report does not match the number of policies or endorsement in force at the end of the reporting period for the first prior year report, an explanation of the difference is needed.
90620	E	If there is endorsements to a policy other than homeowners (excess coverage) data to report, then EOEC data elements must not be blank.
90621	E	If there is no endorsements to a policy other than homeowners (excess coverage) data to report, then all EOEC data elements must be blank.
90642	W	EOEC: The number of private flood policies in force at the beginning of the reporting period in this report (Q71) minus the number of policies in force at the end of the reporting period for the first prior year report (Q70) should = the amount reported for Q74.
90643	W	EOEC: Number of endorsements in force at end of period should be <= the sum of number of new endorsements written during the period.
90644	W	EOEC: Number of endorsements in force at end of period should be >= number of new endorsements written during the period.
90645	W	EOEC: If number of new endorsements written during the period > 0, then direct premium written during the period should be > 0.
90649	E	EOEC: All Underwriting data elements must be >= 0 except dollar amount of direct written premium during the period.
90660	E	Endorsements to a policy other than homeowners (excess coverage) claims closed with payment during the period must = sum of EOEC claims closed with payment by day range categories.
90661	E	Endorsements to a policy other than homeowners (excess coverage) claims closed without payment during the period must = sum of EOEC claims without payment by day range categories.
90663	E	Endorsements to a policy other than homeowners (excess coverage) claims open at the beginning of the period + EOEC claims opened during the period - EOEC claims closed with payment during the period - EOEC claims closed without payment during the period must = EOEC claims open at the end of the period.
90664	W	Endorsements to a policy other than homeowners (excess coverage) claims closed with payment during the period should be >= EOEC claims closed without payment during the period.

90665	W	Endorsements to a policy other than homeowners (excess coverage) claims median days reported on question 57 should correspond to the date range of median claims reported on questions 58-63. For additional information, please reference the MCAS User Guide.
90670	E	Number of endorsements to a policy other than homeowners (excess coverage) lawsuits open + number of EOEC lawsuits opened during the period - number of EOEC lawsuits closed during the period must = number of EOEC lawsuits open at end of period.
90671	W	Number of endorsements to a policy other than homeowners (excess coverage) lawsuits closed during the period should be >= number of EOEC lawsuits closed during the period with consideration for the consumer.

Travel (TRVL)

Coverage ID	Description of Coverage Identifiers
TCDO	Trip Cancellation - Domestic
TCIN	Trip Cancellation - International
TIDO	Trip Interruption - Domestic
TIIN	Trip Interruption - International
TDDO	Trip Delay - Domestic
TDIN	Trip Delay - International
BLDD	Baggage Loss/Delay - Domestic
BLDI	Baggage Loss/Delay - International
EMDDE	Emergency Medical/Dental - Domestic/Excess
EMDDP	Emergency Medical/Dental - Domestic/Primary
EMDIE	Emergency Medical/Dental - International/Excess
EMDIP	Emergency Medical/Dental - International/Primary
ETRD	Emergency Transportation/Repatriation - Domestic
ETRI	Emergency Transportation/Repatriation - International
OTDO	Other - Domestic
OTIN	Other - International

Rule ID	Type	Description
100001	E	Since all Travel data-to-report indicators=N, do not submit Travel for this state
100002	E	If significant event or business strategy change = Y, an explanation is required.
100003	E	If significant event or business strategy change = N, then no explanation is allowed.
100004	E	If any of this business was sold, closed, or moved to another company, an explanation is required.
100005	E	If none of this business was sold, closed, or moved to another company, then no explanation is allowed.
100006	E	An answer is required regarding treatment of supplemental or additional payments on previously closed claims.
100007	E	If any third party administrators (TPAs) were used for purposes of supporting the travel insurance business being reported, names and functions of each TPA are required.
100008	E	If no third party administrators (TPAs) were used for purposes of supporting the travel insurance business being reported, no TPA data is needed.
100009	E	If any managing general agents (MGAs) were used for purposes of supporting the travel insurance business being reported, names and functions of each MGA are required.
100010	E	If no managing general agents (MGAs) were used for purposes of supporting the travel insurance business being reported, no MGA data is needed.
100011	E	If any travel administrators were used for purposes of supporting the travel insurance business being reported, names and functions of each travel administrator are required.
100012	E	If no travel administrators were used for purposes of supporting the travel insurance business being reported, no travel administrator data is needed.
100040	E	If the sum of direct written premiums for individual policies, group policies, and blanket policies is less than $50,000, then a Travel filing is not necessary.
100041	E	You indicated that there were polices/certificates in force during the reporting period; however you did not provide a response to any of the Questions 37 to 46.
100042	E	You indicated that there were polices/certificates in force during the reporting period; however you did not provide a response to any of the Questions 37 to 46.
100050	E	TRVL_TOTAL:Number of lawsuits closed during the period must be <= number of lawsuits open beginning period+lawsuits opened during the period
100051	E	TRVL_TOTAL:Number of lawsuits open at the end of the period must be <= number of lawsuits open beginning period+lawsuits opened during the period-Number of lawsuits closed during the period
100052	W	TRVL_TOTAL:Number of lawsuits closed with consideration for the consumer should be <= number of lawsuits closed during the period
100099	E	Attestor information must include first name, last name, & title.

