DEPARTMENT OF Managed Health Care

2025 CHECKLIST AND ATTACHMENT FOR QUALIFIED DENTAL PLANS ON THE CALIFORNIA HEALTH BENEFIT EXCHANGE

In anticipation of Qualified Dental Plans (QDP) filings in relation to the Qualified Dental Plan Certification Application for Plan Year 2025, for Individual and Covered California for Small Business (CCSB) issued by the California Health Benefit Exchange (Exchange or Covered California), the Department of Managed Health Care (Department) offers the following checklist with some helpful hints to expedite approval based on previous experience working with Covered California and QDP filings. The checklist takes into account the Knox-Keene Act (Act or Sections) and implementing regulations at California Health & Safety Code Sections 1351 and 1352, and California Code of Regulations (Rules) Sections 1300.51 and 1300.52.

This checklist is not intended to be all-inclusive. Additional information, as needed, may be requested by the Department within the course of review. This checklist applies both to (1) dental plans that contract directly with Covered California to offer standalone dental products and (2) dental plans that contract with Full Service Qualified Health Plans (QHP) to offer pediatric dental essential health benefits (embedded). ***Information specific to only standalone or embedded filings is noted in brackets throughout the checklist.***

I. This checklist is provided to the plan's e-Filing designated contact and is available on the Department's website.

II. **Filing Timeframes**

Prior to Covered California certification, plans must have regulatory approval from the Department of necessary filings including, but not limited to, networks[1] and products. **To ensure adequate time for the Department's review, the filing due date is earlier than Covered California application deadline.**

Plan Year 2025	**New Applicant; QDP Proposing New Line of Business**	**Recertification**
All Other Exhibits as Necessary	No later than March 1	No later than April 1
Product Designs	No later than March 1	No later than April 1

[1] For Networks filing requirements and timeframes, please see the 2025 Networks Checklist and Worksheet for Qualified Health Plans and Qualified Dental Plans in the California Health Benefit Exchange on the Department's website.

III. General Filing Information

A. For dental plans licensed pursuant to the Act, the Department has primary responsibility for regulatory review and issuing preliminary recommendations with respect to certain selection criteria identified by Covered California. The Department will evaluate whether an applicant is in "good standing," in addition to applying the minimum licensure requirements.

B. Filing Process: Prepare and submit an Amendment or Material Modification,[2] addressing compliance with the Act, Rules, California Patient Protection and Affordable Care Act (CA-ACA) and Federal Patient Protection and Affordable Care Act of 2010 (ACA) laws and regulations relative to QDP certification.

1. When submitting your filing, please:

   a. **Use the subject title "HBEX QDP Application 2025"**

   b. **Select "QDP" under "Product & Issues - Issues" in the e-Filing system.** This selection will allow the Department to effectively track QDP-related filings.

C. File standalone dental benefits and embedded pediatric dental benefits as separate filings from each other.

D. ***[Embedded Filings]*** File contractual relationships (plan-to-plan agreements) with QHP(s) for embedded Essential Health Benefits (EHB) pediatric dental benefits separately from the plan's benefits filing(s).[3]

E. Network Filings for embedded EHBs and standalone products are to be filed separately from the plan's QDP Benefits Filing(s). In both the QDP Benefits Filing(s) Exhibit E-1(s) and the Network Filing Exhibit E-1(s), cross-reference both the QDP Benefits Filing Number(s) and the Network Filing Number(s). **Note**: No Network issues will be reviewed in the Plan's Benefit Filing(s). Please file the narrative of the Network(s) used on-exchange, any 10% change updates and relevant Network affirmations in the Plan's separate Network filing.[4] In the QDP benefit filing, please only include the Filing Number of the Network Filing(s).

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[2] If the QDP is revising its products such that the revisions result in a new "product," please submit the product revision as a Material Modification, pursuant to Sections 1351 and 1352.
[3] For additional information regarding QHP filing requirements, please see the 2025 Qualified Health Plan Filing Checklist on the Department's website.
[4] Please see the 2025 Networks Checklist and Worksheet for Qualified Health Plans and Qualified Dental Plans in the California Health Benefit Exchange on the Department's website.

