NOTICE: This checklist must be completed in its entirety and submitted with each individual and group HMO stand-alone 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. 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.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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.	
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	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		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.	
General Policy Provisions			
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.	
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, health maintenance organizations, health services plans, credit 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.	
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.	
Claims Paid to Insureds for Services from Nonpar. Providers	§ 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.	
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.	
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.	
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;	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
		the earned premiums shall be computed pro rata, Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation	
EOC Must Be Provided	14VAC5-211-210 A	Each subscriber shall be entitled to an Evidence of Coverage (EOC).	
Misleading Statements	14VAC5-211-210 B 2	No EOC shall contain statements that are unjust, unfair, untrue, inequitable, misleading, deceptive or misrepresentative.	
Complete Statement of Benefits	14VAC5-211-210 B 3	An EOC shall contain a complete summary of health care services and other benefits the enrollee is entitled.	
States Limits and Copayments	14VAC5-211-210 B 4	An EOC shall contain any limits on services, including deductibles and copayments	
Describes Services Delivery	14VAC5-211-210 B 6	EOC must contain where and in what manner services may be obtained.	
Contributory/Non-contributory	14VAC5-211-210 B 7	EOC must state if plan is contributory or non-contributory if group plan, and premium amount for individual contracts.	
Complaint Procedures	14VAC5-211-210 B 8	EOC must contain enrollee complaint procedures.	
Provider List/Service Area		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 monthly.	
Continuation of Coverage (Group Only)	14VAC5-211-70 A 14VAC5-211-210 B 9	Each policy shall contain a provision that provides for continuation of coverage.	
COB/Liability Coverage Prohibited	14VAC5-211 80 A	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 worker's comp. laws or govt. programs nor shall it prohibit coordination of benefits between insurance contracts.	
Cost Sharing	14VAC5-211-90 A	Copayment must be shown in EOC as a specified dollar or as a coinsurance, not both.	
Cost Sharing Notification	14VAC5-211-90 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	14VAC5-211-210 B 1	EOC must contain name, address and telephone number of HMO.	
Effective Date and Term of Coverage	14VAC5-211-210 B 5	EOC must contain effective date and term of coverage.	
Arbitration	14VAC5-211-210 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	14VAC5-211-210 B 11	EOC must contain any coordination of benefits provision.	

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
Assignment Restrictions	14VAC5-211-210 B 12	EOC must contain any assignment restrictions in contract.	
Claim Filing/Proof of Loss	14VAC5-211-210 B 13	EOC must contain the plan's claim procedures and proof of loss requirements.	
Eligibility Requirements	14VAC5-211-210 B 14	Conditions under which dependents may be added, limiting age for dependents.	
Entire Contract	14VAC5-211-210 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 the 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	14VAC5-211-210 B 16	EOC shall contain a provision that the policyowner 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 to Termination	14VAC5-211-230 A	Plan may not terminate a 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	14VAC5-211-230 B	EOC must contain terms and conditions under which coverage may be terminated. An HMO must provide a 31-day notice of termination, except for non-payment of premiums and change in eligibility status.	
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.	
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.	

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 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		
F. Medically Necessary Orthodontia			

REVIEW REQUIREMENTS	FEDERAL AND/OR VIRGINIA CITATION	COMMENTS	PAGE NO.
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)			

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

Signed: ____

Name (please print): __________________________ __________________

Company Name: ____

Date: _________________________ Phone No: (____) _____________________ Fax No: (____) _____________________

E-Mail Address:________________________________