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Form Filing Review Checklist
INDIVIDUAL STAND-ALONE DENTAL PLAN ORGANIZATIONS

NOTICE: This checklist must be completed in its entirety and submitted with each individual stand-alone dental plan organizations 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. Access to Administrative Letters, Administrative Orders, Regulations and Laws is available at: Virginia SCC - Administration of Insurance Regulation in Virginia

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			
Source of Filing	14 VAC 5-101-40	Filings shall be submitted in SERFF or submitted in writing to the commission. If filed by a third-party, filing authorization must be included.	
Filing Description	14 VAC 5-101-50 C 1	Filing description must include the type of insurance form, including a description of the form and the market for which the form is intended; intentions to concentrate on a specialized market should be noted.	
	14 VAC 5-101-50 C 2	Filing description must include the form number of each form that is being filed.	
	14 VAC 5-101-50 C 3	Filing description must state whether submitted form is new, or if replacing, revising, or modifying a previously approved form and the exact changes that are intended.	
	14 VAC 5-101-50 C 4	Filing description must identify any change in benefits and indicate whether the change affects premium rates for the form.	
	14 VAC 5-101-50 C 5	Filing description must state if approval of a form submitted has been withdrawn by another regulatory body and the reasons for such a withdrawal.	
	14 VAC 5-101-50 F	Any form filed that is to be used with a previously approved form, including an application, shall identify the form number, approval date, and SERFF or state tracking number in the new filing.	
	14 VAC 5-101-50 G	Any amendment, endorsement, or rider that intends to revise a previously approved form shall be accompanied by the previously approved form filed as supporting documentation.	
HELP TIP:		If a form filing is submitted as new in Virginia, but was previously disapproved, withdrawn or rejected in Virginia, please provide details such as the SERFF or State tracking information, form number, and the date that the form filing was disapproved, withdrawn or rejected if available.	
Forms			
Form Number	14 VAC 5-101-60 1	Form Number must appear in the lower left-hand corner of the first page of the form. It shall consist of numbers, letters, or a combination of both. The form number shall distinguish the form from all other forms used by the company.	
Company Name and Address	14 VAC 5-101-60 2	The full licensed name of the company, including the address of the home office, shall appear in prominent print at the top of the cover page of any policy, application, or enrollment form. The full licensed name of the company shall appear in prominent print on all other forms.	
Marketing name or Logo	14 VAC 5-101-60 3	A marketing name or logo also may be used on the form, provided that the marketing name or logo does not mislead as to the identity of the filing company.	
	14 VAC 5-101-60 4	The cover page of a policy also shall include the address of an office that will administer the policy, if different from the home office, a company telephone number, and company website address.	
Final Form – John Doe	14 VAC 5-101-60 5	Form must be submitted in “final form” and in “John Doe fashion” to indicate its intended use.	

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Electronic Version	14 VAC 5-101-60 6	Each form that is to be used in an electronic version shall be filed in a format that matches the electronic version exactly.	
Readability	14 VAC 5-101-70 A	Each form submitted for review or approval shall be written in simplified language, logically and clearly arranged, and printed in a legible format and understandable to a person of average intelligence without special insurance knowledge or training.	
	14 VAC 5-101-70 B	A policy of more than three pages shall include a table of contents listing the principal sections and provisions and the pages on which they are found.	
	14 VAC 5-101-70 C	Defined words and terms shall be placed in a separate definition section that is clearly identified, unless only used in one section.	
	14 VAC 5-101-70 D	A policy shall be divided into logically arranged sections with an appropriately named caption or heading for ease in locating desired content. Captions and headings shall be clearly set apart from the general text.	
	14 VAC 5-101-70 E	Any form submitted for review or approval shall be printed in at least 10-point type size.	
	14 VAC 5-101-70 F	Any policy shall achieve a minimum Flesch reading ease score of 50 or an equivalent score using another comparable test, unless otherwise specified by statute, or an exception requested pursuant to 14 VAC 5-101-70 G.	
Variability	14 VAC 5-101-80	Use of variable bracketed information shall be limited. Use of brackets within brackets is not permitted. Each instance of variable text shall appear in brackets on a form and shall be separately and completely explained in detail in a Statement of Variability document. Each explanation of variability shall appear in the same order that it appears on the form. Additional guidance is attached to SERFF General Instructions.	
Certificate of Compliance	14 VAC 5-101-110	Each form filing shall contain a Certificate of Compliance signed by an officer of the company certifying the Flesch reading ease score of at least 50; that a review of the form has been conducted and is consistent and complies with the requirements of Title 38.2 and applicable rules and regulations; and a statement that failure to comply with these requirements will result in disapproval of the filing.	

