Nebraska Department of Insurance
Life & Health Division

FORM REVIEW CHECKLIST
Stand Alone Pediatric Dental Plans - Plan Year 2019

This checklist must be submitted with all Stand Alone Pediatric Dental Plans requesting certification, subject to the Affordable Care Act (ACA), applicable federal and Nebraska state regulations, offered on or off the Marketplace (Exchange). These standards are summaries only. Review of the entire statute or rule may be necessary. Complete each "Category" by marking the check box to verify a "yes" response and indicate the page on which it can be found. Not submitting a completed checklist may cause your filing to be considered incomplete and returned without review. The following standards are subject to change.

Company Name:_____
Product Name: _____
Plan(s):_____

Category	State	Federal	Requirements	Page Number(s)
☐ **Provides Essential Health Benefit for Pediatric Dental to age 19.**		PHSA §2707	Must be substantially similar to benchmark plan - BCBS. Coverage at least until the end of month in which the enrollee turns 19 years of Age. Can be higher age but not lower.	
☐ **No lifetime dollar limits on pediatric dental benefits, which are considered Essential Health Benefits (EHB).** **Applies to both in or out-of-network.**		PHSA §2711 75 Fed Reg. 37188, 45 CFR §147.126 and 155.1065(a)(2)	Issuers are not prohibited from using lifetime limits for specific benefits that are not EHB. **Tip**: Check benefit maximums on schedule and in policy language to ensure there are no dollar limits.	

☐ **No annual dollar limits on pediatric dental benefits, which are EHB.** **Applies to both in or out-of-network.**		PHSA § 2711 75 Fed Reg. 37188 45 CFR § 147.126; and 155.1065(a)(2)	Issuers are not prohibited from using annual limits for specific benefits that are not EHB. **Tip**: Check benefit maximums on schedule and in policy language to ensure there are no dollar limits.	
☐ **Annual limitation on Cost Sharing** Cost sharing for a stand-alone pediatric dental plan must be $350 per child, $700 for two or more children.		45 CFR §156.150(a)	**Once any enrolled child reaches $350 in out of pocket spending, the plan may not charge additional out of pocket costs for that child; regardless of whether the plan has one or more enrolled children.** **The $700 limit applies to two or more enrolled children. A family cannot be charged further out of pocket costs once all enrolled children collectively have reached $700 in out of pocket costs.**	
☐ **Actuarial Value:** Must calculate the actuarial value. High and low AV plans no longer required and do not need to be entered into the template. No cost sharing reduction (CSR) for SADPs.		45 CFR § 156.150(b)	AV is measured as a percentage of expected health care costs a will cover; based on the cost-sharing provisions for a set of benefits. The level of coverage must be calculated and certified by a member of the American Academy of Actuaries using generally accepted actuarial principles. **Submit Rate Template, Actuarial Memorandum and actuarial certification.** Indicate if rates are estimated or guaranteed. The URRT is not applicable to Dental.	
☐**No Waiting Periods on EHB's**			No waiting periods allowed on pediatric dental such as orthodontia.	

☐ **Provide and disclose enrollment periods for qualified individuals**: ☐ Annual Open Enrollment compliance ☐ Special Enrollment Periods		26 CFR 54.9801-6(a)(3)(i) through (iii) 45 CFR 155.725	Special enrollment applicant must provide documentation to verify qualifying event within 30 days.	
☐ **Effective Dates of Coverage** For Small group market: For plan selections received between the 1st and 15th day of month, coverage is effective on the first day of the following month. For plan selections received between the 16th and last day of the month, coverage is effective on the first day of the second following month.				
☐ **Orthodontia is covered if medically necessary only.** Includes treatment for a child with severe, dysfunctional handicapping malocclusion.		45 CFR 156.115(d)	Issuer of a plan offering EHB may not include non-medically necessary orthodontia as an EHB. No waiting periods allowed.	
☐ **Network Adequacy** Reasonable accessibility, non-discrimination, sufficient number of specialists, and 20% ECPs. No partial counties unless **substantial** justification provided. Easy access to accurate, current provider directory.				

Claims Procedures: • Acknowledge any claims communication within 15 days. • Determination for claim must be made within 15 days of receipt. • Written notice of denial must be sent within 15 days of determination. • Extension up to 30 days allowed if necessary due to matters beyond the control of the issuer. • Notice of extension must be provided to the claimant prior to expiration of the initial 15 day period. •The claimant has at least 45 days from the receipt of notice to provide the specified information.	Claims Procedures Required: §44-710.03 Chapter 61 §006, 008.	ERISA 29 CFR § 2560.503-1	• The issuer must indicate the circumstances requiring the extension and date by which the issuer expects to render a decision. • If claimant fails to provide necessary information, the issuer must provide notice, which includes the specific information needed to make a decision.	
□ Internal appeal - processes, rights and required notices: • A Covered Person or their representative has the right to appeal. • A Covered Person or their representative may review the claim file and submit evidence as part of the internal appeals process. • A Covered Person has 180 days to file an appeal. • The determination must be made in writing within 15 working days after receipt of the claimant's appeal. • Urgent or expedited reviews require a decision within 72 hours after the review is commenced.	NE Grievance Procedures: NE Rev. Stat. § 44-7308, 44-7310, 44-7311	PHSA §2719 (75 Fed Reg. 43330; 76 Fed Reg. 37208, 45 CFR §147.136)	The External Review is not available for Dental plans.	