2024 Qualified Dental Plan (QDP) Filing Instructions in SERFF (4/26/23)

Each QDP filing contains a binder with all the data necessary for stand-alone dental plans offered inside the New York State of Health (NYSOH) for the individual marketplace and SHOP. Binders should also be filed for NYSOH-certified stand-alone dental plans offered outside NYSOH in the individual market only. Small group off Exchange-only binders do not need to be submitted. Issuers should submit one binder per market type (individual or small group) for each NAIC Company Code. Also, if an issuer uses two different DBAs (or marketing name) within the same NAIC Company Code, it should submit separate binders for each DBA.

NYSOH Filings: Issuers should file QDP binders with all required templates in SERFF. If an issuer is offering a QDP inside the NYSOH and the same plan outside the NYSOH as a NYSOH-certified stand-alone dental plan, the issuer should indicate, as described below in the Plans & Benefits Template, that the particular HIOS Plan ID is available both inside and outside the NYSOH under the QDP/Non-QDP field. Issuers should not submit duplicate plans in a separate off Exchange binder. Issuers should not include any specific HIOS Plan ID in more than one binder. If an issuer wants QDPs to display on the Marketplace portal for SHOP, the HIOS Plan IDs must be marked as available both inside and outside the NYSOH in the QDP/Non-QDP field.

Off NYSOH Filings: The issuer should submit at binder for plans available outside the NYSOH for the individual market only. Binders are not required for small group NYSOH-certified stand-alone dental plans offered outside NYSOH that the issuer does <u>not</u> want to display on the Marketplace portal. A separate binder should be submitted per licensee.

General Instructions for QDP Filing

Build your QDP filing according to any instructions provided by SERFF. Follow the instructions below for the submission of QDP filings to New York. The following templates are required for QDP Binder filings:

Service Area Template	Information identifying an issuer's geographic service area.
Network Template	Information identifying an issuer's provider network.
Plans & Benefits Template	Collects plan and benefit data.
Rate Template	Collects rates necessary for display on the web portal.
Business Rules Template	Collects rules to explain the rating tables.

Submission Requirements on the Supporting Documentation Tab. Each issuer must submit the following documents or attachments on the Supporting Documentation Tab:
1. Statement of Detailed Attestation Responses for SBMs Issuers (required for on Exchange binders only);
2. Logo File (required for on Exchange binders only); and
3. Administrative Template.

Associate Schedule Items Tab. When building the QDP filing, use the Associated Schedule Item Tab to link forms and any variable material to a HIOS Plan ID. Do not associate any other items from the form and rate filing, such as the rate manual, any certifications forms, or checklists. Issuers may only associate schedule items submitted using the same SERFF instance.

Network Adequacy Review. The Service Area Template and Network Template should be submitted but no additional information regarding network adequacy should be submitted through SERFF. See the [NYSOH Application](#) for submission of network adequacy information. Please note that the Department of Financial Services (DFS) does not collect the Essential Community Providers or Network Adequacy Templates.

URLs. Issuers should submit the NYSOH URL Template along with their Plan Invitation for on Exchange binders. URLs are not needed for off Exchange binders.

<u>Technical Requirements</u>
1. **Form and Rate Filings.** Issuers should also submit their traditional form and rate filing in SERFF before creating their binder so that they can associate schedule items such as forms to their QDP filing. The form and rate filing instructions, checklists, and model form language can be found on the [DFS website](#).
2. **SERFF Instance.** Issuers must submit the binder using the same SERFF instance as the previously submitted form and rate filings.
3. **Apostrophes.:** None of the content in any of the SERFF templates fields can contain apostrophes for binders to be transmitted to the NYSOH. The transmission will fail for the entire binder.

Template Instructions

Issuers should use the 2024 template versions when submitting their 2024 binder filings through SERFF. Copies of templates, detailed instructions provided by CCIIO including explanations of fields, data dictionary, and other more technical information regarding the data templates is available on the [CMS QHP Certification website](#). These New York specific instructions below are intended to assist issuers when submitting QDP filings to New York. Before submitting a binder through SERFF, issuers are strongly encouraged to run their templates through the Data Integrity Tool to avoid data submission errors.