IV. **Helpful Hints Based on the Department's Review of Plan Year 2024**

A. Naming Convention: Please refer back to Covered California's naming convention for on-exchange plans and off-exchange mirror products pursuant to Government Code section 100503(f).

B. Benchmark Plan: The pediatric dental Benchmark Plan is the 2014 Medi-Cal Dental Program.[5]

1. The Benchmark Plan is the same plan used for Plan Years 2017 through 2024.

2. The Benchmark Plan (based on the 2014 Medi-Cal Program) uses *outdated* CDT codes. Covered California's Standard Benefit Design (SBD) for Plan Year 2025 reflects the most recent CDT codes. Please utilize the SBD provided by Covered California for Plan Year 2025.

3. If you need a copy of the Benchmark Plan, please reach out to your OPL assigned reviewer as soon as possible.

V. **Exhibit E-1**[6] Please include the following information in the narrative:

A. Explain the types of products the plan intends to offer in 2025. The options for products on the 2025 Exchange are: Individual Family, Individual Child-only, CCSB Family, or CCSB Child-Only.

B. State if any of the products offered in 2025 are new for the plan.

C. Specify the regions, by regional number or county, where each identified product will be offered for 2024, highlighting any new region for 2025.

D. ***[Embedded Filings]*** Identify the full service plan to which this filing pertains[7] and provide a brief explanation of the nature of the contractual relationship, including:

1. Explanation of the type of contractual relationship (i.e., renting/leasing (no financial risk) of the network through a provider contract or an ASA or through a plan-to-plan (risk arrangement) contract.

[5] Senate Bill 43 (Hernandez) modified Section 1367.005(a)(5) in 2015.
[6] Pursuant to Sections 1351 and 1352, the Exhibits and information listed in Section V-Section VIII may need to be included in the Plan's QDP Filing. If applicable, please file.
[7] QDPs should file a separate QDP benefit filing for each full service plan it contracts with.

a. Explain whether this is a new or previously approved contractual relationship. If previously approved, provide the filing number.

b. If the plan-to-plan agreement will be revised or updated (e.g., to include the Plan Year 2025 benefits) file the plan-to-plan agreement(s) in a separate filing and cross-reference the QDP benefits Filing Number.

2. Explain any functions (i.e., utilization management, grievances and appeals, etc.) the plan will perform in whole or in part, on behalf of the QHP.

a. Further, if the QDP itself is not performing functions delegated by the QHP, but rather the QDP further delegates performance, identify the entity actually performing the delegated function and the filing number where the Department previously approved the arrangement.

E. Identify the type of product(s) to which the filing pertains.

1. Examples of types of products are: HMO, PPO, POS, EPO

2. ***[Embedded Filings]*** In the Exhibit E-1, provide an affirmation that the plan is licensed for the type of product utilized for the QHP filing. *See* Affirmation Section below.

a. For example, if the QHP is offering an EPO product, affirm the QDP is licensed to offer an EPO product in the proposed service area.

b. If the plan cannot affirm (e.g., the Plan is not licensed for the type of product utilized in the QHP filing), describe the contractual relationship that allows the Plan to offer embedded dental products for the full-service plan. For example, if the QHP is offering a group PPO product, explain how the Plan can offer embedded dental products if the QDP is only licensed to offer an HMO product.

3. Note: File any network revisions in a separate Amendment or Material Modification, as required under the Act based on the change. *See* Section III(e) and the 2054 Networks Filing Checklist and Worksheet for QHP & QDP Plans (available on the Department's website).

F. Confirm the plan has made all necessary changes to its EOC and other documents to ensure compliance with applicable legislative updates.[8] Provide the relevant filing number(s).

G. Evidence of Coverage (EOC): Provide the filing number for the EOC previously approved for use on the Exchange and explain whether the plan is making any changes.

1. Identify any changes to the EOC by page and section number(s). *See* Exhibit S, T, U Section for more information. File any changes.

2. ***[Embedded Filings]*** If the information on dental benefits is contained within the full service EOC (rather than through an attachment or addendum) file the portions of the EOC containing the dental information in the separate embedded filing.

H. Schedule of Benefits (SOB): Provide the filing number of the previously approved SOB. Identify any redlined changes made to the SOB previously approved for use on the Exchange by page and section number(s).