100160	E	TCDO:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100161	E	TCDO:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.

100162	E	TCDO:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100163	W	TCDO:if number of claims closed with payment >0 then median days should be greater than 0.
100164	E	TCDO:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100165	E	TCDO:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100166	E	TCDO:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100167	E	TCDO:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100168	E	TCDO:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100169	E	TCDO:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100170	E	TCDO: Number of claims closed during the period, with payment>= 1 then Dollar amount of claims closed with payment>=1
100260	E	TCIN:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100261	E	TCIN:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100262	E	TCIN:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100263	W	TCIN:if number of claims closed with payment >0 then median days should be greater than 0.
100264	E	TCIN:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100265	E	TCIN:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100266	E	TCIN:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100267	E	TCIN:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100268	E	TCIN:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100269	E	TCIN:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100270	E	TCIN:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100360	E	TIDO:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100361	E	TIDO:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100362	E	TIDO:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100363	W	TIDO:if number of claims closed with payment >0 then median days should be greater than 0.
100364	E	TIDO:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment

100365	E	TIDO:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100366	E	TIDO:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100367	E	TIDO:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100368	E	TIDO:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100369	E	TIDO:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100370	E	TIDO:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100460	E	TIIN:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100461	E	TIIN:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100462	E	TIIN:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100463	W	TIIN:if number of claims closed with payment >0 then median days should be greater than 0.
100464	E	TIIN:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100465	E	TIIN:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100466	E	TIIN:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100467	E	TIIN:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100468	E	TIIN:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100469	E	TIIN:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100470	E	TIIN:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100560	E	TDDO:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100561	E	TDDO:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100562	E	TDDO:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100563	W	TDDO:if number of claims closed with payment >0 then median days should be greater than 0.
100564	E	TDDO:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100565	E	TDDO:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100566	E	TDDO:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100567	E	TDDO:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100568	E	TDDO:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100569	E	TDDO:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment

100570	E	TDDO:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100660	E	TDIN:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100661	E	TDIN:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100662	E	TDIN:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment

100663	W	TDIN:if number of claims closed with payment >0 then median days should be greater than 0.
100664	E	TDIN:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100665	E	TDIN:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100666	E	TDIN:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100667	E	TDIN:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100668	E	TDIN:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100669	E	TDIN:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100670	E	TDIN:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100760	E	BLDD:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100761	E	BLDD:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100762	E	BLDD:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100763	W	BLDD:if number of claims closed with payment >0 then median days should be greater than 0.
100764	E	BLDD:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100765	E	BLDD:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100766	E	BLDD:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100767	E	BLDD:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100768	E	BLDD:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100769	E	BLDD:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100770	E	BLDD:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100860	E	BLDI:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100861	E	BLDI:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100862	E	BLDI:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100863	W	BLDI:if number of claims closed with payment >0 then median days should be greater than 0.

100864	E	BLDI:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100865	E	BLDI:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100866	E	BLDI:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100867	E	BLDI:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100868	E	BLDI:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100869	E	BLDI:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment

100870	E	BLDI:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
100960	E	EMDDE:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
100961	E	EMDDE:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
100962	E	EMDDE:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
100963	W	EMDDE:if number of claims closed with payment >0 then median days should be greater than 0.
100964	E	EMDDE:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
100965	E	EMDDE:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
100966	E	EMDDE:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
100967	E	EMDDE:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
100968	E	EMDDE:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
100969	E	EMDDE:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
100970	E	EMDDE:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101060	E	EMDDP:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101061	E	EMDDP:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101062	E	EMDDP:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101063	W	EMDDP:if number of claims closed with payment >0 then median days should be greater than 0.
101064	E	EMDDP:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101065	E	EMDDP:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101066	E	EMDDP:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101067	E	EMDDP:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101068	E	EMDDP:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment

101069	E	EMDDP:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101070	E	EMDDP:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101160	E	EMDIE:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101161	E	EMDIE:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101162	E	EMDIE:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101163	W	EMDIE:if number of claims closed with payment >0 then median days should be greater than 0.
101164	E	EMDIE:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101165	E	EMDIE:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101166	E	EMDIE:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101167	E	EMDIE:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101168	E	EMDIE:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101169	E	EMDIE:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101170	E	EMDIE:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101260	E	EMDIP:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101261	E	EMDIP:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101262	E	EMDIP:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101263	W	EMDIP:if number of claims closed with payment >0 then median days should be greater than 0.
101264	E	EMDIP:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101265	E	EMDIP:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101266	E	EMDIP:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101267	E	EMDIP:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101268	E	EMDIP:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101269	E	EMDIP:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101270	E	EMDIP:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101360	E	ETRD:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101361	E	ETRD:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.