Service Area Template

1. Enter the HIOS Issuer ID and State.
2. Click the Create Service Area IDs button. Create as many Service Areas as necessary to indicate the various area QDPs will be available. For example, if the issuer has a limited network plan only available in two out of the five counties within their overall service area, the issuer will need to create two Service Area IDs. The issuer will then use the Service Area IDs in the Plans & Benefits Template to associate QDPs to a particular Service Area.
3. Select a Service Area ID that was generated by the template.
4. Enter a name in Service Area Name.
5. Indicate whether the Service Area covers the entire state.
6. If the Service Area does not cover the entire state, choose each county that is within the Service Area.
7. Repeat steps 4-6 for every county within a Service Area.
8. If the issuer has more than one Service Area, repeat steps 3-7 for each Service Area.
9. One Service Area Template may include multiple Service Areas.
10. Verify that each service area matches the service area outlined in the Definitions section of the Certificate, Contract or Policy associated with that specific HIOS Plan ID on the Associated Schedule Items Tab.

11. An issuer must create separate service area IDs for Individual market service areas and small group market service areas. An issuer must use the same Service Area Template across all binders or ensure that no service area IDs repeat across the binders.
12. If an issuer is a dual-product issuer (QHPs and QDPs),it must create two different service area IDs, one each for QHPs and QDPs, regardless of whether the service area is intended to serve both plan types. For example, if an issuer offers QHP, SHOP, and QDP, they must have three different service area ID's, even if the service area is the same for all three programs. For dual-product issuers, the word "dental" should be used in the service area name to distinguish it from the QHP service area.

Network Template

1. Enter the HIOS Issuer ID and State.
2. Click the Create Network IDs button. Indicate the number of networks the issuer has.
3. Enter Network Name. Include the word "Marketplace" in the network name for all Marketplace binders.
4. Select a Network ID that was generated by the template to associate with the Network Name.
5. If the issuer has more than one network, repeat steps 2-4 for each network. One Network Template may include multiple networks.
6. If an issuer participates in both the Individual and SHOP markets, do not use the same network ID for both networks. An issuer should use the same Network Template across all binders or ensure that no network IDs repeat across the binders.
7. If an issuer is a dual-product issuer (QHPs and QDPs), it must create two different network IDs, one each for QHPs and QDPs, regardless of whether the specific network is intended to serve both product types. For example, the Individual Market network ID should be NYN001, the SHOP network ID should be NYN002, and the QDP network ID should be NYN003. For dual-product issuers, the word "dental" should be used in the Network ID name to distinguish it from the QHP Network ID.

Plans & Benefits Template

General Information

1. The Service Area and Network Templates should be completed prior to completing the Plans & Benefits Template.
2. All fields indicated with a red asterisk are required.
3. Download the most recent version of the 2024 Plans & Benefits Add-In file.

HIOS Plan IDs (Standard Component IDs)

1. The HIOS Plan ID is the key identifier used by the NYSOH to populate the QDPs on the web portal, associate the corresponding provider network, associate the corresponding quality information, and complete enrollment. QDPs that were sold in 2023 must keep the same HIOS Plan ID in 2024. New HIOS Plan IDs may only be assigned when a new QDP is being submitted for certification.
2. The issuer must register their HIOS Plan IDs (Standard Component IDs) via HIOS.
3. Any variation in benefits or cost-sharing must be submitted using separate HIOS Plan IDs.
4. A HIOS Plan ID should only be submitted to the State in one binder.
5. HIOS Plan ID Limitations: The current limit of HIOS Plan IDs in a single binder is 350. If an issuer has a binder that will exceed that limit, contact the SERFF Help Desk. SERFF can temporarily

increase the limit in order to allow the submission of the binder. Do not split the binder up into multiple binders.

Benefits Package Tab

1. A Benefits Package Tab consists of all QDPs that have the identical plan structure (including any quantitative limits and exclusions.) QDPs should be grouped together as much as possible to minimize the use of added Benefit Package Tabs. Added Benefit Package Tabs may be needed if the explanation provided for the "Design" box is different among plans.
2. Cost sharing variations will be defined in the Cost Share Variances Tab.
3. Complete the top section of each Benefits Package worksheet that contains the HIOS Issuer ID, Issuer State, Market Coverage, and Dental Only Plan.

Plan Identifiers

1. Complete this section for each Benefit Package.
2. Complete a line per each HIOS Plan ID (Standard Component ID) for each QDP.