1. Please note, changes are anticipated to a plan's previously approved 2024 SOB, because Covered California modeled its 2025 SBD on CDT-2024 by the American Dental Association and the 2024 SOB is based on the CDT-2023. *See* Exhibit S, T, U Section for more information.

2. CDT codes: Covered California will base its SBD on the 2024 CDT codes in effect at the time of its Board approval (typically March) and will not require updates to the CDT codes when the American Dental Association releases its new and revised codes for 2025 (usually May/June). SOBs should mirror the CDT codes contained in Covered California's SBD for 2025.

3. ***[Embedded Filings]*** If the information on dental benefits is contained within the full service SOB (rather than through an attachment or addendum) file the portions of the SOB containing the dental information in the separate embedded filing.

I. Endnotes:

1. Endnotes are not required to be duplicated word for word. However, the information contained in the SBD endnotes needs to be substantially similar and easily understandable for the plan's enrollees.

[8] Please refer to the All Plan Letter (APL) 23-025.

2. Provide the exhibit, page(s) and section number(s) in the SOB where the Covered California SBD endnotes are located within the QDP filing.

3. ***[Embedded Filings]*** Provide the page(s) and section(s) where the Covered California SBD endnotes are located within the QDP SOB or QHP SOB. *See* Exhibit S, T, U Sections for more information.

J. Describe any changes to the plan's organizational charts, administrative capacity, delegation of functions, utilization management, quality assurance system, provider contracts, marketing, broker/solicitor agreements, fiscal solvency and/or grievance and appeals process regarding Covered California filings. Note the page and section number where the changes were made and file the applicable exhibit(s). Provide the filing number(s) of previously approved exhibits.

K. Confidentiality: Note whether the plan will be applying for confidential treatment of any exhibits. If applicable, file a Request for Confidentiality and comply with Rule 1007.

L. Affirmation Section:

1. Please file the affirmation section within the plan's Exhibit E-1.

2. For any differences from the Benchmark Plan for an SBD product in a) CDT codes, b) limitations and exclusions and/or c) endnotes, please include an affirmation that the differences led the plan to offer a benefit that is identical or better than the benefits provided in the Benchmark Plan.

    a. The Department will accept a general affirmation from the plan (versus an affirmation per CDT code or per limitation or per endnote).

    b. If the Department identifies additional revisions needed to the plan's a) CDT codes, b) limitations and exclusions and/or c) endnotes, during the course of the Department's review, the plan may need to provide a specific affirmation per a) CDT code, b) limitation and exclusion, and/or c) endnote.

    c. During the course of the Department's review, the Department may need to ask follow up comments regarding the plan's a) CDT codes, b) limitations and exclusions and/or c) endnotes in addition to the Plan's affirmation.

3. Please affirm the QDP has filed the Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC) pursuant to Section 1363.04. Please see Section VI for additional requirements. If QDP

has not filed, refer to Section VI. Note: The SDBC Matrix will need approval prior to the Covered California filing deadline.

4. ***[Embedded Filings]*** Only one EOC and one SOB for each filing type (i.e., HMO, PPO, and/or EPO) that is an SBD are required to be filed for embedded filings. If the product is an SBD, affirm the filed EOC and SOB will apply to all metal levels. If the product filed is for a non-SBD, e.g., an alternative, file all alternative EOCs and SOBs.

5. Affirm any anticipated change in the plan's enrollment for its Covered California products is less than 5% of the plan's total enrollment and would not have a material impact on the plan's financial position. Note: If the plan's anticipated enrollment is 5% or greater or the change in enrollment would have a material impact on the plan's financial position, the plan must submit as Exhibit HH two (2) years of financial projections and as Exhibit CC (Individual Contracts) and/or Exhibit DD (Group Contracts) two (2) years of enrollment projections. The first year of projections should be prepared on a monthly basis and the second year on a quarterly basis.

VI. **Summary of Dental Benefits and Coverage Disclosure Matrix (SDBC)**

A. ***[Standalone Filings]*** Pursuant to Rule 1300.63.4 of title 28 of the California Code of Regulations, which implements Health and Safety Code Section 1363.04, QDPs that offer standalone dental products must have on file an approved SDBC template that encompasses the QDP's stand-alone on-exchange product(s).