101362	E	ETRD:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101363	W	ETRD:if number of claims closed with payment >0 then median days should be greater than 0.
101364	E	ETRD:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101365	E	ETRD:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101366	E	ETRD:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101367	E	ETRD:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101368	E	ETRD:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101369	E	ETRD:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101370	E	ETRD:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1

101460	W	ETRI:Number of claims closed during the period with payment should must number of claims closed with payment from 0 to 90 plus days.
101461	E	ETRI:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101462	E	ETRI:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101463	W	ETRI:if number of claims closed with payment >0 then median days should be greater than 0.
101464	E	ETRI:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101465	E	ETRI:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101466	E	ETRI:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101467	E	ETRI:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101468	E	ETRI:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101469	E	ETRI:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101470	E	ETRI:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101560	E	OTDO:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101561	E	OTDO:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101562	E	OTDO:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101563	W	OTDO:if number of claims closed with payment >0 then median days should be greater than 0.
101564	E	OTDO:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101565	E	OTDO:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101566	E	OTDO:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment

101567	E	OTDO:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101568	E	OTDO:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101569	E	OTDO:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101570	E	OTDO:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1
101660	E	OTIN:Number of claims closed during the period with payment must equal number of claims closed with payment from 0 to 90 plus days.
101661	E	OTIN:Number of claims closed during the period without payment must equal the number of claims closed without payment from 0 to 90 plus days.
101662	E	OTIN:Number of claims open at the end of the period must equal the number of claims opened at the beginning of the period + number claims opened during the period - number of claims closed with payment - number of claims closed without payment
101663	W	OTIN:if number of claims closed with payment >0 then median days should be greater than 0.
101664	E	OTIN:Number of claims closed with payment within 0-30 days must be <= Number of claims closed during the period, with payment
101665	E	OTIN:Number of claims closed with payment within 31-90 days must be <= Number of claims closed during the period, with payment
101666	E	OTIN:Number of claims closed with payment beyond 90 days must be <= Number of claims closed during the period, with payment
101667	E	OTIN:Number of claims closed without payment within 0-30 days must be <= Number of claims closed during the period, without payment
101668	E	OTIN:Number of claims closed without payment within 31-90 days must be <= Number of claims closed during the period, without payment
101669	E	OTIN:Number of claims closed without payment beyond 90 days must be <= Number of claims closed during the period, without payment
101670	E	OTIN:Number of claims closed during the period, with payment>=1 then Dollar amount of claims closed with payment >=1

Short-Term Limited Duration (STLD)

Coverage ID	Description of Coverage Identifiers
STLDI 90	STLDI <= 90
STLDI 180	STLDI 91-180
STLDI 364	STLDI 181 - 364
STLDINS 90	STLDI Not Sitused <= 90
STLDINS 180	STLDI Not Sitused 91-180
STLDINS 364	STLDI Not Sitused 181 - 364
STLDIS 90	STLDI Sitused <= 90
STLDIS 180	STLDI Sitused 91-180
STLDIS 364	STLDI Sitused 181 - 364

Rule ID	Type	Description
110001	E	Responses must be provided to all Interrogatories in the 'Yes/No Response' column.
110002	E	You are not required to submit a MCAS Filing for this state since you answered 'No' to Interrogatory questions regarding having in-force STLD insurance coverage.
110003	E	If there is a state where STLDI products are marketed, some duration data elements must be present.
110004	E	The number of STLDI forms offered to residents in this state must not be greater than the number of STLDI forms offered in all states.
110005	E	The number of STLDI forms filed in this state must not be greater than the number of STLDI forms filed in all states.
110006	E	You indicated that you have waiting periods that exceed the policy/certificate term; however, you did not provide any additional comments.
110007	E	You indicated that you do not have any waiting periods that exceed the policy/certificate term; therefore no additional comments are allowed.
110008	E	You indicated that you issue STLDI products through associations; however you did not list the associations, nor indicate if you have a contractual relationship with each association.
110009	E	You indicated that you do not issue STLDI products through associations; therefore no list of associations is allowed. Neither is an indication of a contractual relationship with each association needed.
110012	E	You indicated that you have a contractual relationship with each association; however you did not answer the subsequent questions.
110016	E	You indicated that you do not have a contractual relationship with each association; therefore you must not answer the subsequent questions.
110020	E	You indicated that you issue STLDI products through trusts; however you did not indicate how many.
110021	E	You indicated that you do not issue STLDI products through trusts; therefore a count of how many is not allowed.
110022	E	You indicated that you issue STLDI products through administrators; however you did not indicate how many.
110023	E	You indicated that you do not issue STLDI products through administrators; therefore count of how many is not allowed.
110024	E	You indicated that you contract with third-party administrators for administrative services related to STLDI products; however you did provide a response to any of the Questions 26 - 32.
110025	E	You indicated that you did not contract with third-party administrators for administrative services related to STLDI products; therefore a response is not allowed on Questions 26 - 32.
110026	E	You indicated that you audit Third parties to whom you have delegated responsibilities; however you did not indicate the frequency of the audits.
110027	E	You indicated that you do not audit Third parties to whom you have delegated responsibilities; therefore the frequency of the audits is not allowed.
110028	E	You indicated that you do offer renewals/reissues; however you did not answer the subsequent questions.
110029	E	You indicated that you do not offer renewals/reissues; therefore you must not answer the subsequent questions.
110036	E	You indicated that you do offer renewals/reissues; however you did not indicate if any of the renewals/reissues are subject to optional or mandatory underwriting.