Plan Attributes

1. Indicate whether the plan is a new or existing plan.
2. Select Plan Type and Level of Coverage.
3. For the QDP/non-QDP field, indicate whether the plan will be offered inside the NYSOH, outside the NYSOH or both. Do not assign more than one HIOS Plan ID to the same plan that is offered both inside and outside the NYSOH.
4. Child-Only Plans: The standard pediatric dental plan should be marked Allows Child Only. All other plans should be marked either Allows Child if non-standard plan covers pediatric dental benefits only or Allows Child and Adults if the non-standard plan covers both pediatric and adult dental benefits.

Stand-Alone Dental Only

1. Complete the fields required for stand-alone dental plans.
2. EHB Apportionment for Pediatric Dental: Enter the percentage of the monthly premium that is allocated for the pediatric dental EHB. If the rates are age-banded, use the EHB percent that applies to the pediatric rates. If the rates are family-tiered, use the EHB percent of the individual rate assuming a child enrollment. This percentage is used to determine the amount of the advance payment of the premium tax credit required under 45 CFR 155.340(e)(2).

Plan Dates

1. Enter the appropriate Plan Effective Date and Plan Expiration Date. For NYSOH filings, the Plan Effective Date must be 1/1/2024 and the Plan Expiration Date must be 12/31/2024 for both the Individual Marketplace and the SHOP Marketplace.

Geographic Coverage

1. Indicate whether the QDP provides coverage outside the U.S. or outside the service area.

Benefit Specific Information

1. Standard QDPs: Click the Refresh EHB button. Use the benefits the template provides without any changes.
2. Design. For all NYSOH filings, add a custom benefit called "Design". This field will be used to describe the benefit design features that are not otherwise obvious to the consumer. Limit your explanation to 1,500 characters. If more characters are needed, contact your Plan Manager. Be sure to select "NO" for the Quantitative Limit. Include the following description in the design field:
   - Whether or not referrals are required to access care (i.e., gatekeeper);
   - Custom network features (e.g., tiered network) (NOTE: The Marketplace currently is designed to only display one tier of cost-sharing); and
   - The type of deductible the plans have, either embedded or family. This may mean that issuers may need to add more "Benefit Package" tabs so that the type of deductible is the same for all plans on the tab.
   - Other features of the benefit design that will aid consumers in making their plan selection decisions.
3. Benefit Explanation and Mapping to Model Language: Issuers should add language to each benefit explanation box to describe the dental benefit, adding examples of items or services covered under each benefit. Issuers should use the following guide to map the benefits to the model language on the pediatric dental benefit and add appropriate explanations based on the model language.

Template Benefit	Model Language or Possible Adult Benefit
Dental Checkup for Children	Preventive Dental Care (cleanings, fluoride & sealants)
Basic Dental Care - Child	Routine Dental Care (exams, x-rays, simple extractions & fillings)
Major Dental Care - Child	Endodontics, Periodontics, Prosthodontics and Oral Surgery
Orthodontia - Child	Orthodontics
Basic Dental Care - Adult	Cleanings and Exams
Routine Dental Service - Adult	X-rays, Fillings, and Simple Extractions
Major Dental Care - Adult	Endodontics Periodontics, Prosthodontics and Oral Surgery
Orthodontia - Adult	Orthodontics
Accidental Dental	Coverage Depends on Adult Benefit Design (also covered under medical plans)

Non-Standard QDPs

1. Use the benefits the template provides for the pediatric essential health benefit. Use the adult dental benefits provided in the template. Benefits may be added (e.g., cosmetic orthodontia) but do not manually add any benefits already listed on the template.
2. Issuers may add benefits (e.g., cosmetic orthodontia) to a non-standard QDP in accordance with guidance found in the NYSOH Application and in the product checklists found on the DFS website.
3. If only varying the limits on the benefits listed above, then edit the limits without adding any new benefits. Identify any major benefit limitations (i.e., annual or lifetime limit on cosmetic orthodontia, age limit for cosmetic orthodontia, or annual limit on adult dental services).
4. If adding the benefits below, follow these instructions:

a. <u>Adult Dental Care:</u> Use the benefits (Routine Dental Services (Adult); Basic Dental Care – Adult; Major Dental Care –Adult; Orthodontia – Adult), as applicable, available on the main benefit list.

b. <u>Any Other Additional Benefits:</u> If the benefit the issuer wants to add is not otherwise listed, then use the Add Benefits Button. Use the drop-down list of benefits to see if it matches a benefit there first. If not, then issuers may add a Custom Benefit using the Add Benefits Button. For NYSOH filings, if you add a Custom Benefit that you would like displayed on the Marketplace, please notify your Plan Manager as the information needs to be coded into the Marketplace system.

