

Form Filing Review Checklist
GROUP STAND-ALONE DENTAL PLAN ORGANIZATIONS

NOTICE: This checklist must be completed in its entirety and submitted with each group dental plan organization product. The failure to submit a completed checklist will result in a delay of the review of the submission, and may result in the rejection of the filing.

This document is intended to assist carriers in preparing form filings for approval by the Bureau of Insurance. It provides guidance based on current Virginia laws and regulations. It should be noted, however, that this checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products and plans comply with all relevant statutory and regulatory requirements. Note that some regulatory references in the comments column are approximate. Please review the applicable citation for the full text of the requirement.

The Life and Health Division, Forms Section will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9110 if you have questions or need additional information about these requirements.

Company Name:			
Product Name:		SERFF Tracking Number:	
Plan:		Submission Includes Plans Intended for:	
		<input type="checkbox"/>	Inside the Exchange
		<input type="checkbox"/>	Outside the Exchange; Exchange-certified
		<input type="checkbox"/>	Outside the Exchange; not Exchange-certified
		<input type="checkbox"/>	Inside and Outside the Exchange

Review Requirements	Reference	Comments
The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified		
<input type="checkbox"/> Minimum actuarial value <input type="checkbox"/> Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit at either: <input type="checkbox"/> A low level of coverage with an AV of 70 percent; or <input type="checkbox"/> A high level of coverage with an AV of 85 percent; and <input type="checkbox"/> Within a de minimis variation of +/-2 percentage points. <input type="checkbox"/> The level of coverage must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.	45 CFR § 156.150(b) § 38.2-326	

Group Stand-Alone Dental Plan Organizations
June 2013
Updated March, 2016

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REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
General Filing Requirements			
	14 VAC 5-100-40 1	Each form submitted must have a number which may consist of digits, letters or a combination of both. The number must distinguish the form from all other forms used by the insurer.	
	14 VAC 5-100-40 3	Certification of Compliance signed by General Counsel or officer of company or attorney or actuary representing company is required.	
	14 VAC 5-100-40 5	Description of market for which the form is intended.	
Form Number	14 VAC 5-100-50 1	Form number must appear in lower left-hand corner of first page of each form.	
Company Name and Address	14 VAC 5-100-50 2	Full and proper corporate name (including "Inc." or "The") must prominently appear on cover sheet of all policies and other forms. Home office address of insurer must prominently appear on each policy.	
Final Form	14 VAC 5-100-50 3	Form must be submitted in the final form in which it will be issued and completed in "John Doe" fashion to indicate its intended use.	
Application	14 VAC 5-100-50 4	Any form, which is to be issued with an attached application, must be filed with a copy of the application completed in "John Doe" fashion to indicate its intended use. (If application was previously approved, provide SERFF tracking number or copy with approval date.)	
Type Size	14 VAC 5-100-50 5	Group Accident and Sickness forms must be printed with type size of at least eight-point type.	
Table of Contents	14 VAC 5-110-50	Required for policy of more than 3 pages (does not apply to groups with more than 10 members).	
Readability Certification	14 VAC 5-110-60	Disclose the score, number of words, sentences, and syllables for each form (does not apply to groups with more than 10 members).	
Additional SERFF Filing Requirements	<i>Administrative Letter 2012-03</i>	<i>Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings. Failure to provide the applicable information may result in a "REJECTED" filing.</i>	
General Information – Filing Description		(i) Description of each form by name, title, edition date, and intended use.	
		(ii) Identification of changes in benefits and premiums (previously approved or filed forms). [Place changed contract provisions (red-lined or highlighted) in Supporting Documentation].	
		(iii) Identification of SERFF or state tracking number for the previously approved or filed form for which the new form revises, replaces, or is intended to be used.	

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		(iv) A statement as to whether any other regulatory body has withdrawn approval of the form because the form contains one or more provisions that were deemed to be misleading, deceptive or contrary to public policy.	
<i>MCHIP Requirements</i>			
		Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, this filing must include the following: 1. A detailed description of the criteria used to determine how a provider is included in the network or allocated to a tier within the network. 2. An explanation of whether or not the network change or tiered network will result in any material change in the method of operation that is currently on file with the Financial Regulation Division. Pursuant to Administrative Letter 1998-11, any change that increases or decreases, or is likely to increase or decrease a health carrier's revenues, expenses, or net worth in an amount that exceeds 5% of the health carrier's current net worth qualifies as a material change that must receive prior approval from the Financial Regulation Division. 3. A response as to whether or not the Virginia Department of Health (VDH) has determined that the network is adequate.	
Provider Lists	§ 38.2-5803 A 1	List of providers and their locations shall be available to the enrollee. If an electronic version is made available, the coverage document must include a direct workable URL so that the insured can access the specific provider directory applicable to that particular plan. The insured must not be required to log in to access this information, and must be provided all information necessary to determine the applicable provider network.	
Service Area	§ 38.2-5803 A 2	Description of service area or areas shall be described in the policy.	
Complaints	§ 38.2-5803 A 3	Description of method of resolving complaints.	
Bureau of Insurance and Department of Health Notice	§ 38.2-5803 A 4	Each EOC shall contain a notice: "This Company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1."	