110037	E	You indicated that you do not offer renewals/reissues; therefore a response to Questions 36 is not allowed.
110038	E	You did not provide a response to Question 37.

110039	E	You indicated that you offer renewal(s) without underwriting for an additional charge; however you did not identify the products or plans subject to underwriting for an additional charge.
110040	E	You indicated that you do not offer renewal(s) without underwriting for an additional charge; therefore a response is not allowed on Question 40.
110041	E	You did not provide a response to Question 41
110042	E	You did not provide a response to Question 42
110043	E	You did not provide a response to Question 43
110099	E	Attestor information must include first name, last name, & title.
110101	E	STLDI 90:Total number of claims denied, rejected or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110102	E	STLDI 90:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110103	E	STLDI 90:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110104	E	STLDI 90:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110105	E	STLDI 90:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110106	E	STLDI 90:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110107	E	STLDI 90:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110108	E	STLDI 90:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110109	E	STLDI 90:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110110	E	STLDI 90:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110111	E	STLDI 90:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110113	E	STLDI 90:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected or returned.
110114	E	STLDI 90:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110115	E	STLDI 90:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110116	E	STLDI 90:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110117	W	STLDI 90:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110118	E	STLDI 90:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110119	W	STLDI 90:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110121	W	STLDI 90:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110122	E	STLDI 90:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + lawsuits opened during the period - lawsuits closed during the period.
110123	E	STLDI 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.

110124	E	STLDI 90:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <=Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110125	E	STLDI 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.

110126	E	STLDI 90:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110127	E	STLDI 90:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110128	E	STLDI 90:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110129	W	STLDI 90:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110130	E	STLDI 90:Number of applications initiated via phone must be <= Number of applications received.
110131	W	STLDI 90:Number of applications completed via phone should be <= Number of applications received.
110132	W	STLDI 90:Number of applications initiated face-to-face should be <= Number of applications received.
110133	W	STLDI 90:Number of applications completed face-to-face should be <= Number of applications received.
110134	W	STLDI 90:Number of applications initiated online (Electronically) should be <= Number of applications received.
110135	W	STLDI 90:Number of applications completed online (Electronically) should be <= Number of applications received.
110136	W	STLDI 90:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110137	W	STLDI 90:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110138	W	STLDI 90:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110139	W	STLDI 90:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110140	W	STLDI 90:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110141	W	STLDI 90:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110142	W	STLDI 90:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110143	W	STLDI 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110144	W	STLDI 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110146	W	STLDI 90:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110147	W	STLDI 90:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110201	E	STLDI 180:Total number of claims denied, rejected, or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110202	E	STLDI 180:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.

110203	E	STLDI 180:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110204	E	STLDI 180:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110205	E	STLDI 180:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110206	E	STLDI 180:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of Claims Pending at the Beginning of the Period + Number of Claims Received.
110207	E	STLDI 180:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110208	E	STLDI 180:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110209	E	STLDI 180:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= number of claims pending at the beginning of the period + number of claims received.
110210	E	STLDI 180:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110211	E	STLDI 180:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110213	E	STLDI 180:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected, or returned.
110214	E	STLDI 180:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110215	E	STLDI 180:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110216	E	STLDI 180:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110217	W	STLDI 180:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110218	E	STLDI 180:Number of claims paid must be <= Number of Claims Pending at the Beginning of the Period + Number of Claims Received.
110219	W	STLDI 180:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110221	W	STLDI 180:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110222	E	STLDI 180:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110223	E	STLDI 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of Applications Received.
110224	E	STLDI 180:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110225	E	STLDI 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110226	E	STLDI 180:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110227	E	STLDI 180:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110228	E	STLDI 180:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.

110229	W	STLDI 180:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110230	E	STLDI 180:Number of applications initiated via phone must be <= Number of applications received.
110231	W	STLDI 180:Number of applications completed via phone should be <= Number of applications received.
110232	W	STLDI 180:Number of applications initiated face-to-face should be <= Number of applications received.
110233	W	STLDI 180:Number of applications completed face-to-face should be <= Number of applications received.
110234	W	STLDI 180:Number of applications initiated online (Electronically) should be <= Number of applications received.
110235	W	STLDI 180:Number of applications completed online (Electronically) should be <= Number of applications received.
110236	W	STLDI 180:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110237	W	STLDI 180:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110238	W	STLDI 180:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110239	W	STLDI 180:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110240	W	STLDI 180:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110241	W	STLDI 180:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110242	W	STLDI 180:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110243	W	STLDI 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110244	W	STLDI 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110246	W	STLDI 180:Number of Prior Authorizations Approved During the Period should be <= Number of Prior Authorizations Requests Pending at the Beginning of the Period + Number of Prior Authorization Requests During the Period.
110247	W	STLDI 180:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110301	E	STLDI 364:Total number of claims denied, rejected or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110302	E	STLDI 364:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110303	E	STLDI 364:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110304	E	STLDI 364:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110305	E	STLDI 364:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110306	E	STLDI 364:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110307	E	STLDI 364:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110308	E	STLDI 364:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.

110309	E	STLDI 364:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110310	E	STLDI 364:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110311	E	STLDI 364:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110313	E	STLDI 364:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected or returned.
110314	E	STLDI 364:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110315	E	STLDI 364:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110316	E	STLDI 364:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.

