



2024 Qualified Dental Plan (“QDP”) & Qualified Health Plan (“QHP”) with Embedded Dental Benefits & Cost-Sharing Template Instructions

1. Background

Due to limitations with the Plans & Benefits Templates that are provided by CMS for use in SERFF, we have created a separate Benefits and Cost-Sharing Template that clearly defines cost-sharing for several of the most common dental procedures. This information will be displayed on the New York State of Health Dental Plan Comparison Tool for use by consumers when shopping and comparing coverage.

2. Points of Emphasis for 2024

Please continue to submit one template per NAIC company code for individual market products only. The template should contain both stand-alone dental plans that include adult/family benefits and qualified health plans that have embedded adult/family dental benefits. *Do not list plans that provide standard pediatric dental benefits only.*

Please submit only the cost-sharing for the -01 (standard on exchange) cost-share variation of each product. If you are copying and pasting data from SERFF, please remove the cost-sharing data from all of the other product variations prior to submitting the template.

For QHPs that contain embedded dental benefits and these benefits are subject to the product’s overall deductible, please list the deductible for the overall product in the dental deductible fields (Please see Section D for detailed instructions). Please also ensure that the cost-sharing information contains “after deductible” when populating the cost-sharing amount (Ex: \$20 after deductible).

3. Template Instructions

Issuers must submit one template per licensee/NAIC Company Code for Individual Market products only. While the templates are based, in part, on the existing plans and benefits template, the macros and field validations have been removed from the original plans and benefits template and modified to account for additional information needed by New York State of Health. For specific instructions on what type of data is expected, please also refer to the original SERFF filing instructions for the Plans and Benefits Template: http://www.serff.com/plan_management_data_templates.htm for detailed instructions provided by CCIIO, including explanations of fields, data dictionary, and other more technical information regarding the original plans and benefits template. The instructions below are

intended to assist issuers when submitting the additional fields and information required for New York State of Health.

A. Benefit Specific Instructions: Follow these instructions for submission of all products (Non-Standard QDPs only).

1. Non-Standard Adult/Family Dental Plans: Use the benefit categories that have been provided. You may manually add additional covered benefits to the bottom of the template but limit the number of added benefits. If you are varying the limits on the preloaded benefits provided, 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, etc.).
2. Please note that only products with the same covered benefits should be included on each set of benefits and cost-sharing tabs (Ex. Adult/Family Benefits 1 and Adult/Family Cost-Sharing 1). If you need to add additional tabs to include products with different benefit designs, one additional set (Adult/Family Benefits 2 and Adult/Family Cost-Sharing 2) has been added for you. To add additional tabs beyond this scenario, you will need to manually copy and paste additional Benefits and Cost-Sharing worksheets.
3. Please populate each field as all fields contain required information.

B. Completing the Plan Identifiers and Attributes Within the Benefits Tabs:

1. Complete the top portion of the Benefits Package Sheet first that contains the HIOS Issuer ID, State, Market Coverage, etc.
2. Complete one line per HIOS Plan ID (Standard Component ID) for each QDP and please also follow the instructions found below regarding riders. *Please note that for purposes of the New York State of Health Dental Plan Comparison Tool, you should only submit data for the -01 cost-share variation of each HIOS ID. Please work across the row for each HIOS Plan ID filling in all fields.*
3. HIOS Plan ID: The HIOS Plan ID (Standard Component ID) must be obtained from the HIOS system. HIOS will supply the Insurer with a set of HIOS Plan IDs. Out of this supply of IDs, the Insurer will assign the product to the IDs in the Plan Benefits Template.
4. Plan Marketing Name: Please ensure that your plan marketing names match the requirements set for the Invitation.
5. Indicate the Plan Type: (Ex. "PPO")
6. For Dental Waiting Periods, indicate "None" or list the period of time followed by the applicable services (Ex. "12 months for adult TMJ").
7. Dental Out-of-Network Coverage: Indicate "Yes" or "No".
8. Referrals Required for a Dental Specialist: Indicate "Yes" or "No".
9. Dental Specialist(s) requiring a Referral: Provide details on when a referral is

needed (Ex. “Referrals are required to see all providers other than your primary care dentist.”).

