FLORIDA OFFICE OF INSURANCE REGULATION

Life and Health Product Review Unit

The Florida Office of Insurance Regulation (Office) has developed the following worksheet to assist companies making PPACA (Patient Protection and Affordable Care Act)-compliant form filings. The Office encourages companies to download, complete, scan and upload this form as a part of the form filing submitted to the Office via I-File. This will expedite the review process and increase speed to market. This worksheet will be updated on a continuing basis as additional federal guidance is issued. You are encouraged to use the most recently updated version. The worksheet may not contain all of the PPACA requirements The Office offers this worksheet as guidance only, and should not be considered a directive by the Office.

Stand-Alone Dental Small and Large Group Contract Worksheet

Florida Provisions (Blue); PPACA/FEDVIP Provisions (Red)

Legend: CFR=Title 45, except where otherwise indicated; CMS=Centers for Medicare & Medicaid Services; EHB=Essential Health Benefits; FEDVIP=Federal Employee Dental and Vision Insurance Program; PHSA=Public Health Service Act; GP=Grandfathered Plan; NGP=Non-grandfathered Plan; QHP=Qualified Health Plan; SADP= Stand-alone Dental Plan

Statute/Rule	Filing Compliance	Yes	No	N/A	Page #
69O-149.021(6)(b)	Review filings for correct product codes, properly completed UDL, inclusion of all required documents for a complete review and other requirements. Incorrect product codes and incomplete filings will be returned as incomplete with a letter of explanation.				
69O-149.021(1)(b)	Required information to be submitted within the filing.				
69O-149.023(4)	Cover letters must include a description of the distribution system (e.g. internet filing, direct marketing, agents, financial institutions, etc.) and intended target population.				
69O-149.021(6)(c)	Provide the form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 01-23456), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted.				
627.651(1)	Group contracts must be issued or delivered to one of the groups provided for in 627.653 through 627.656.				
	Policy Cover Page				
627.602(2) 627.662(2)	Deductible statement must appear in 18-point font on the policy or certificate of coverage.				
627.416	Execution of Policies: Every form shall contain the signature of a company official.				
627.6651	Replacement or termination of the group: When a purchaser of insurance terminated or replaces an existing group with another such policy, the prior insurer shall remain liable only to the extent of its accrued liabilities and extensions of benefits as required by s. 627.667				

	Required Policy Contents				
627.657(1)(a)	Required: statements in applications are representations , not warranties..				
627.657(1)(b)	Required: a provision that a certificate must be furnished to the policyholder for delivery to the employee or member setting forth the essential features of the policy.				
627.657(1)(c)	Required: a provision that new members or employees may be added to the group in accordance with the policy provision.				
627.65755 78 FR 12834 CMS QHP Dental FAQ May 10, 2013 PPACA 1302(b)(1)(J) PHSA 2722(c)(1) & 2791(c)(2) CFR 156.110(a)(10) & (b)(2)-(3) CFR 155.1065(a) 50 CMS QHP Dental FAQ May 10, 2013 CFR 156.115(a)(6)	(GP) Any contract that provides coverage for anesthesia and hospitalization must provide for dental care to a person under age 8 if the dental condition is likely to result in a medical condition that if left untreated and the child's dentist and physician determine dental treatment in a hospital or ambulatory surgical center is necessary due to the complex nature of the procedure or due to a significant or undue medical risk. Off-Exchange dental benefit. Individuals enrolling in off-Exchange health insurance coverage must be offered the full ten EHB categories, including the pediatric dental benefit. When an issuer is reasonably assured that an individual has obtained such coverage through an Exchange-certified SADP offered outside an Exchange, the issuer is not noncompliant with EHB requirements if the issuer offers that individual a policy that, when combined with the Exchange-certified stand-alone dental plan, ensures full coverage of EHB. On-Exchange SADP. An on-Exchange SADP must cover at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act. Only the pediatric dental benefit, and not any non-pediatric coverage, would be subject to EHB standards, including complying with the requirement to offer benefits that are substantially equal to the benchmark and meeting AV and out-of-pocket limit requirements for SADP..A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of pediatric oral benefits from one of the following: • The FEDVIP dental plan with the largest national enrollment that is described in and offered to federal employees under 5 U.S.C. 8952; or • The benefits available under that State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment. Only the pediatric dental benefit, and not any non-pediatric coverage, is subject to EHB standards, including the requirement to offer benefits that are substantially equal to the benchmark and meeting AV and out-of-pocket limit requirements for SADP. Pediatric services must be covered until the end of the month in which the enrollee turns 19.				
69O-154.105(2)	Conditions of eligibility				
627.419(2) 627.6699(12(d)7. Small Group	Construction of policies: "physician or medical doctor" when used in contract which includes payment for surgical procedures specified in the contract and performed in a hospital in consultation with a licensed physician. Includes dentists, optometrist, podiatric and chiropractic.				
627.4131	Contact information. Telephone number required for policyholders and certificate holders to present inquiries or obtain information about coverage				