110317	W	STLDI 364:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110318	E	STLDI 364:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110319	W	STLDI 364:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110321	W	STLDI 364:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110322	E	STLDI 364:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110323	E	STLDI 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110324	E	STLDI 364:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110325	E	STLDI 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110326	E	STLDI 364:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110327	E	STLDI 364:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110328	E	STLDI 364:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110329	W	STLDI 364:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110330	E	STLDI 364:Number of applications initiated via phone must be <= Number of applications received.
110331	W	STLDI 364:Number of applications completed via phone should be <= Number of applications received.
110332	W	STLDI 364:Number of applications initiated face-to-face should be <= Number of applications received.
110333	W	STLDI 364:Number of applications completed face-to-face should be <= Number of applications received.
110334	W	STLDI 364:Number of applications initiated online (Electronically) should be <= Number of applications received.
110335	W	STLDI 364:Number of applications completed online (Electronically) should be <= Number of applications received.
110336	W	STLDI 364:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.

110337	W	STLDI 364:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110338	W	STLDI 364:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110339	W	STLDI 364:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110340	W	STLDI 364:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110341	W	STLDI 364:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110342	W	STLDI 364:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110343	W	STLDI 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110344	W	STLDI 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.

110346	W	STLDI 364:The number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110347	W	STLDI 364:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110401	E	STLDINS 90:Total number of claims denied, rejected, or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110402	E	STLDINS 90:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110403	E	STLDINS 90:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110404	E	STLDINS 90:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110405	E	STLDINS 90:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110406	E	STLDINS 90:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110407	E	STLDINS 90:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110408	E	STLDINS 90:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110409	E	STLDINS 90:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110410	E	STLDINS 90:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110411	E	STLDINS 90:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110413	E	STLDINS 90:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected, or returned.
110414	E	STLDINS 90:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110415	E	STLDINS 90:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.

110416	E	STLDINS 90:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110417	W	STLDINS 90:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110418	E	STLDINS 90:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110419	W	STLDINS 90:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110421	W	STLDINS 90:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110422	E	STLDINS 90:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110423	E	STLDINS 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110424	E	STLDINS 90:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110425	E	STLDINS 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110426	E	STLDINS 90:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110427	E	STLDINS 90:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110428	E	STLDINS 90:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110429	W	STLDINS 90:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110430	E	STLDINS 90:Number of applications initiated via phone must be <= Number of applications received.
110431	W	STLDINS 90:Number of applications completed via phone should be <= Number of applications received.
110432	W	STLDINS 90:Number of applications initiated face-to-face should be <= Number of applications received.
110433	W	STLDINS 90:Number of applications completed face-to-face should be <= Number of applications received.
110434	W	STLDINS 90:Number of applications initiated online (Electronically) should be <= Number of applications received.
110435	W	STLDINS 90:Number of applications completed online (Electronically) should be <= Number of applications received.
110436	W	STLDINS 90:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110437	W	STLDINS 90:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110438	W	STLDINS 90:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110439	W	STLDINS 90:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110440	W	STLDINS 90:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110441	W	STLDINS 90:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110442	W	STLDINS 90:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.

110443	W	STLDINS 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110444	W	STLDINS 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110446	W	STLDINS 90:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110447	W	STLDINS 90:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110501	E	STLDINS 180:Total number of claims denied, rejected or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110502	E	STLDINS 180:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110503	E	STLDINS 180:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110504	E	STLDINS 180:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110505	E	STLDINS 180:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + number of claims received.
110506	E	STLDINS 180:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110507	E	STLDINS 180:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110508	E	STLDINS 180:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110509	E	STLDINS 180:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110510	E	STLDINS 180:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110511	E	STLDINS 180:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + number of claims received.
110513	E	STLDINS 180:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected or returned.
110514	E	STLDINS 180:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110515	E	STLDINS 180:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110516	E	STLDINS 180:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110517	W	STLDINS 180:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110518	E	STLDINS 180:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110519	W	STLDINS 180:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110521	W	STLDINS 180:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110522	E	STLDINS 180:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of Lawsuits opened during the period - Number of Lawsuits closed during the period.

110523	E	STLDINS 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110524	E	STLDINS 180:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be<= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110525	E	STLDINS 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110526	E	STLDINS 180:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110527	E	STLDINS 180:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110528	E	STLDINS 180:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110529	W	STLDINS 180:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110530	E	STLDINS 180:Number of applications initiated via phone must be <= Number of applications received.
110531	W	STLDINS 180:Number of applications completed via phone should be <= Number of applications received.
110532	W	STLDINS 180:Number of applications initiated face-to-face should be <= Number of applications received.
110533	W	STLDINS 180:Number of applications completed face-to-face should be <= Number of applications received.
110534	W	STLDINS 180:Number of applications initiated online (Electronically) should be <= Number of applications received.
110535	W	STLDINS 180:Number of applications completed online (Electronically) should be <= Number of applications received.