10. Out of Country and Out of Service Area Dental Coverage: Indicate whether the plans provide coverage outside of the US or outside of the Service Area (Ex. “Yes” or “No”).
11. National Dental Network: Indicate “Yes” or “No”.
12. Dental Benefit Limits: Please list all benefit limitations for the product. (Ex. “2 cleanings per calendar year; Full set of x-rays every 3 years.”).
13. Dental Benefit Exclusions: Please list any benefit exclusions and the details here.

C. Completing the Benefit Information Within the Benefits Tabs:

1. Benefits Mapped to Model Language: Use the following guide to map the benefits to the model language on the dental benefits:

Template Benefit	Model Language or Possible Adult Benefit
Dental Checkup for Children	Preventive Dental Care
Basic Dental Care - Child	Routine Dental Care & Endodontics
Major Dental Care - Child	Prosthodontics
Orthodontia - Child	Orthodontics
Basic Dental Care - Adult	Checkup/Cleaning/X-rays
Routine Dental Services (Adult)	Fillings & Endodontics
Major Dental Care - Adult	Prosthodontics
Orthodontia - Adult	Orthodontics

2. EHB: Indicate whether each benefit is an essential health benefit by populating each field with a “Yes” or “No”.
3. Covered Benefit: Indicate whether each benefit is covered by populating each field with a “Yes” or “No”.

D. Completing the Cost-Share Variance Tabs: Once the Benefits Package sheet is complete, complete the cost-sharing tab for each worksheet. The set of benefits that were pre-populated in the template have their own pre-populated cost-sharing section on the benefits tab. If you added additional benefits to the Benefits tab, you will have to manually add them to the cost-sharing tab. As indicated above, please note that only products with the same covered benefits should be included on each set of benefits and cost-sharing tabs (Ex: Adult/Family Benefits 1 and Adult/Family Cost-Sharing 1). If you need to add additional tabs to include products with different benefit designs, one additional set (Adult/Family Benefits 2 and Adult/Family Cost-Sharing 2) has been added for you. To add additional tabs beyond this scenario, you will need to manually copy and paste additional worksheets.

1. HIOS Plan ID: Copy and paste the HIOS Plan IDs from the corresponding benefits tab to the cost-sharing tab.
2. Plan Marketing Name: Please ensure that your plan marketing names match the requirements set forth in the Invitation.
3. Annual Dental Benefit Maximum: Enter the annual dental benefit maximum for the product with a dollar sign, followed by any qualifying information that applies (Ex: "\$750 per adult"). If the product has benefit specific annual maximums, include this information after the product's total annual benefit maximum (Ex: "\$750 per adult; \$300 maximum for TMJ services"). If there is no maximum, please enter "None".
4. Lifetime Dental Benefit Maximum: Enter the lifetime dental benefit maximum for the product with a dollar sign, followed by any qualifying information that applies (Ex: "\$1,000 per adult"). If the product has benefit specific lifetime maximums, include this information after the product's total lifetime benefit maximum (Ex: "\$1,000 per adult; \$1,500 maximum for major dental services"). If there is no maximum, please enter "None".
5. Dental Deductible: Enter the amount of the deductible for each child/adult group with a dollar sign (Ex: "\$50"). If there is no deductible, please enter "\$0". You may enter qualifying information after the amount (Ex: "\$50 per person"). For QHP issuers who embed dental benefits within medical products and the cost-sharing for dental services is subject to the overall deductible, please enter the amount of the product deductible in this field for both the adult and children columns (Ex: If the overall product deductible is \$2000, then enter "\$2000" in the child deductible and also enter "\$2000" in the adult deductible).
6. Dental Maximum Out-of-Pocket ("MOOP"): Enter the MOOP for each child/adult group with a dollar sign (Ex: "\$350"). If there is no MOOP, please enter "None".
7. 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. Please enter a range of the costs that a consumer could expect based upon the CPT codes that are utilized (Ex: "\$20-\$50 copayments"). Issuers should carefully review the cost-sharing amounts entered and verify that they are accurate and not misleading as these amounts will be displayed publicly when consumers are shopping for coverage.
8. In-Network and Out-of-Network Cost-Sharing:
 - a) Copayments: If you charge an in-network copayment, enter the dollar amount in this field (Ex: "\$25"). If a consumer can expect a range of copayments based upon the service and CPT codes utilized by a provider, please enter the range of copayments that a consumer could potentially expect (ex: \$25-\$50 copayments). If no copayment is charged, enter "Not Applicable". If the benefit is not covered, enter "Not Covered".