5. <u>Benefit Explanation.</u> Issuers should add language to each benefit explanation box to describe the dental benefit, adding examples of items or services covered under each benefit. **Any waiting periods or benefit maximums for adult dental care benefits must be clearly listed in the benefit explanation field.**

6. <u>EHB Variance Reason:</u> For any variation from EHB or additional benefit, indicate why the issuer is varying from EHB by selecting the appropriate reason (substitution, above EHB, etc.).

7. <u>Out of Pocket Exceptions Fields:</u> Complete these fields with the appropriate Yes/No answer. For EHB, the benefits should not be excluded from the Out-of-Pocket Limit. For additional benefits beyond EHB, select the appropriate answers.

Cost Share Variance Tab

General Information

1. Confirm all the QDPs are listed on the Benefits Package sheet **before** creating the Cost Share Variance Sheet.

2. Once the Benefits Package sheet is complete, click the Create Cost Share Variance Sheet button. When the Create Cost Share Variance Sheet is created, it will automatically create each of the necessary variant plans by adding a hyphen and a two-digit number to the HIOS Plan ID. Enter data (cost-sharing amounts, deductible & out-of-pocket amounts) for the standard plans (-01) first before entering information for any of the required cost sharing information for the variant plans. The two-digit numbers indicate the following:

   00 - Standard Off Exchange Plan
   01 - Standard On Exchange Plan

Cost Sharing Attributes

1. Complete all information and respond to all the questions before completing the cost-sharing information.

Maximum Out-of-Pocket and Deductible Information

1. Complete all information as required.

2. <u>Family Maximum Out-of-Pocket and Family Deductible:</u> If a plan embeds a maximum out-of-pocket or deductible for each person within the family, enter the number as the per person amount. Check the "Not applicable" box when the plan does not embed an amount for each person within the family. Enter the dollar amount that applies to the family collectively as the per group amount.

Cost Sharing Information

1. The cost-sharing in the Plans & Benefits Template reflects the cost-sharing the consumer pays for the service.

2. Certain benefits have varying cost-sharing depending on the type of service performed under the benefit. For example, Preventive Dental Care could have various cost-sharing depending on the CPT Code entered for the procedure. Enter the highest cost-sharing amount for the category of service. In the alternative, issuers may also choose to enter the predominant cost-sharing amount for a given service. For QDPs offered on the NYSOH, issuers should carefully review the cost-sharing amounts entered and verify that they are accurate and not misleading as those amounts will display on the NYSOH portal.
3. If the QDP charges a copayment, enter "Not Applicable" in the In-Network Coinsurance fields. If the QDP charges coinsurance, enter "Not Applicable" in the In-Network Copayment fields. All cost-sharing fields must be completed to pass validation.
4. If a QDP does not have out-of-network benefits for a given category, enter "Not Applicable" for the out-of-network copay fields and 100% for the out-of-network coinsurance fields. All cost-sharing fields must be completed to pass validation.
5. The deductible information must be entered in for each cost-sharing amount on the Cost Share Variance Sheet. Select the correct option when selecting the cost-sharing amount on the Cost Variance Sheet.
   a. <u>Plans with No Deductible:</u> If a QDP does not have a deductible, indicate the cost-sharing using "$X Coinsurance" or "$X Copay" without any reference to a deductible (e.g., $20 Copay).
   b. <u>Plans with Deductibles:</u> If the cost sharing for a specific benefit is subject to a deductible, note the cost-sharing is applied after the deductible. (e.g., $20 Copay after deductible). If a QDP has a deductible with some benefits subject to the deductible and other not subject to the deductible, note the benefits subject to the deductible using the after deductible language (e.g., $20 Copay after deductible). Note benefits with cost-sharing before the deductible using "$X Copay with deductible" option. The cost-sharing drop-down "$X copay with deductible," will now take the place of the option "$X copay before deductible" that was shown in previous years.