110536	W	STLDINS 180:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110537	W	STLDINS 180:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110538	W	STLDINS 180:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110539	W	STLDINS 180:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110540	W	STLDINS 180:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110541	W	STLDINS 180:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110542	W	STLDINS 180:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110543	W	STLDINS 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110544	W	STLDINS 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110546	W	STLDINS 180:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110547	W	STLDINS 180:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.

110601	E	STLDINS 364:Total number of claims denied, rejected or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110602	E	STLDINS 364:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110603	E	STLDINS 364:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110604	E	STLDINS 364:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110605	E	STLDINS 364:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110606	E	STLDINS 364:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110607	E	STLDINS 364:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110608	E	STLDINS 364:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110609	E	STLDINS 364:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110610	E	STLDINS 364:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110611	E	STLDINS 364:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110613	E	STLDINS 364:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected, or returned.
110614	E	STLDINS 364:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110615	E	STLDINS 364:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= number of claims appeals received during the period.

110616	E	STLDINS 364:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110617	W	STLDINS 364:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110618	E	STLDINS 364:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110619	W	STLDINS 364:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110621	W	STLDINS 364:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110622	E	STLDINS 364:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110623	E	STLDINS 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110624	E	STLDINS 364:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110625	E	STLDINS 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110626	E	STLDINS 364:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110627	E	STLDINS 364:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.

110628	E	STLDINS 364:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110629	W	STLDINS 364:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110630	E	STLDINS 364:Number of applications initiated via phone must be <= Number of applications received.
110631	W	STLDINS 364:Number of applications completed via phone should be <= Number of applications received.
110632	W	STLDINS 364:Number of applications initiated face-to-face should be <= Number of applications received.
110633	W	STLDINS 364:Number of applications completed face-to-face should be <= Number of applications received.
110634	W	STLDINS 364:Number of applications initiated online (Electronically) should be <= Number of applications received.
110635	W	STLDINS 364:Number of applications completed online (Electronically) should be <= Number of applications received.
110636	W	STLDINS 364:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110637	W	STLDINS 364:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110638	W	STLDINS 364:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110639	W	STLDINS 364:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110640	W	STLDINS 364:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110641	W	STLDINS 364:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110642	W	STLDINS 364:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110643	W	STLDINS 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110644	W	STLDINS 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110646	W	STLDINS 364:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110647	W	STLDINS 364:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110701	E	STLDIS 90:Total number of claims denied, rejected, or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110702	E	STLDIS 90:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110703	E	STLDIS 90:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110704	E	STLDIS 90:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110705	E	STLDIS 90:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110706	E	STLDIS 90:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.

110707	E	STLDIS 90:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110708	E	STLDIS 90:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110709	E	STLDIS 90:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110710	E	STLDIS 90:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110711	E	STLDIS 90:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110713	E	STLDIS 90:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected or returned.
110714	E	STLDIS 90:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110715	E	STLDIS 90:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110716	E	STLDIS 90:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110717	W	STLDIS 90:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110718	E	STLDIS 90:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110719	W	STLDIS 90:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110721	W	STLDIS 90:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110722	E	STLDIS 90:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110723	E	STLDIS 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110724	E	STLDIS 90:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110725	E	STLDIS 90:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110726	E	STLDIS 90:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110727	E	STLDIS 90:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110728	E	STLDIS 90:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110729	W	STLDIS 90:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110730	E	STLDIS 90:Number of applications initiated via phone must be <= Number of applications received.
110731	W	STLDIS 90:Number of applications completed via phone should be <= Number of applications received.
110732	W	STLDIS 90:Number of applications initiated face-to-face should be <= Number of applications received.
110733	W	STLDIS 90:Number of applications completed face-to-face should be <= Number of applications received.
110734	W	STLDIS 90:Number of applications initiated online (Electronically) should be <= Number of applications received.

110735	W	STLDIS 90:Number of applications completed online (Electronically) should be <= Number of applications received.
110736	W	STLDIS 90:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110737	W	STLDIS 90:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110738	W	STLDIS 90:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110739	W	STLDIS 90:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110740	W	STLDIS 90:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110741	W	STLDIS 90:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110742	W	STLDIS 90:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110743	W	STLDIS 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110744	W	STLDIS 90:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110746	W	STLDIS 90:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110747	W	STLDIS 90:Number of prior authorizations denied during the period should be <= Number of prior authorization requests pending at the beginning of the period + Number of prior authorization requests during the period.
110801	E	STLDIS 180:Total number of claims denied, rejected or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110802	E	STLDIS 180:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110803	E	STLDIS 180:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110804	E	STLDIS 180:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110805	E	STLDIS 180:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110806	E	STLDIS 180:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110807	E	STLDIS 180:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110808	E	STLDIS 180:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110809	E	STLDIS 180:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110810	E	STLDIS 180:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110811	E	STLDIS 180:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110813	E	STLDIS 180:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected, or returned.