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. Documentation 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. Attach copies of approvals under Supporting Documentation. Is the language in the submitted forms identical in substance to the approved language?**	
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 that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care	

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		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.	
Contents of Policy			
Entire Consideration	§ 38.2-3500 A 1	The entire consideration must be expressed in the policy.	
Effective-Termination	45 CFR § 144.103 45 CFR § 147.104(b)(2) § 38.2-3500 A 2	The clock time at which the policy becomes effective and terminates must be expressed in the policy.	
Payor of Last Resort	§ 38.2-3500 A 7	Each policy must contain a statement regarding the status of the Department of Medical Assistance Services as the payor of last resort.	
Definition of Eligible Family Member	§ 38.2-3500 C	The definition recognizes dependent children without regard as to whether such children reside in the same household as the policyowner.	
Important Notice	§ 38.2-3502 A	Each policy must display on the **first page** the specified caution notice. The caution notice should not include the phrase regarding medical history.	
Return of Policy/Free Look	§ 38.2-3502 A	Each policy must display on the **first page** the 10-day free look provision.	
Required Provisions			
Assignment of Benefits – Dentists/Oral Surgeons	§ 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.	
Entire Contract	§ 38.2-3503 A 1	The policy, including endorsements and attached papers, constitutes the entire contract of insurance. No change in the policy is valid until approved by an executive officer of the company, and such approval endorsed on or attached to the policy. No agent has the authority to change or waive policy provisions.	
Time Limit on Certain Defenses Incontestable	§ 38.2-3503 A 2 (a) § 38.2-3503 A 2 (a)	One of these versions must appear in the policy. After 2 years from the date of the policy, only fraudulent misstatements in the application may be used to void the policy or deny a claim. After the policy has been in force for 2 years during the insured's lifetime, the company cannot contest statements in the application.	
Grace Period	§ 38.2-3503 A 3	If a renewal premium is not paid on time, it may be paid during the following 31 days. During the 31 days, the policy shall continue in force. Please review the entire statute for variations, and refer to the Affordable Care Act (ACA) requirements.	
Reinstatement	§ 38.2-3503 A 4	If a renewal premium is not received within the grace period, the policy will lapse, and the individual may apply for reinstatement based on the company's guidelines. The reinstated	

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		policy will cover only a loss that results from injury sustained after the reinstatement date and sickness that starts more than 10 days after such date.	
Notice of Claim	§ 38.2-3503 A 5	Written notice of claim must be given to the company within 20 days after covered loss starts or as soon as reasonably possible, and should include the name of the insured or claimant, and policy number. The location should be indicated for sending notice to the company.	
Claim Forms	§ 38.2-3503 A 6	The company must provide the claimant with claim forms within 15 days of notification of a claim. If not, proof of loss is met by giving the company a written statement of the nature and extent of the loss within the time limit expressed in the proof of loss provision.	
Proof of Loss	§ 38.2-3503 A 7	For periodic payment, written proof of loss must be given to the company within 90 days after the end of each period for which the company is liable. For any other loss, proof must be given within 90 days after the loss. If not reasonably possible to give proof in the time provided, the company shall not reduce or deny a claim if proof is filed as soon as reasonably possible. In any event, except in the absence of legal capacity proof must be given no later than 1 year from the time specified.	
Time of Payment of Claims	§ 38.2-3503 A 8	After the company receives written proof of loss, it shall pay benefits according to a specified frequency for a specified loss. Benefits for any other loss will be paid as soon as written proof is received.	
Payment of Claims	§ 38.2-3503 A 9	Benefits will be paid to the insured if living, otherwise to the beneficiary or the insured's estate. In the absence of a valid release, the company may pay up to $2,000 to someone whom the company deems entitled.	
Physical Examination/Autopsy	§ 38.2-3503 A 10	The company, at its own expense, may have the insured examined as often as reasonably necessary while a claim is pending. An autopsy may also be made unless prohibited by law.	
Legal Actions	§ 38.2-3503 A 11	No legal action may be brought to recover on the policy within 60 days after written proof of loss has been given. No legal action may be brought after 3 years from the time written proof of loss is required to be given.	
Change of Beneficiary	§ 38.2-3503 A 12	The insured may change the beneficiary at any time, but the beneficiary's consent is required in the case of an irrevocable beneficiary designation.	
Cancellation by Insured	§ 38.2-3503 A 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.	
Optional Provisions			
Misstatement of Age	§ 38.2-3504 2	If the insured's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.	