	and to provide assistance in resolving complaints.				
627.6044 627.662(13)	Claims methodology.				
627.613 627.662(6)	Claims payments, company must pay or deny within 45 days..				
627.6131 627.662(6)	Claims payments.				
69O-154.104	Definitions shall be contained in the contract.				
627.645(1) 627.662(7)	Denial of claims.				
627.657(3)	No group policy shall contain any provision relative to notice or proof of loss, to the time for paying benefits, or to the time within which suit may be brought on the policy, which provision is less favorable to the individuals insured than would be permitted by the comparable provision required for individual health insurance policies.				
	Discrimination/benefit design. (NGP)				
PPACA 1302(b)(4) CFR 156.125(a)	An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.				
80 FR 10822	Three examples of potentially discriminatory practices: 1. attempting to circumvent coverage of medically necessary benefits by labeling them a pediatric service. 2. refusing to cover a single-tablet drug regimen or extended-release product customarily prescribed and just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal. 3. placing most or all drugs that treat a specific condition on the highest cost tiers.				
	Enrollment periods/annual open enrollment				
627.65615 627.6699(5)(h)7.	No express provisions because stand-alone dental is considered a supplemental plan. Insurers establish their own open enrollment periods based on an 18-month minimum, but preferably every 12 months. However, provisions applicable to major medical group (ss. 627.65615, 627.6699(5)(h)7.) may provide guidance for GP and off- Exchange NGP (e.g., 30-day minimum enrollment period).				
CFR 147.104(b)(1) CFR 155.725(b), (e) & (f)	(NGP) A health insurance issuer in the group market must allow a qualified employer to purchase coverage for a small group health plan at any point during the year. Enrollment in the SHOP is on a rolling basis. Insurers may impose an annual enrollment period from November 15 to December 15 for plan sponsors unable to comply with a employer contribution or group participation rules as allowed under applicable state law and as permitted by §156.285.				
CFR 155.720(b)	The SHOP must establish a uniform enrollment timeline and process for all QHP issuers and qualified employers to follow. The SHOP must provide advance notice to a qualified employer of the annual open enrollment period. The FF-SHOP must provide qualified employers with a standard election period				

	prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year. Employers may offer one health plan to their employees, or choose a coverage category, like Bronze or Silver, and allow employees to select any plan in that category. The plan year must consist of a 12-month period.				
CFR 155.725(e)	Length: The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.				
CFR 147.104(b)(4)	Enrollees must be provided 30 calendar days after the date of the qualifying event.(described in (b)(3) which seems to apply to special enrollment periods, but then seems a potential inconsistency with (b)(4)				
CFR 155.725(g)	A newly qualified employee must have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.				
	Enrollment/Special enrollment periods.				
627.65615 627.6699(5)(h)7.	No express provisions because SADP are considered supplemental plans. However, provisions applicable to major medical group (ss. 627.65615, 627.6699(5)(h)7.) may provide guidance for GP and off-Exchange NGP (30-day minimum period). **Off-Exchange**				
CFR 147.104(b)(3)	Qualifying events: Health insurance issuers must provide special enrollment periods based on qualifying events as defined under s. 603 of ERISA. These are in addition to any other special enrollment periods required under federal or state law and include: 1. The death of the employee; 2. The termination (other than through employee's gross misconduct) or reduction of hours of covered employee; 3. The divorce or legal separation of the covered employee from spouse; 4. The covered employee becoming entitled to Medicaid benefits (Title XVIII, SSA); 5. The dependent child ceasing to be a dependent child under generally applicable requirements of the plan; 6. A proceeding in a case under title 11 with respect to the employer.				
CFR 147.104(b)(4)	Length: The enrollment period must run for 60 days from the date of the qualifying event. **On Exchange**				
CFR 155.420(c), (d)(1)-(10) & (e) 80 FR 10798	The Exchange must provide special enrollment periods for qualified individuals to enroll in QHPs and enrollees to change QHP (or SADP) upon the occurrence of one of the following qualifying events: 1. A qualified individual or dependent loses minimum essential coverage; is				