1. In the Exhibit E-1 for the QDP's standalone product, furnish the filing number(s) for the plan's most recently approved SDBC representative template(s) pursuant to APL 22-023 and affirm the plan's on-exchange standalone products benefit designs are within the approved ranges.

2. If the QDP's on-exchange standalone product benefit designs are not within the previously-approved ranges, file a revised SDBC template within the Covered CA QDP filing. The QDP must have an approved SDBC template on file contemporaneous with approval of the QDP's EOC for Covered California.

VII. **Product Design Exhibits: Exhibits S, T, U:**

A. New and revised product designs must be filed (e.g., cost-sharing, EOCs, etc.). All QDPs must comply with Covered California's SBDs and Covered California's naming convention pursuant to Government Code Section 100503(f) (if applicable).

B. ***[Embedded Filings]*** General Instructions:

1. If the plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are filed in a separate addendum from the contracted QHP, file only one addendum for each filing type (i.e., HMO, PPO, EPO, Catastrophic and AI/AN)[9] and include the affirmation that the filed SBD dental benefits will apply to all metal levels. *See* Affirmation Section above.

    a. For example, if the QDP has six HMO benefit designs and three PPO benefit designs, the QDP will only need to file four EOCs: 1) one for the HMO benefit designs, (2) one for the PPO benefit designs, (3) one for the AI/AN benefits, and (4) one for catastrophic benefits.

    b. If the QHP full-service plan is utilizing alternative benefits, the QDP should also file all alternative EOCs and SOBs and affirm the dental benefits will apply to all designs. *See* Affirmation Section(V)(L)(4) above.

2. If the plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are listed within a QHP's EOC (not a separate addendum), follow all instructions for embedded filings and additionally file an affirmation in the plan's QDP Exhibit E-1, stating that the dental benefits (EOC, limitations and exclusions, SOB, and endnotes) are identical across all metal levels for each filing type (HMO, PPO, EPO). *See* Affirmation Section above.

    a. If the plan's SBD dental benefits (EOC, CDT Codes, limitations and exclusions, SOB, and endnotes) are not identical across all metal levels per product, please contact your assigned OPL reviewer.

3. If the QDP SBD dental benefits are embedded in a QHP in two or more markets (Individual Family, CSSB Family, or CSSB Child-Only), file an affirmation for each market. *See* Affirmation Section above.

[9] Alaska Native/American Indian.

4. If the dental benefits (EOC, CDT codes, limitations and exclusions, SOB, and endnotes) are not SBD, but rather an alternative benefit design, please contact your assigned OPL reviewer.

C. Evidence of Coverage (EOC) or combined EOC and Disclosure Form (Exhibit T or U): Please ensure all EOCs have been revised for consistency with new legislation or regulations effective on or after January 1, 2024, including but not limited to AB 1048 (if applicable). See APL 23-025.

D. Schedule of Benefits (SOB) (Exhibit S, T, or U)

1. Copayment: For efficiency and review of the Copay SOB, the Department recommends the plan follow the same order and text of CDT codes as listed in the 2025 Covered California Dental SBD. Plans are not required to include CDT codes listed as "not covered" in the SBD for pediatric benefits.

2. Coinsurance: Plans are not required to file the list of CDT codes with associated text. However, following the SOB's CDT list and text, and inserting the plan's coinsurance amounts will expedite review. Plans must follow the Covered CA cost share listed in the SBD.

3. CDT codes: Plans must affirm the CDT codes have the identical or better effect than the Benchmark Plan. *See* Affirmation Section, above.

4. Include the top portion of the Covered California SBD matrix (i.e., waiting periods, out of pocket max, etc.) at the top of the plan's SOB.

5. ***[Embedded Filings]*** File a separate SOB for AI/AN benefit and catastrophic benefit. Rather than file separate SOBs for each metal level of AI/AN benefits, please affirm in the Exhibit E-1 that the AI/AN benefits and cost-share are identical across all metal levels. The eligibility section and explanation of the cost share for these two benefit designs should be contained in the full service health plan disclosure documents. Please work with your contracting full service plan to ensure this eligibility and cost sharing information is disclosed to the enrollees.