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Ombudsman Notice	§ 38.2-5803 A 5	A prominent notice in the EOC stating: "If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided which have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance." Such notice must also include the toll free telephone number, mailing address and electronic mailing address of the Office of the Managed Care Ombudsman.	
General Policy Provisions			
Table of Contents	14 VAC 5-110-50	Required for policy of more than 3 pages does not apply to groups with 10 or fewer members.	
Contents of Policy	§ 38.2-305 A & B	Each policy shall specify: (1) names of parties to contract, (2) subject of insurance, (3) risk insured against, (4) time the insurance takes effect and period during which insurance is to continue, (5) conditions pertaining to insurance. Policy must also contain an important notice regarding who to contact with questions.	
Limiting Jurisdiction Prohibited	§ 38.2-312 2	Contract shall not deprive courts of Virginia jurisdiction in actions against insurer.	
Insurance Fraud Notice Not Applicable	§ 38.2-316 D 1	Any notice citing Code of Virginia § 52-40 defining insurance fraud and penalties associated with this section must be removed. This section does not apply to accident and sickness insurance.	
Subrogation	§ 38.2-3405 A	Policy cannot allow subrogation of any person's right to recovery for personal injuries from a third party.	
COB/Liability Insurance Prohibited	§ 38.2-3405 B	No plan shall require beneficiary to pay back any benefits from the proceeds of a recovery by such beneficiary from any other source. This provision shall not prohibit an exclusion of benefits paid under workers' compensation laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.	
Workers' Compensation	§ 38.2-3405 D	Under specified circumstances, issuers shall not exclude coverage from any medical condition whenever benefits payable under workers' compensation are excluded from coverage.	
Incontestability	§ 38.2-3528	The provision defines the incontestability period.	
Entire Contract	§ 38.2-3529	The provision defines the contents of the entire contract.	
Misstatement of Age	§ 38.2-3532	Each policy shall contain a provision that an equitable adjustment of premiums, benefits, or both, shall be made if the age of a person insured has been misstated.	
Notice of Claim	§ 38.2-3534	Each policy shall contain a provision that written notice of a claim shall be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy.	
Claim Forms	§ 38.2-3535	Each policy shall contain a provision that the insurer shall furnish forms for filing proof of loss within 15 days after the insurer has received notice of any claim.	

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Proof of Loss	§ 38.2-3536	Each policy shall contain a provision that written proof of loss shall be furnished to the insurer within 90 days after the date of loss.	
Time of Payment of Claims	§ 38.2-3537	The provision specifies when benefits will be paid.	
Payment of Claims	§ 38.2-3538	The provision specifies to whom benefits will be paid.	
Physical Examinations and Autopsy	§ 38.2-3539	The provision must specify "while a claim is pending."	
Legal Actions	§ 38.2-3540	Each policy shall contain a provision that the no action at law or in equity shall be brought to recover on a policy within 60 days after proof of loss has been filed in accordance with policy requirements and that no such action shall be brought after the expiration of 3 years from the time that proof of loss was required to be filed.	
Continuation	§ 38.2-3541	Each policy shall contain a provision that provides for continuation of insurance.	
<i>DPO Contract Provisions</i>			
	§ 38.2-6105 A 1	Effective date of contract	
	§ 38.2-6105 A 2	Subscription fees/premiums	
	§ 38.2-6105 A 3	Grace period provision	
	§ 38.2-6105 A 4	Eligibility requirements/effective date for subscribers and dependents (group)	
	§ 38.2-6105 A 5	Description of benefits	
	§ 38.2-6105 A 6	Description of copays/deductibles/fixed indemnity benefits	
	§ 38.2-6105 A 7	Description of service area	
	§ 38.2-6105 A 8	Emergency out-of-area benefits	
	§ 38.2-6105 A 9	Referral to non-plan specialist	
	§ 38.2-6105 A 10	Plan dentist unable to render care provision	
	§ 38.2-6105 A 11	Termination terms	
	§ 38.2-6105 A 12	Grievance procedure (20 days)	
	§ 38.2-6105 B 1	Extension of benefits/treatment in process	
	§ 38.2-6105 B 2	Extension of benefits/completion of procedure	
	§ 38.2-6105 B 3	Extension of benefits/orthodontia (60 days)	
	§ 38.2-6105 B 4	Extension of benefits not required for nonpayment of premium	
	§ 38.2-6107	31 day grace period	
<i>Optional DPO Provisions</i>			
	§ 38.2-6106 1	Missed appointment fee	
	§ 38.2-6106 2 a	Premium increases with 60 days notice	
	§ 38.2-6106 2 b (1)	Individual contract rates not changed for at least 12 months	
	§ 38.2-6106 2 b (2)	Group contract rates in effect for at least 12 months	
	§ 38.2-6106 3	Financial penalty for withdrawal prior to 12 months	