Please choose from the following (note that there are no dropdown boxes in this template, you will have to manually enter or paste in the response):

- No Charge - No cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Please use *Not Applicable* for copayment if a coinsurance is charged.
 - No Charge after deductible - After the consumer first meets the deductible, no copayment is charged (this indicates that this benefit is subject to the deductible).
 - \$X - The consumer pays just the copay, and you pay the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). If the issuer has a cost-sharing range for the benefit scenario, enter the range with a dash in the template accordingly (Ex: "\$250-\$1000 copayments").
 - \$X Copay after deductible - after the consumer meets the deductible, the consumer is responsible only for the copay (this indicates that this benefit is subject to the deductible). If the issuer has a cost-sharing range for the benefit scenario, enter the range with a dash in the template accordingly (Ex: "\$250-\$1000 copayments after deductible").
 - \$X Copay with deductible - after the consumer pays the copay, any net remaining allowed charges accrue to the deductible (this indicates that this benefit is subject to the deductible). If the issuer has a cost-sharing range for the benefit scenario, enter the range with a dash in the template accordingly (Ex: "\$250-\$1000 copayments with deductible").
 - Not Applicable - the consumer pays only a coinsurance. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
 - Not Covered - the benefit is not covered by the plan.
- b) **Coinsurance:** If you charge an in-network coinsurance, enter the percentage the consumer will pay in this field (Ex: "10%"). If you do not charge a coinsurance, enter "Not Applicable". If the benefit is not covered, enter "Not Covered".

Please choose from the following (note that there are no dropdown boxes in this template, you will have to manually enter or paste in the response):

- No Charge - no cost sharing is charged (this indicates that this benefit is not subject to the deductible). Note: Please use *Not Applicable* for coinsurance if only a copay is charged.
- No Charge after deductible - after the consumer meets the deductible, no coinsurance is charged (this indicates that this benefit is subject to the deductible).

- X% - The consumer pays just the coinsurance, and you pay the remainder of allowed charges (this indicates that this benefit is not subject to the deductible). If the issuer has a cost-sharing range for the benefit scenario, enter the range with a dash in the template accordingly (Ex: "10-20% coinsurance").
 - X% Coinsurance after deductible - after the consumer meets the deductible, the consumer pays the coinsurance portion of allowed charges (this indicates that this benefit is subject to the deductible). If the issuer has a cost-sharing range for the benefit scenario, enter the range with a dash in the template accordingly (Ex: "10-20% coinsurance after deductible").
 - Not Applicable - the consumer only pays a copay. If both copay and coinsurance are Not Applicable, this indicates that this benefit is not subject to the deductible and no cost sharing is charged to the consumer for any services received related to this covered benefit.
 - Not Applicable - the benefit is not covered by the plan.
9. Out-of-Network Cost-Sharing: If you have products that do 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.* If you have products that do offer out-of-network benefits, please follow the same rules above for entering the cost-sharing amounts.

E. Templates and Riders/Make Available Options: The templates do not allow for the use of a separate line to account for rates relating to riders. Any additional or variations in benefits must be accounted for using a separate HIOS Plan ID (Standard Component ID). No additional HIOS Plan IDs are required for individual coverage as the Age 29 option does not apply to stand-alone dental coverage.

4. Questions

Any questions concerning the template should be submitted to the Plan Management BML at nyhxp@health.ny.gov. New York State of Health will track the questions we receive and create a FAQ document, which we will share with issuers and update as needed.