Rate Template

1. Issuers should complete the Rate Template to provide the NYSOH with the rates for each QDP.
2. All fields indicated with a red asterisk are required.
3. <u>Small Group & Rolling Rates:</u> For all small group binders, the issuer should submit the rates for each quarter separately, creating a new sheet using the Add Sheet button. The issuer should then enter in the dates for each quarter in the Rate Effective Date and Rate Expiration Date to reflect effective dates for these premium rates. For example, an issuer submitting rates for the first quarter of 2024 would enter a rate effective date of 1/1/24 and a rate expiration date of 3/31/24. Do not include an expiration date of 2025. The purpose of the effective dates is to show what the rate will be on the first effective date of the plan year.
4. <u>Estimated Rates for SHOP QDPs.</u> SHOP QDPs may now use estimated rates due to the roll out of SHOP Direct Enrollment. If the issuer wants to use estimated rates, then the issuer should contact their plan manager. If using estimated rates due to the template not taking all rating factors into account, then enter the rate that would be the most common for a group purchasing the QDP in that particular rating region.
5. <u>Rating Regions.</u> See the [DFS website](#) for a listing of the counties within these rating regions:
   a. Rating Area 1 – Albany Area
   b. Rating Area 2 – Buffalo Area
   c. Rating Area 3 – Mid-Hudson Area
   d. Rating Area 4 – New York City Area
   e. Rating Area 5 – Rochester Area

     f.   Rating Area 6 – Syracuse Area
     g. Rating Area 7 – Utica/Watertown Area
     h. Rating Area 8 – Long Island

Standard QDPs (Covering the Pediatric Dental Essential Health Benefit Only) or Non-standard QDPs Providing Coverage for Pediatric Dental Care Only:

1. Create a new Rate Table by clicking the Add Sheet button.
2. For Rating Method, select Age-Based Rates.
3. Complete Plan ID and Rating Area. <u>Only one Rating Area can be selected per line.</u>
4. For Tobacco, select No Preference.
5. Enter the rate for a single child monthly premium rate in the Individual Rate box.
6. <u>Validation Issue:</u> QHPs must enter a value above $0.00 for all age bands under the Individual Rate column unless the response Allows Child-Only under Child-Only Offering in the Plans & Benefits Template. QHP Child-Only offerings must enter a positive non-zero value for the 0–14, 15, 16, 17, 18, 19,and 20 age bands and are allowed to enter a value of $0.00 for adult age bands 21 through 64 and over. None of this information for ages 18 and older will be used but is necessary to pass validations.

Non-standard QDPs (Providing Coverage for Pediatric and Adult Dental Benefits):

1. Complete the top portion of the sheet first, inputting HIOS Issuer ID, Rate Effective Date and Rate Expiration Date.
2. For Rating Method, select Family-Tiered Rates.
3. Complete HIOS Plan ID and Rating Area.
4. For Tobacco, select No Preference.
5. Select Family Option for Age.
6. Complete Individual column with the monthly premium rate for the Individual Tier.
7. Complete Couple column with the monthly premium rate for the Individual and Spouse Tier.
8. Complete Primary Subscriber and One Dependent, Primary Subscriber and Two Dependents, and Primary Subscriber and Three or More Dependents columns with the monthly premium rate for the Parent and Child/Children Tier. **Note that the same premium must be entered into all three columns.**
9. Complete the Couple and One Dependent, Couple and Two Dependents, and Couple and Three or More Dependents columns with the monthly premium rate for the Family Tier. **Note that the same premium must be entered into all three columns.**
10. Repeat steps 2-9 for each applicable Rating Area.
11. Any QDP that offers family coverage must complete each tier of the four-tier rating structure (Individual, Individual and Spouse, Parent + Children and Family).

Business Rules Template

1. Issuers should complete the Business Rules Template in order to provide the NYSOH with the rules regarding rates for each QDP.
2. All fields indicated with a red asterisk are required.
3. Enter the HIOS Issuer ID and indicate that the template is "Dental."
4. Complete the first line to indicate the General Business Rules. Unless otherwise specified below, answer all questions as appropriate to reflect the rules you follow.

a. Tobacco: Marked as Not Applicable.
b. Dependent Relationships (column H): The following relationships are required to be checked and the residing question answered "No": spouse, child, and stepson or stepdaughter. A "Life Partner" is a domestic partner. Issuers should check the Life Partner box and respond "Yes" to the residency question.
5. List **each** HIOS Plan ID in the binder below the General Business Rules line and respond to each question, even if it duplicates the general business rules line. The NYSOH needs each HIOS Plan ID listed separately.
6. <u>Maximum Age of Dependents:</u> Enter the maximum dependent age. The template permits entry of any age 18 or older.
7. <u>Domestic Partner Coverage:</u> Domestic partner coverage is required on all QDPs offered on NYSOH. All HIOS Plan IDs on the Business Rules Template must select "Life Partner, Yes" under the question "What relationships between primary and dependent are allowed, and is the dependent required to live in the same household as the primary subscriber."