

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

**NOTE: This checklist was developed as a resource for carriers for product design purposes. This checklist is offered to assist carriers but may be subject to change; accordingly, it is not binding on the Bureau or the federal Department of Health and Human Services. This checklist should not be used exclusive of other important resources, including, but not limited to, any and all other applicable state and federal insurance laws and associated rules and regulations. It is the responsibility of the carriers to verify that their products comply with all relevant statutory and regulatory requirements.**

**This checklist must be completed in its entirety and submitted with each individual and group HMO dental 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.**

Company Name:		
Product Name:		
Plan:		
Review Requirements	Reference	Comments
<b>The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified</b>		
<input type="checkbox"/> <b>Minimum actuarial value</b>  <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)	

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<b><i>General Filing Requirements</i></b>			
	14 VAC 5-100-40 1	Forms submitted and described in transmittal letter must have a number that consists of digits, letters, or a combination of both.	
	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.	
<b><i>Additional SERFF Filing Requirements</i></b>	<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.	
<b><i>Forms</i></b>			
Form Number	14 VAC 5-100-50 1	Form number must appear in lower left-hand corner of <b>first page</b> of each form.	
Company Name, Address and Telephone Number	14 VAC 5-100-50 2	Full and proper corporate name (including “Inc.”) 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, advise date of approval.)	
Type Size	14 VAC 5-100-50 5	Individual Accident and Sickness forms must be printed with type size of at least ten-point. Group Accident and Sickness forms must be printed with type size of at least eight-point.	
Arbitration	14 VAC 5-211-210 B	A description of arbitration procedures.	

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Fraud Notice	§ 38.2-316 D 1	Title 38.2 of the Insurance Code does not define "Insurance Fraud." Any notice regarding insurance fraud is in non-compliance with this section of the Code. Variations in a notice warning of consequences of making fraudulent statements are acceptable. The notice may disclose that it does not apply in Virginia or may disclose states where applicable.	
<b>General Provisions</b>			
Contents of Policies/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.	
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 (Group Only)	§ 38.2-3432.1	Each insurer shall renew or continue in force coverage with respect to all insureds at the option of the employer with numerous exceptions listed in this section of the Code.	
Renewability (Individual)	§ 38.2-3430.7 § 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.	
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 noncontributory 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.	

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Effective Date and Term of Coverage	14 VAC 5-211-210 B 5	EOC must contain effective date and term of coverage.	
Assignment Restrictions	14 VAC 5-211-210 B12	EOC must contain any assignment restrictions in contract.	
Claim Filing/Proof of Loss	14 VAC 5-211-210 B13	EOC must contain the plan's claim filing 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.	
Incontestability	14 VAC 5-211-210 B 15	EOC must have incontestability provision stating that in the absence of fraud, all statements made by subscriber shall be considered representation and not warranties; no statement shall void coverage or deny claims after 2 years from effective date, unless statement was material to the risk.	
Entire Contract	14 VAC 5-211-210 B 16	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 17	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.	
Cancellation by Insured	§ 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 premium of any premium; the earned premium 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.	
Reasons for Termination	14 VAC 5-211-230 A	Plan may not terminate member, except for listed reasons: failure to pay premiums or copayments, fraud or deception, violations of terms of contract, failure to meet eligibility requirements. HMO must provide 31-day notice of termination, except for non-payment of premiums and endangering HMO personnel.	
Termination Rules	14 VAC 5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated.	

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Conversion of Coverage/ Continuation of Coverage	14 VAC 5-211-70 A	Plan must offer to enrollees the right to convert coverage, within 31 days of termination, to individual coverage which must at a minimum provide basic health care services listed in 14 VAC 5-210-90, and shall not be refused because enrollee no longer resides or is employed in the service area.	
Copayment Amount	14 VAC 5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance.	
Copayment Notification	14 VAC 5-211-90 B	Plan shall keep copayment records, shall notify enrollee no later than 30 days after copayment maximum is reached, shall not charge any further copayments that year, and shall promptly refund any excess copayments paid. EOC must clearly state procedures.	
Deductible	14 VAC 5-211-100	An enrollee may be required to pay an annual deductible in accordance with § 38.2-4303 A 8.	
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.	
COB Provisions	14 VAC 5-211-210 B 11	EOC must contain any coordination of benefits provisions.	
<b><i>Pre-Existing Conditions</i></b>			
Pre-Existing Conditions and Credit	§ 38.2-3514.1	Individual contracts must contain pre-existing limitations as outlined in this section.	
Pre-Existing Conditions Exclusions	14 VAC 5-211-220	Plan may not limit coverage because of pre-existing conditions when enrollee transfers from one HMO plan to another during open enrollment, or when conversion option is elected, except to the extent of the limitation left under the original contract.	
<b><i>Prohibited Provisions</i></b>			
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.	
<b><i>MCHIP Requirements</i></b>			
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.	
<b><i>Additional Provisions</i></b>			
No lifetime limits on the dollar value of Essential Health Benefits (EHB):	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126); 45 CFR §155.1065(a)(2); § 38.2-3440	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 (75 Fed Reg 37188, 45 CFR §147.126); 45 CFR §155.1065(a)(2); § 38.2-3440	If there are maximum dollar limits, they must not be for benefits within one of the EHB categories.	
<b>The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified</b>			
Provides Essential Health Benefits (Pediatric Dental Services) – Form reviewer: complete EHB form review and EHB Review Process Steps	PHSA §2707	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	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	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.	

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<b>Annual Limitation on Cost Sharing</b>	45 CFR § 156.150(a)	<p>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.</p> <p>For the 2014 coverage year in the FFE, CMS interprets the word “reasonable” to mean any annual limit on cost sharing that is at or below \$700 for a plan with one child enrollee or \$1,400 for a plan with two or more child enrollees.</p>	

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ESSENTIAL HEALTH BENEFITS CATEGORY	BENCHMARK BENEFIT LIMITS	COMMENTS	PAGE NO.
<b>The section below must be completed for Stand-Alone Dental Plans applying to be Exchange-Certified</b>	Pediatric services - up to 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. Diagnosis 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	Once per year		
C. Restorative Dental Care			
1. Filings	One per tooth per year		
2. Crowns	One per tooth per 5 years		
3. Protective restorations			
4. Veneers	One per tooth per 5 years		
5. Temporary crowns			
D Major Dental Care			
1. Endodontic services	One per tooth per lifetime		
a. Pulp caps, pulpal therapy, and pulpal regeneration			
b. Apicoectomy/periradicular surgery	One per tooth per lifetime		
2. Gingivectomy or gingivoplasty	One per two years per quadrant		
3. Periodontal services	One per two years per quadrant		
a. Scaling and root planning	One per two years per quadrant		
b. Full mouth debridement	One per year		

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c. Osseous surgery	One per five years per quadrant		
d. Provision Splinting			
4. Removable prosthetics			
5. Fixed prosthetics	One per tooth per 5 years		
6. Local anesthesia			
7. Extractions			
E. Orthodontia	Must be medically necessary		