Nebraska Department of Insurance
Life & Health Division

FORM REVIEW CHECKLIST
Stand Alone Pediatric Dental Plans - Plan Year 2017

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 Law	_____	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 ends at either: • end of month following age 19, or • end of plan year that enrollee turns 19.	
☐ **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 compliant with national annual limits.		45 CFR §156.150(a)	Copay for EHBs should not be greater than the MOOP.	
☐ **Minimum actuarial value:** Must demonstrate that the stand-alone dental plan offers the pediatric dental EHB at either: A low level of coverage with an AV of 70%; or A high level of coverage with an AV of 85%; or Within a de minimis variation of +/- 2 percentage points.		45 CFR § 156.150(b)	AV is measured as a percentage of expected health care costs a health plan will cover; calculated based on the cost-sharing provisions for a set of benefits. The level of coverage must be certified by a member of the American Academy of Actuaries using generallly accepted actuarial principles. **Include Rate Template, Actuarial Memorandum and actuarial certification.** The URRT is not applicable to Dental.	

☐ **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		

☐ **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.	
☐ **Network Adequacy** Reasonable accessibility, non-discrimination, sufficient number of specialists, and 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 at least 180 days to appeal a grievance. • Determination must be made in writing within 15 working days after receipt of the claimant's appeal. • If a decision cannot be made within 15 days due to circumstances beyond the issuers control, an extension of 15 days is allowed. The delay letter must explain the reasons for the extension on or before the 15th day after receipt of the appeal.	NE Grievance Procedures: NE Rev. Stat. § 44-7308 Chapter 61	PHSA §2719 (75 Fed Reg. 43330; 76 Fed Reg. 37208, 45 CFR §147.136)	The External Review is not available for Dental plans.	