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Age Limit	§ 38.2-3513 B	If the age of the insured has been misstated, and if according to the correct age of the insured, the coverage provided by the policy would not have become effective or would have ceased prior to the acceptance of the premium, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.	
Other Insurance with Insurer	§ 38.2-3504 3	Insurance effective at any one time on the Insured under a like policy or policies with this Company is limited to one such policy elected by the Insured, his beneficiary or his estate, and the Company will return all premiums paid for all other such policies. (Please review the statute for variations).	
Insurance with Other Companies	§ 38.2-3504 4	If there is other valid coverage providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which the company has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable under the policy plus the total of the like amounts under all such other valid coverages for the same loss of which this company had notice bears to the total like amounts under all valid coverages for such loss.	
Insurance with Other Companies	§ 38.2-3504 5	If there is other valid coverage providing benefits for the same loss on other than an expense incurred basis and of which this Company has not been given written notice prior to the occurrence or commencement of loss, the only liability for such benefits under this policy shall be for such proportion of the indemnities otherwise provided under this policy for such loss as the like indemnities of which the company has notice.	
Unpaid Premium	§ 38.2-3504 7	When a claim is paid, any premium due and unpaid may be deducted from the claim payment.	
Conformity with State Statutes	§ 38.2-3504 9	Any provision of the policy that on its effective date is in conflict with the laws of the state in which the insured resides on that date is amended to conform to the minimum requirements of the laws.	
Illegal Occupation	§ 38.2-3504 10	The company is not liable for any loss that results from the insured committing or attempting to commit a felony or engaging in an illegal occupation.	
Intoxicants and Narcotics	§ 38.2-3504 11	The company is not liable for any loss resulting from the insured being drunk, or under the influence of any narcotic unless taken on the advice of a physician.	
Form Requirements			
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,	

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		(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 Exclusion	§ 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.	
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.	
Definitions	14VAC5-140-40	General terms must be defined in connection with individual accident and sickness coverage to the extent not in conflict with the Affordable Care Act (ACA).	
Continuation of Coverage for Spouse/Deceased Insured	14VAC5-140-50 C	For guaranteed renewable and non-cancellable policies, the age of the younger spouse must be used as the basis for meeting the age and durational requirements of the renewability definitions.	
Military Refund	14VAC5-140-50 E	If a policy includes a status type military exclusion, the insurer will provide for a refund of premium, on a pro rata basis, upon receipt of a written notice of military service.	
Probationary Period Prohibited	14VAC5-140-60 A	Probationary periods are prohibited for all medical conditions except a policy may specify a probationary period not to exceed 6 months for certain conditions.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Authorized Exclusions	14VAC5-140-60 F	Permitted exclusions and limitations apply, except where in conflict with the Affordable Care Act (ACA).	
Renewability	14VAC5-140-80 A 1	Each policy shall contain a renewability provision and it shall appear on the **first page** of the policy.	
Preexisting Condition	14VAC5-140-80 A 5	If a policy contains a preexisting condition limitation, the limitation must appear in a separate paragraph and labeled as "Preexisting Conditions Limitations." Preexisting condition limitations must not apply to pediatric essential health benefits.	
Reduction of Benefits Due to Age	14VAC5-140-80 A 6	If age is used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be disclosed prominently in the policy.	
Limited Benefit Policy Disclosure	14VAC5-140-80 B 14VAC5-140-70 H (i)	Required language – cover sheet. NOTICE: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PROVIDE COVERAGE FOR ANY MEDICAL BENEFITS AND SERVICES. THIS IS AN [EXCHANGE-CERTIFIED]* STAND-ALONE DENTAL POLICY THAT PROVIDES COVERAGE FOR CERTAIN DENTAL BENEFITS AND SERVICES ONLY. (This notice shall be in capital letters and no less than 14-point type). *** "Exchange-Certified" may be omitted if not filing to be exchange-certified.**	
Policies that Include Issue Ages of 65 or Higher	14VAC5-170-150 E 1	Any policy marketed to persons age 65 or older must contain a notice that disclosed that the policy is not a Medicare supplement policy or certificate. **First page.**	
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	
	§ 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	

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	§ 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	
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 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	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 2022 coverage year in the Exchange, the annual limit on cost-sharing may not exceed $375 for each covered child and $750 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.	

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	**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		

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	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. Extractions			
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		

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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 Stolen Retainer			
G. Adjunctive Services			
1. Palliative (emergency pain) treatment			
2. Anesthesia/Sedation			
3. Occlusal Guard (for grinding and clenching of teeth)			

Review Requirements Checklist
INDIVIDUAL STAND-ALONE DENTAL PLAN ORGANIZATIONS

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

Signed: _____

Name (please print): _____ _____

Company Name: _____

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

E-Mail Address:_____