

Form Filing Review Checklist  
GROUP STAND-ALONE DENTAL PLAN ORGANIZATIONS

**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 group 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 first page of each form.	
Company Name and Address	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	Group Accident and Sickness forms must be printed with type size of at least eight-point type.	
Arbitration	§ 38.2-312	Contract may not deprive courts of Virginia jurisdiction in actions against insurer. Arbitration may not be binding.	

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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.	
Readability Certification	14 VAC 5-110-60	Readability certification is required.	
Entire Consideration	§ 38.2-3500 A 1	The entire consideration is expressed in the policy.	
Table of Contents	14 VAC 5-110-50	Required for policy of more than 3 pages.	
<b>General Policy Provisions</b>			
Contents of Policy	§ 38.2-305 A	Parties to policy names; subject of insurance; risks insured against; time insurance takes effect; statement of the premium.	
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.	
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 Payment of Claims	§ 38.2-3537	The provision specifies <b>when</b> benefits will be paid.	
Payment of Claims	§ 38.2-3538	The provision specifies <b>to whom</b> 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.	
Conversion or Continuation	§ 38.2-3541	Each policy shall contain a provision that sets forth two options regarding conversion or continuation of insurance.	

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<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>DPO Contract Provisions</i></b>			
	§ 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	
<b><i>Optional DPO Provisions</i></b>			
	§ 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	
	§ 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	

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	§ 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	
<b><i>MCHIP Requirements</i></b>			
Provider Lists	§ 38.2-5803 A 1	List of providers shall be provided.	
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.	
<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.	

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<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.	
Annual Limitation on Cost Sharing	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. Fillings	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		

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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		
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		