Department of Consumer & Business Services
Oregon Division of Financial Regulation - 5
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Standard Provisions for Stand Alone Dental Plan (Individual and Small Group) BINDER FILINGS

This guide is provided to assist insurers in preparing dental binder filings and is required to be submitted with your filing. These standards are summaries and review of the entire statute or rule may be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the certificate of compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed and an explanation must be provided. Not including the required information may result in disapproval of the filing.
These standards are subject to change as more information becomes available.

Insurer Name: _____ Requested Effective Date: _____

SERFF number of related form filing to plans in this binder: _____

Type of plan: ☐ Individual ☐ Small group
Only submit one binder per market type. Also, individual and small group may not be combined within the same binder filing.

These plans will be offered: ☐ Inside marketplace ☐ Outside marketplace ☐ Inside and outside marketplace

HIOS/Template issues:
If an issuer has questions specific to the HIOS system or Excel templates, contact the CMS Help Desk directly at 855-267-1515 or CMS_FEPS@cms.hhs.gov.

Required documents and information to be included in this dental binder filing	Check answer
Associate Schedule Items tab:	
All relevant rate (individual only), form, and endorsement filings must be referenced, complete with SERFF Tracking Number, Form Name, and Form Number.	Confirmed ☐
The product standards from the form filing must also be associated.	Confirmed ☐

Required documents and information to be included in this dental binder filing		Check answer
Templates tab:		
Download the latest versions of any of the templates mentioned below at : https://www.qhpcertification.cms.gov/s/Application%20Instructions		
Plan and Benefits Template	This is a federal data collection template for high-level plan information, benefit information, and cost-sharing information. For family plans with pediatric and adult coverage, carriers must enter adult information on the template.	Yes ☐ N/A ☐
Service Area Template	This is a federal data collection template which allows issuers to identify service areas by county and ZIP code. Service areas are used in combination with the Rating Engine when determining plan availability and rates. Make sure that this report matches what is entered on the Plan and Benefits Template.	Yes ☐ N/A ☐
ECP/ Network Adequacy Template	This is a federal data collection template for provider and street address information about the Essential Community providers in issuer networks and information about the provider network name and URL for display to a consumer.	Yes ☐ N/A ☐
Rate Data Template (individual only)	This is a federal data collection template which collects rate data for each plan and rating area to be offered on the marketplace. Fill out information for all rating areas the carrier is in. (For example, if a carrier offers coverage statewide, please fill out information for all seven rating areas.)	Yes ☐ N/A ☐
Rating Business Rules Template (individual only)	This is a federal data collection template for the issuer specific business rules to calculate rates based on various factors.	Yes ☐ N/A ☐
Transparency in Coverage Template (on-exchange only)	Discloses transparency reporting information to the Marketplace.	Confirmed ☐
Supporting Documentation tab:		Check answer
4980 Standard Provisions for Dental Binders	This document must be completed and submitted with your binder submission.	Confirmed ☐
Binder Cover Letter	Binder cover letter includes the following: 1. List of all plans being filed, including the plan name, issuer plan identification number, actuarial value, and whether the plan will be sold inside the marketplace only, inside and outside of the marketplace, or outside the marketplace only. 2. For previously-approved plans, a description of changes made to the plans and/or variations between proposed plans. 3. A description of differences between in-network and out-of-network cost-sharing. 4. The contact information of two contacts from your company that can discuss binder filing contents.	Yes ☐ N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐
Certificate of Compliance	Certificate of Compliance form signed and dated by the both filer and an authorized company officer.	Yes ☐ N/A ☐