110814	E	STLDIS 180:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110815	E	STLDIS 180:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110816	E	STLDIS 180:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110817	W	STLDIS 180:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110818	E	STLDIS 180:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110819	W	STLDIS 180:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.
110821	W	STLDIS 180:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110822	E	STLDIS 180:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110823	E	STLDIS 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110824	E	STLDIS 180:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110825	E	STLDIS 180:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110826	E	STLDIS 180:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110827	E	STLDIS 180:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110828	E	STLDIS 180:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110829	W	STLDIS 180:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110830	E	STLDIS 180:Number of applications initiated via phone must be <= Number of applications received.
110831	W	STLDIS 180:Number of applications completed via phone should be <= Number of applications received.
110832	W	STLDIS 180:Number of applications initiated face-to-face should be <= Number of applications received.
110833	W	STLDIS 180:Number of applications completed face-to-face should be <= Number of applications received.
110834	W	STLDIS 180:Number of applications initiated online (Electronically) should be <= Number of applications received.
110835	W	STLDIS 180:Number of applications completed online (Electronically) should be <= Number of applications received.

110836	W	STLDIS 180:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110837	W	STLDIS 180:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110838	W	STLDIS 180:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110839	W	STLDIS 180:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110840	W	STLDIS 180:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.

110841	W	STLDIS 180:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110842	W	STLDIS 180:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110843	W	STLDIS 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.
110844	W	STLDIS 180:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110846	W	STLDIS 180:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110847	W	STLDIS 180:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + number of prior authorization requests during the period.
110901	E	STLDIS 364:Total number of claims denied, rejected, or returned must be <= Number of claims pending at the beginning of the period + Number of claims received.
110902	E	STLDIS 364:Number of denied, rejected, or returned due to claims submission coding error(s) must be <= Number of claims pending at the beginning of the period + Number of claims received.
110903	E	STLDIS 364:Number of denied, rejected, or returned for lack of Prior Authorization must be <= Number of claims pending at the beginning of the period + Number of claims received.
110904	E	STLDIS 364:Number of denied, rejected, or returned as Non-Covered or beyond benefit limitation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110905	E	STLDIS 364:Number of denied, rejected, or returned as Not medically necessary must be <= Number of claims pending at the beginning of the period + Number of claims received.
110906	E	STLDIS 364:Number of denied, rejected, or returned as Subject to pre-existing condition exclusion must be <= Number of claims pending at the beginning of the period + Number of claims received.
110907	E	STLDIS 364:Number denied, rejected, or returned due to failure to provide adequate documentation must be <= Number of claims pending at the beginning of the period + Number of claims received.
110908	E	STLDIS 364:Number denied, rejected, or returned due to being within the waiting period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110909	E	STLDIS 364:Number of denied, rejected, or returned (in whole or in part) because maximum $ limit exceeded must be <= Number of claims pending at the beginning of the period + Number of claims received.
110910	E	STLDIS 364:Number of denied, rejected, or returned for Out-of-Network provider must be <= Number of claims pending at the beginning of the period + Number of claims received.
110911	E	STLDIS 364:Number of Claims Pending at End of Period must be <= Number of claims pending at the beginning of the period + Number of claims received.
110913	E	STLDIS 364:Number of Claim Decision Appeals Received During the Period must be <= Number of claims denied, rejected or returned.
110914	E	STLDIS 364:Number of Claim Decision Appeals Resulting in Decisions Upheld During the Period must be <= Number of claims appeals received during the period.
110915	E	STLDIS 364:Number of Claim Decision Appeals Resulting in Decisions Overturned or Modified During the Period must be <= Number of claims appeals received during the period.
110916	E	STLDIS 364:Number of Claim Decision Appeals Rejected and Not Considered for Any Reason must be <= Number of claims appeals received during the period.
110917	W	STLDIS 364:Number of Claim Decision Appeals Pending at End of Period should be <= Number of claims appeals received during the period.
110918	E	STLDIS 364:Number of claims paid must be <= Number of claims pending at the beginning of the period + Number of claims received.
110919	W	STLDIS 364:Number of complaints resulting in claims reprocessing should be <= Number of complaints received by company (other than through the DOI) + Number of complaints received through the DOI.

