Print Reset Form

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 Forms and Rates Section of the Life and Health Division will review submissions based on the requirements noted in this checklist. Please contact this Section at (804) 371-9532 if you have questions or need additional information about these requirements.

Company Name:			
Product Name:		SERFF Tracking Number:	
Plan:		Submission Includes Plans Intended for:	
		☐	Inside the Exchange
		☐	Outside the Exchange; Exchange-certified
		☐	Outside the Exchange; not Exchange-certified
		☐	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		
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	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
General Filing Requirements			
	14VAC5-100-40 1	Each form 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.	
	14VAC5-100-40 3	Certification of Compliance signed by the General Counsel or officer of company or attorney or actuary representing the company is required.	
	14VAC5-100-40 5	Description of market for which the form is intended.	
Form Number	14VAC5-100-50 1	Form number must appear in lower left-hand corner of the **first page** of each form.	
Company Name and Address	14VAC5-100-50 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	14VAC5-100-50 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	14VAC5-100-50 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	14VAC5-100-50 5	Group Accident and Sickness forms must be printed with type size of at least 8-point type.	
Table of Contents	14VAC5-100-50 B	Required for policy or more than 3 pages (does not apply to groups with more than 10 members).	
Readability Certification	14VAC5-110-60	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	***14VAC5-100-40 and SERFF General Instructions***	***Additional SERFF filing requirements must be met as specified below for life and health forms and rate filings.***	
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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
MCHIP Requirements			
		Regarding the plan submitted with this filing, is the provider network consistent with the information previously filed and approved under Section 38.2-5802? ☐ Yes ☐ 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 as to 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. **Provide most recent approval date of Complaints and Appeals process from the Bureau of Insurance and Virginia Department of Health. Please attach copies of approvals under Supporting Documentation. Is the language in the submitted forms identical in substance to the approved language?**	
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 that 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
General Policy Provisions			
Table of Contents	14VAC5-100-50	Required for policy of more than 3 pages (does not apply to groups with more than 10 members).	
Contents of Policy	§ 38.2-305 A	Each policy/contract shall specify the: (1) The names of parties to the contract, (2) The subject of the insurance, (3) The risk insured against, (4) The time the insurance takes effect and, the period during which the insurance is to continue, (5) A statement of premium, and (6) The conditions pertaining to the insurance.	
Important Notice	§ 38.2-305 B	Each new or renewal policy/contract/certificate/evidence of coverage shall be accompanied by an important notice as stated in the statute.	
Limiting Jurisdiction Prohibited	§ 38.2-312 2	Contract shall not deprive courts of Virginia of jurisdiction in actions against insurer.	
Fraud Notice	§ 38.2-316 D 1	Title 38.2 of the Code of Virginia does not define “Insurance Fraud.” Any fraud notice that includes the term “insurance fraud” is not in compliance with this section of the Code. In Virginia, a fraud notice relating to life insurance, annuities, accident and sickness and credit life insurance should not include references to imprisonment or fines. Variations in a notice warning of consequences of making fraudulent statements will be considered.	
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 a 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.	
Assignment of Benefits	§ 38.2-3407.13	No company may refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by an insured, subscriber or plan enrollee.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Newborn Children	§ 38.2-3411	Coverage on an expense incurred basis that provides coverage for a family member of the insured shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to a newly born child of the insured from the moment of birth.	
Incontestability	§ 38.2-3528	The provision defines the incontestability provision.	
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 of 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.	
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 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 explanation 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. Please read this section of the Code for complete details of continuation requirements.	
DPO Contract Provisions			
	§ 38.2-6105 A 1	Effective date	
	§ 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	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
	§ 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	
Optional DPO Provisions			
	§ 38.2-6106 1	Missed appointment fee	
	§ 38.2-6106 2 a	Premium increases with 60 day 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	
	§ 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	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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(s) Required	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	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 EHBs 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 2020 coverage year in the FFM, the annual limit on cost-sharing may not exceed $350 for each covered child and $700 for two or more covered children.	
No Lifetime Limits on the Dollar Value of Essential Health Benefits (EHBs)	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 EHBs.	
No Annual Limits on the Dollar Value of EHBs	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.	

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, and Pulpal Debridement			
b. Endodontic Therapy, Retreatment of Previous Root Canal	One per tooth per lifetime		

ESSENTIAL HEALTH BENEFITS CATEGORY	BENCHMARK BENEFIT LIMITS	COMMENTS	PAGE NO.
c. Apicoectomy/Retrograde Filling	One per tooth per lifetime		
2. Periodontal services			
a. Gingivectomy or Gingivoplasty	One per two years per quadrant		
b. Scaling and Root Planning	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. Anesthesia			
3. Tooth Reimplantation and/or Stabilization due to accident			
4. Biopsy			
5. Alveoloplasty	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		

ESSENTIAL HEALTH BENEFITS CATEGORY	BENCHMARK BENEFIT LIMITS	COMMENTS	PAGE NO.
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 Stolen Retainer			
G. Adjunctive Services			
1. Palliative (emergency pain) treatment			
2. Anesthesia/Sedation			
3. Occlusal Guard (for grinding and clenching of teeth)			

I hereby certify that I have received the attached group stand-alone dental plan organization filing and determined that it is in compliance with the group stand-alone dental plan organizations checklist.

Signed: _____

Name (please print): _____

Company Name: _____

Date: _____ Phone No: (____) _____ Fax No: (____) _____

E-Mail Address: _____