Supporting Documentation tab:		Check answer
Partial County Service Area justification	If the issuer is requesting to cover a service area containing a partial county, the issuer must provide the included ZIP codes, a justification for why the entire county will not be served, and a detailed description that illustrates why the request is not discriminatory. To satisfy county integrity requirements, issuers must identify proposed service areas. In almost all situations, only service areas covering full counties will be approved.	Yes ☐ N/A ☐
Plan Relativities (individual only)	Submit the plan relativities as outlined in this form. This document should be the same Plan Relativities document as submitted in the rate filing.	Yes ☐ N/A ☐
Essential Community Provider Supplemental Response Form	For all issuers that do not qualify for the alternate standard described at 45 CFR 156.235(b). Under the alternate standard, the issuers must have a sufficient number and geographic distribution of employed providers and hospital facilities, or contracted medical group providers and hospital facilities, to ensure reasonable and timely access for low-income, medically underserved individuals in their service area.	Yes ☐ N/A ☐
Program Attestations for SBE Issuers	Applicant attests that any stand-alone dental plans offered will adhere to the standards set forth by HHS for the administration of advance payments of the premium tax credit.	Yes ☐ N/A ☐
Stand-Alone Dental Plan Actuarial Value Supporting Documentation and Justification	Complete the form as provided. We need one document for high and one document for low (or one if it covers both high and low) and has to include the following: 1. a statement that the AV was calculated as the ratio of estimated claims cost paid by the plan to allowed claims 2. an actuary certification and signature	Yes ☐ N/A ☐
Plan ID Crosswalk Template	This is a federal data collection template for insurers to map plan ID's from one year to the next.	Yes ☐ N/A ☐
Network Adequacy Template	This is a federal data collection template that QHP issuers are required to complete showing that network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible to enrollees without unreasonable delay.	Yes ☐ N/A ☐
Stand-Alone Dental Plan—Description of EHB Allocation	Complete the form as provided. Document must be signed by an actuary.	Yes ☐ N/A ☐

OTHER REQUIREMENTS, GUIDELINES, AND REFERENCES

Category	Description of review standards requirements
Covered and non-covered services	The link provides the details of the required pediatric dental services (D code list): http://dfr.oregon.gov/rates-forms/Documents/2017-pediatric-covered.pdf *(under the "Covered and Non-Covered Dental Services" section)*

Category	Reference	Description of review standards requirements	Answers
Annual or lifetime limits prohibited	PHSA 2711, 75 FR 37188, 45 CFR 147.126, 45 CFR 155.1065	No annual or lifetime dollar limits are allowed on pediatric dental essential health benefits (EHB). Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply.	Confirm ☐
Essential health benefits	ACA section 1302(b)(1)(J)	The pediatric dental essential health benefits listed in the plan are substantially equal to the benefits offered in the Oregon benchmark (CHIP) plan.	Confirm ☐
Form filing	ORS 742.005(2)	The plan benefit cost shares were within the variables approved in the form filing.	Confirm ☐
Actuarial Value	45 CFR 156.150(b)	The stand-alone dental plans must have the plan's actuarial value of coverage for pediatric dental essential health benefit certified by a member of the American Academy of Actuaries using generally accepted actuarial principals and reported to the Exchange.	Confirm ☐
Network adequacy	45 CFR 156.230	The service areas and provider networks are identified in this binder filing.	Confirm ☐
Number of plans allowed	Outside marketplace only	The Oregon Health Insurance Marketplace will certify 2020 Stand Alone Dental Plans (SADPs) offered by any licensed carriers, regardless of marketplace participation.	Confirm ☐
	Inside marketplace	Carriers may submit up to three high plans and three low plans per market for certification.	Confirm ☐
Out of pocket maximum (OOPM)	45 CFR 156.150(a)	The out-of-pocket maximum for pediatric dental essential health benefits (EHB) is $350 for one child and $700 for two or more children. Forms, benefit summaries, and the Plan and Benefits Template should accurately reflect these amounts.	Yes ☐ N/A ☐
Pediatric dental benefits	OAR 836-053-0012 (2)(c)(B) and (2)(f)	"Pediatric dental benefits" means the benefits described in the children's dental provisions of the State Children's Health Insurance Plan as set forth on the Division of Financial Regulation website. Pediatric dental benefits are payable to persons under 19 years of age.	Confirm ☐
Pediatric dental benefits	OAR 836-053-0012 (2)(D)(f)	Issuer covers pediatric benefits through the end of the month the child turns 19 or longer.	Confirm ☐
Provider non-discrimination	PHSA 2706	Benefits do not discriminate against providers based on provider type.	Confirm ☐
Stand alone dental plans	45 CFR 155.1065	Requires all marketplace stand-alone dental plans to cover the pediatric dental EHB.	Yes ☐ N/A ☐