110921	W	STLDIS 364:Number of Lawsuits Closed During the Period with Consideration for the Consumer should be <= Number of lawsuits closed during the period.
110922	E	STLDIS 364:Number of Lawsuits Open at End of Period must be = Number of lawsuits open at the beginning of the period + Number of lawsuits opened during the period - Number of lawsuits closed during the period.
110923	E	STLDIS 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of individual applications pending at the beginning of the period + Number of applications received.
110924	E	STLDIS 364:Number of New Individual Applications Denied During the Period due to Health Status or Condition must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110925	E	STLDIS 364:Number of New Individual Applications Denied During the Period for Any Reason must be <= Number of Renewal/Reissue individual applications received during the period.
110926	E	STLDIS 364:Number of Renewal/Reissue Individual Applications Denied During the Period due to Status or Condition must be <= Number of Renewal/Reissue individual applications received during the period.
110927	E	STLDIS 364:Number of New Individual Applications Approved During the Period must be <= Number of Individual Applications Pending at the Beginning of the Period + Number of applications received.
110928	E	STLDIS 364:Number of Renewal/Reissue Individual Applications Approved During the Period must be <= Number of Renewal/Reissue Individual Applications Received During the Period.
110929	W	STLDIS 364:Number of Individual Applications Pending at the End of the Period should be = Number of Individual Applications Pending at the Beginning of the Period + Number of applications received - Number of New Individual Applications Denied During the Period for Any Reason.
110930	E	STLDIS 364:Number of applications initiated via phone must be <= Number of applications received.
110931	W	STLDIS 364:Number of applications completed via phone should be <= Number of applications received.
110932	W	STLDIS 364:Number of applications initiated face-to-face should be <= Number of applications received.
110933	W	STLDIS 364:Number of applications completed face-to-face should be <= Number of applications received.
110934	W	STLDIS 364:Number of applications initiated online (Electronically) should be <= Number of applications received.
110935	W	STLDIS 364:Number of applications completed online (Electronically) should be <= Number of applications received.
110936	W	STLDIS 364:Number of New Individual Applications initiated by Mail During the Period should be <= Number of applications received.
110937	W	STLDIS 364:Number of New Individual Applications completed by Mail During the Period should be <= Number of applications received.
110938	W	STLDIS 364:Number of New Individual Applications initiated by Any Other Method During the Period should be <= Number of applications received.
110939	W	STLDIS 364:Number of New Individual Applications completed by Any Other Method During the Period should be <= Number of applications received.
110940	W	STLDIS 364:Number of new policies issued during the period should be <= Number of new policies/applications received during the period - Number of new policies/applications denied during the period.
110941	W	STLDIS 364:Number of new policies denied during the period should be <= Number of new policies/applications received during the period - Number of new policies issued during the period.
110942	W	STLDIS 364:Number of policies/certificates renewed/reissued during the period should be <= Number of renewals/reissues allowed.
110943	W	STLDIS 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policies/certificates cancelled during the free look period.

110944	W	STLDIS 364:Number of Policies/Certificates Cancelled at the Initiation of the policyholder/certificate holder During the Free Look Period During the Period should be <= Number of policy/certificate terminations and cancellations initiated by the policyholder/certificate holder.
110946	W	STLDIS 364:Number of prior authorizations approved during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.
110947	W	STLDIS 364:Number of prior authorizations denied during the period should be <= Number of prior authorizations requests pending at the beginning of the period + Number of prior authorization requests during the period.

Median Day Validation

A median is defined as the middle value in a series of ordered values. A median is found by counting the entities in the series and selecting the entity that has an equal number of entities above it and below it. MCAS is requesting the days to payment of the median (or the middle) claim which was closed with payment. To verify that the value reported in this field passes the "reasonableness" test, a validation is performed using the following steps.

Example using an **odd** number of claims closed with payment:

<table>
<tr><th>Calculation Steps</th><th colspan="2">Example</th></tr>
<tr><td>1. Divide the value reported as "claims closed with payment" by 2 to determine median value. When the total claims are an odd number, the median value is definite.</td><td colspan="2">Claims closed with payment = 101
101/2 = 50.5
Median = 51 (rounded up)

Because an equal number of values come before (1-50) and after (52-101) the number 51, it is the middle value.</td></tr>
<tr><td rowspan="6">2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim value is reached.</td><td></td><td>Running Total</td></tr>
<tr><td>0-30 days = 30</td><td>30</td></tr>
<tr><td>31-60 days = 14</td><td>(30 + 14) = 44</td></tr>
<tr><td>61-90 days = 12</td><td>(44 + 12) = 56</td></tr>
<tr><td>91-180 days = 21</td><td>(56 + 21) = 77</td></tr>
<tr><td>181-365 days = 24</td><td>(76 + 24) = 101</td></tr>
<tr><td>3. Compare value entered in MCAS to timeframe bucket calculated.</td><td colspan="2">MCAS value entered = 66
Median range calculated = 61-90</td></tr>
<tr><td>4. Test that the 51st value is within the 61 - 90 range AND the MCAS entered value of 66 is also within the 61 - 90 range.</td><td colspan="2">Validation passes.</td></tr>
</table>

Example using an **even** number of claims closed with payment:

Calculation Steps	Example	
1. Divide the value reported as "claims closed with payment" by 2 to determine median value. When the total claims are an even number, the median value includes the calculated number and the calculated number +1 in order to maintain an equal number of entities above and below the median.	Claims closed with payment = 100 100/2 = 50 Median = 50 and 51 To have an equal number of values before and after 100, the median would be 50.5. This is not a valid number of claims, therefore 50 and 51 are both used.	
2. Count the number of claims reported in each timeframe bucket (0-30 days, 31-60 days, etc.) until the median claim values are reached. Both median values must be tested for the timeframe bucket. *		Running Total
	0-30 days = 30	30
	31-60 days = 14	(30 + 14) = 44
	61-90 days = 12	(44 + 12) = **56**
	91-180 days = 20	(56 + 20) = 76
	181-365 days = 24	(76 + 24) = 100
3. Compare value entered in MCAS to timeframe bucket calculated.	MCAS value entered = 62 Median range calculated = 61-90	
4. Test that both the 50th and 51st values are within the 61 - 90 range AND the MCAS entered value of 62 is also within the 61 - 90 range.	Validation passes.	

*If the 50th claim was in the 31-60 timeframe bucket and the 51st claim was in the 61-90 timeframe bucket, then an acceptable MCAS "median days to final payment" value would be a number that falls between 31-90 days.