6. Limitations and Exclusions: Please ensure the QDP's limitations and exclusions mirror the Benchmark Plan.

    a. If the plan's limitations and exclusions deviate from the Benchmark Plan, to ensure compliance with the Act, the plan must affirm the limitations and exclusions have an identical

or better effect upon the enrollee's coverage than the Benchmark Plan. *See* Affirmation Section above.

b. The format in the Benchmark Plan lists the limitations and exclusions by CDT codes.

c. For each limitation and exclusion, include the corresponding CDT code.

i. If the plan wishes to not include the CDT codes in its published documents, include the corresponding CDT code in parentheses or brackets for Departmental review. Plans may choose to remove the corresponding CDT codes prior to printing Plan documents.

ii. Many plans have chosen to add the limitations and exclusions to the copay schedule by developing a chart. *See* Attachment.

iii. If the plan chooses not to utilize a limitation and exclusion chart, but instead lists the limitations and exclusions per service in another format, the plan will still need to include the corresponding CDT codes for Departmental review.

7. Endnotes: Incorporate the endnotes provided by Covered California into the plan's SOB.

a. Endnotes do not need to be word for word, but in order to be in compliance with the Act, the plan must affirm the plan's endnotes have an identical or a better effect for the enrollee's coverage as Covered California's endnotes. *See* above.

VIII. **Other Relevant Exhibits:** These exhibits may be required to be filed or revised. The plan is not required to file these exhibits unless changes have been made to the previously approved documents utilized by the plan for its Covered California filings.

A. ***[Standalone Filings]*** Exhibit I-9: Please file the Renewal Notice using the Covered CA Template.

B. ***[Standalone Filings]*** Exhibit FF-4: *See* Actuarial Value Verification Section below.

C. Exhibit H and Exhibit I: File in the separate Network Filing, if required by the 2025 Networks Checklist and Worksheet for Qualified Health Plans and Qualified Dental Plans in the California Health Benefit Exchange.

D. ***[Embedded Filings]*** Exhibit N-1 or P-5: Administrative service agreements (ASA) for administrative services or plan-to-plan agreements related to Covered California products. If there is no change to the previously approved contracts, please indicate that in Exhibit E-1. Provide the filing number(s) for the previously approved ASA or plan-to-plan contract. If there are changes to the Exhibit N-1 or P-5, please file in a separate filing referencing the benefit filing.

1. ***[Embedded Filings]*** File as an Exhibit P-5 plan-to-plan contract where the dental plan is at financial risk.

2. ***[Embedded Filings]*** File as an Exhibit N-1 administrative services contract when the dental plan is not at financial risk, i.e., renting the network.

E. Exhibit P and Exhibit Q: individual or group dental plan contracts. ***[Embedded Filings]*** Dental plans that contract with QHPs to offer EHB dental benefits should work with their QHP regarding the separate Off-Exchange mirror filing.[10]

F. ***[Embedded Filings]*** Summary of Benefits and Coverage (SBC): The Individual Silver SBC will be filed in the QHP Filing. Do not file the SBC in the dental filing.

IX. Actuarial Value Verification:

A. ***[Standalone Filings]*** Actuarial Value Calculation Exhibit FF-4: Please file the following documents as Exhibit FF-4.

1. Actuarial Value Supporting Documentation & Justification: Pursuant to 45 CFR § 156.150(b)(2), a certification of the calculation of the actuarial value of coverage for pediatric dental essential health benefits provided by a member of the American Academy of Actuaries using generally accepted actuarial principles.

2. Description of EHB Allocation: Pursuant to 45 CFR § 156.470, the dollar allocation of the expected premium for the plan as performed

[10] For additional information regarding QHP off-exchange mirrored filing requirements, please see the Plan Year 2025 Checklist for Non-Grandfathered Individual and Small Group Market Product(s) Off of the California Health Benefits Exchange.

by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies to:

a. The pediatric dental essential health benefit, and

b. Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit.

2025 ATTACHMENT FOR QUALIFIED DENTAL PLANS IN THE CALIFORNIA HEALTH BENEFIT EXCHANGE

CDT Code	Description	Pediatric Copay	Adult Copay	Limitation/Exclusion for Pediatric enrollee
*D0120**	*Periodic Oral Evaluation – established patient*	*No cost*	*No Cost*	*1 in 6 months per dentist*
	Repeat as necessary			

**example*