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	§ 38.2-6106 3 a	No penalty for withdrawal after 12 months	
	§ 38.2-6106 3 b	Penalty may not exceed reasonable & customary for services received	
	§ 38.2-6106 4	Increase of patient charge schedule	
	§ 38.2-6106 4 a	Patient charge schedule must be in effect for at least 12 months	
	§ 38.2-6106 4 b	Written notice to contract holder of increase at least 60 days before increase effective date	
	§ 38.2-6106 5	Refusal to follow recommended course of treatment	
	§ 38.2-6106 6	Fraudulent use of ID card	
	§ 38.2-6106 7	Termination for unsatisfactory dentist-patient relationship	
	§ 38.2-6106 7 a	Plan must permit change of primary dentist	
	§ 38.2-6106 7 b	Written notice to enrollee at least 30 days prior to termination	
	§ 38.2-6106 8	Handicapped dependent child provision	
The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified			
Provides Essential Health Benefits (Pediatric Dental Services) – Form reviewer: complete EHB form review and EHB Review Process Steps	PHSA §2707 § 38.2-326	Exchange-certified stand-alone dental plans are required to provide coverage for pediatric dental essential health benefits.	
Special enrollment period	45 CFR §155.420 45 CFR §156.260 § 38.2-326	Qualified individuals must be able to enroll in or change plans in the Exchange during special enrollment periods.	
Open enrollment period(s) required	45CFR §155.410 45 CFR §156.260 § 38.2-326	Enrollment period for plans inside the Exchange is set by the Exchange. Outside the Exchange, issuers may determine the number and length of open enrollment periods, unless otherwise set according to state law.	
Annual Limitation on Cost Sharing	45 CFR § 156.150(a) § 38.2-326	A stand-alone dental plan covering the pediatric dental EHB must demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services. For the 2017 coverage year in the FFM, the annual limit on cost-sharing remains unchanged at \$350 for one covered child and \$700 for two or more covered	

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		children.	
No lifetime limits on the dollar value of Essential Health Benefits (EHB)	PHSA §2711 45 CFR §147.126; 45 CFR §155.1065(a)(2); § 38.2-326	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB.	
No annual limits on the dollar value of EHB	PHSA §2711 45 CFR §147.126; 45 CFR §155.1065(a)(2); § 38.2-326	If there are maximum dollar limits, they must not be for benefits within one of the EHB categories.	

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ESSENTIAL HEALTH BENEFITS CATEGORY	BENCHMARK BENEFIT LIMITS	COMMENTS	PAGE NO.
The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified	Pediatric services – must be covered until at least the end of the month the enrollee turns age 19		
A. Preventive and Diagnostic Dental Care			
1. Oral Exams	One routine oral evaluation per 6 months, beginning with the eruption of the first tooth		
2. X-rays			
3. Diagnostic casts			
B. Basic Dental Care			
1. Cleanings	Once every 6 months		
2. Topical Fluoride Treatments	Once every 6 months		
3. Sealants	One per lifetime per tooth		
4. Space maintainers	One per 2 years per quadrant (unilateral), per arch (bilateral)		
C. Restorative Dental Care			
1. Fillings	One per tooth per surface per year		
2. Porcelain/ceramic onlay	One per tooth per 5 years		
3. Crowns	One per tooth per 5 years		
4. Protective restorations			
5. Veneers	One per tooth per 5 years		
6. Temporary crowns			
D. Major Dental Care			
1. Endodontic services	One per tooth per lifetime		
a. Pulp caps, pulpotomy, pulpal therapy, pulpal debridement and pulpal regeneration			
b. Endodontic therapy, retreatment of previous root canal	One per tooth per lifetime		
c. Apicoectomy/periradicular surgery, retrograde filling	One per tooth per lifetime		
2. Periodontal services			
a. Gingivectomy or gingivoplasty	One per two years per quadrant		
b. Scaling and root planing	One per two years per quadrant		

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c. Full mouth debridement	One per year		
d. Osseous surgery	One per five years per quadrant		
e. Provision Splinting			
f. Grafting			
3. Removable prosthodontics	One per five years		
a. Adjust, repair			
b. Reline denture	One per tooth per two years		
c. Tissue conditioning			
4. Maxillofacial prosthetics (feeding aid)			
5. Fixed prosthodontics – Pontic, retainer, crown	One per tooth per 5 years		
E. Oral and Maxillofacial Surgery			
1. Local anesthesia			
2. Extractions			
3. Tooth reimplantation and/or stabilization due to accident			
4. Biopsy			
5. Alveoplasty	One per quadrant per lifetime		
6. Removal of cysts, tumors, and growths			
7. Drainage of abscess			
8. Occlusal orthotic device for TMJ			
9. Frenulectomy/Frenuloplasty	One per lifetime		
F. Medically Necessary Orthodontia			
1. Comprehensive orthodontia	One per lifetime		
2. Removable appliance therapy (includes appliances for thumb sucking and tongue thrusting)			
3. Fixed appliance therapy (includes appliances for thumb sucking and tongue thrusting)	One per lifetime		
4. Replacement of lost or broken retainer			
G. Adjunctive Services			
1. Palliative (emergency pain) treatment			
2. Anesthesia/sedation			
3. Occlusal guard (for grinding and clenching of teeth)			