

Form Filing Review Checklist
INDIVIDUAL AND GROUP HMO STAND-ALONE DENTAL PLAN

NOTICE: This checklist must be completed in its entirety and submitted with each individual and group HMO dental plan 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	

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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	Individual Accident and Sickness forms must be printed with type size of at least ten-point type. Group Accident and Sickness forms must be printed with a type size of at least eight-point type.	
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.	
		(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.	

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<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.	
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."	
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.	
<i>General Policy Provisions</i>			
Contents of Policy/Important Notice	§ 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) a statement of premium, except in the case of group insurance, (6) conditions pertaining to insurance. Policy must also contain an important notice regarding who to contact with questions.	

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INDIVIDUAL AND GROUP HMO STAND-ALONE DENTAL PLAN

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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.	
Claims Paid to Insureds For Services from Nonpar. Provider	§ 38.2-3407.13:2	When an HMO follows a policy of sending payment to enrollee, the certificate and explanation of benefit must include notice for the enrollees, when services are performed by a non-participating provider, informing the enrollee of his or her responsibility to apply the plan payment to the claim from such non-participating provider.	
Adopted Children	§ 38.2-3411.2	An adopted child shall be eligible for coverage from the date of adoptive or parental placement with insured for the purpose of adoption.	
Renewability (Individual)	§ 38.2-3514.2	HMOs cannot refuse to renew individual plan, except for 5 reasons listed in this section. Renewal is at the option of the enrollee.	
Cancellation by Insured (Individual)	§ 38.2-3503 13	The insured may cancel this policy at any time by written notice to the company. In the event of cancellation, the company shall promptly return the unearned premiums of any premium; the earned premiums shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.	
Termination Notice Employer	§ 38.2-3542 C	Notice must be given to employer at least 15 days prior to terminating contract due to non-payment of premiums.	
EOC Must Be Provided	§ 38.2-4306 A 1	Each subscriber shall be entitled to an Evidence of Coverage (EOC).	
Misleading Statements	§ 38.2-4306 A 3	No EOC shall contain statements that are unjust, unfair, untrue, inequitable, misleading deceptive or misrepresentative.	
Complete Statement of Benefits	§ 38.2-4306 A 4 (a)	An EOC shall contain a complete summary of health care services and other benefits the enrollee is entitled.	
States Limits and Copayments	§ 38.2-4306 A 4 (b)	An EOC shall contain any limits on services, including deductibles and copayments	
Describes Service Delivery	§ 38.2-4306 A 4 (c)	EOC must contain where and in what manner services may be obtained.	
Contributory/Non-contributory	§ 38.2-4306 A 4 (d)	EOC must state if plan is contributory or non-contributory if group plan, and premium amount for individual contracts.	
Complaint Procedures	§ 38.2-4306 A 4 (e)	EOC must contain enrollee complaint procedures.	
Provider List/Service Area	§ 38.2-4306 A 4 (f)	Provider list and service area description must be presented with EOC, if information is not given to subscriber at enrollment. Provider lists and service area description must be available on request or provided at least annually.	
Continuation of Coverage (Group Only)	14 VAC 5-211-70 A	Each policy shall contain a provision that provides for continuation of coverage.	

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COB/Liability Coverage Prohibited	14 VAC 5-211 80 A	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 worker comp. laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.	
Cost Sharing	14 VAC 5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance.	
Cost Sharing Notification	14 VAC 5-211-90 B	Plan shall keep cost sharing records, shall notify enrollee no later than 30 days after out-of-pocket maximum or cost sharing is reached, shall not charge any further cost sharing that year, and shall promptly refund any excess cost sharing paid. EOC must clearly state procedures.	
Name, Address and Telephone Number	14 VAC 5-211-210 B 1	EOC must contain name, address and telephone number of HMO.	
Effective Date and Term of Coverage	14 VAC 5-211-210 B 5	EOC must contain effective date and term of coverage.	
Arbitration	14 VAC 5-211-210 B 7	A description of the HMO's method of resolving enrollee complaints, including a description of any arbitration procedure if complaints may be resolved through a specified arbitration agreement.	
COB Provisions	14 VAC 5-211-210 B 11	EOC must contain any coordination of benefits provision	
Assignment Restrictions	14 VAC 5-211-210 B 12	EOC must contain any assignment restrictions in contract.	
Claim Filing/Proof of Loss	14 VAC 5-211-210 B 13	EOC must contain the plan's claim procedures and proof of loss requirements.	
Eligibility Requirements	14 VAC 5-211-210 B 14	Conditions under which dependents may be added, limiting age for dependents.	
Entire Contract	14 VAC 5-211-210 B 15	EOC shall contain a provision that the policy, any application of the policyowner, and any individual applications of the persons insured shall constitute the entire contract. It shall state that a copy of the application of the policyowner shall be attached to policy when issued, that all statements made by the policyowner and insureds shall be deemed representations and not warranties and that no written statement made by any person insured shall be used in any contest unless a copy of the statement is furnished to the person, his beneficiary or personal representative.	
Grace Period	14 VAC 5-211-210 B 16	EOC shall contain a provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due, except for the first premium.	
Reasons for Termination	14 VAC 5-211-230 A	Plan may not terminate member, except for listed reasons: failure to pay premiums, fraud or misrepresentation of material fact, discontinuance of group, or failure to meet group participation or contribution requirements.	
Termination Rules	14 VAC 5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated. HMO must provide 31-day notice of termination, except for non-payment of premiums and change in eligibility status.	

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Pre-Existing Conditions and Credit	§ 38.2-3514.1	Individual contracts may contain pre-existing limitations if provided as outlined in this section. Pre-existing limitations must not apply to pediatric essential health benefits for an exchange-certified stand-alone dental plan.	
Subrogation	§ 38.2-3405 A	No policy shall contain a provision regarding subrogation of any person's right to recovery for personal injuries from a third person.	
Liability Insurance	§ 38.2-3405 B	Benefits may not be reduced due to benefits payable due to benefits provided by a liability insurance contract.	
Workers' Compensation	§ 38.2-3405 D	The statute discusses exceptions to exclusions due to benefits payable under workers' compensation.	
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	45CFR §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	45 CFR §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 children.	

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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 at least until the end of the month 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		

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b. Scaling and root planing	One per two years per quadrant		
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			

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ESSENTIAL HEALTH BENEFITS CATEGORY	BENCHMARK BENEFIT LIMITS	COMMENTS	PAGE NO.
3. Occlusal guard (for grinding and clenching of teeth)			