	enrolled in any non-calendar year group health plan or individual health insurance coverage (outside of an Exchange, including grandfathered and transitional plans), even if the qualified individual or his or her dependent has the option to renew such coverage; loses pregnancy-related coverage under Medicaid; or loses medically needy coverage (Medicaid). [Note: See the circumstances described in 26 CFR 54-9801-6(a)(3)(i)- (iii).; "loss of coverage" does not include voluntary termination or other loss di=ue to nonpayment of premiums, including COBRA premiums and situations allowing for rescission.] 2. A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or in foster care. 3. An individual, who was not previously a citizen, national, or lawfully present individual gains such status. 4. A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction. 5. An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee. 6. An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan. A qualified individual in a non-Medicaid expansion State who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL, who was ineligible for Medicaid during that same timeframe, and who has experienced a change in household income that makes the qualified individual newly eligible for advance payments of the premium tax credit. 7. A qualified individual or enrollee gains access to new QHPs as a result of a permanent move. 8. An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month. 9. A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide. 10. The Exchange determines that a qualified individual, enrollee, or dependent, did not enroll in QHP coverage or is eligible but not receiving premium tax credits or reduced cost sharing as a result of misconduct on the part of a non-Exchange entity providing enrolment assistance or activities.				
CFR 155.420(c)(3)	Length: 60 days from the date of the qualifying event. May be some other length not exceeding 60 days for qualifying events 4, 5, 9 and 10, as appropriate based on circumstance.				

	Effective dates of coverage.				
627.413(1)(d)	(GP and off-Exchange NGP) Every policy shall specify the time when the insurance thereunder takes effect and the period during which the insurance is to continue. Effective date of coverage following open or special enrollment left to the insurer and the insured.				
	SHOP				
CFR 147.104(b)(1)(C) CFR 155.720(e) CFR 155.725(a),(e), & (h)	Notification of effective date. For plan years beginning before 1/1/17, the SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP through the SHOP of the effective date of coverage. For plan years beginning on or after 1/1/17, the SHOP must ensure that a QHP issuer notifies an enrollee enrolled in a QHP through the SHOP of the effective date of coverage.				
CFR 155.720(e)	When a primary subscriber and his or her dependents live at the same address, a separate notice of the effective date of coverage need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the coverage effective date for the primary subscriber and his or her dependents at that address.				
CFR 147.104(1)(i)	Annual enrollment periods Coverage in the group market, and large group market if coverage is offered through a SHOP, becomes effective consistent with dates applicable to SHOP in CFR 155.725.				
CFR 155.725(a) & (h)(1)	Coverage effective dates. SHOP must establish effective dates of coverage for qualified employees: • enrolling in coverage for the first time, and • enrolling during the annual open enrollment period prior to the completion of the employer's plan year.				
CFR 155.725(h)(2)	Coverage effective dates applicable both inside and outside a SHOP: • Enroll 1st-15th day of month, effective Day 1 of following month • Enroll 16th-last day of month, effective Day 1 of 2nd following month				
CFR 147.106(b)(5)	Special enrollment periods. Coverage must become effective consistent with dates in CFR 155.420, both inside and outside of (SHOP) Exchange				
CFR 155.420(b)(1)-(2)	Regular effective dates— • Enroll 1st-15th day of month, effective Day 1 of following month • Enroll 16th-last day of month, effective Day 1 of 2nd following month Special effective dates— • Date of event or may permit the enrollee to elect Day 1 of the following month: For birth, adoption or placement for adoption, or placement in foster care. • Day 1 of following month: For marriage or loss of minimum essential coverage. • The date of the triggering event or the regular effective dates:				

	o enrollment or nonenrollment is unintentional; o enrollment or nonenrollment is the result of error or misrepresentation or inaction of the Exchange or HHS QHP in which person was enrolled violated a material provision of the contract relative to the enrollee; o where enrollee meets other exceptional circumstances.or qualified individual was not enrolled in QHP coverage as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or activity. A (SHOP) Exchange may set earlier effective dates for certain special enrollment periods.				
CFR 155.420(b)(3)					
627.662(3) 627.635	Excess insurance: if a policy contains a provision that no benefits will be paid until all benefits are paid by all other contracts; this is excess insurance, and the contract shall have EXCESS INSURANCE stamped or printed on the face page.				
627.667 FEDVIP	Extension of benefits provision – 90 days (N/A to Vision) Under FEDVIP, there is no 31-day extension of coverage; however, the company will pay benefits for a 31-day period after the insurance ends if before coverage ends the dentist: • prepared the abutment teeth for the completion of installation of prosthetic devices; • made an impression; • prepared the tooth for cast restoration; or • opened the pulp chamber before the insurance ends and the device is installed or treatment is finished within 31 days after the termination of coverage.				
627.6577(1)	Free choice of dental providers. Any employer, group, or organization that pays or contributes to the premium of a group health insurance plan or dental service plan corporation which provides dental coverage only upon the condition that services be rendered by an exclusive list of dentists or groups of dentists shall provide an alternative to enable the insured to have a free choice of dentist.				
CFR 156.270	Grace periods. (NGP Exchange-only plans.) Individuals receiving an advanced premium tax credit and who lose coverage due to non-payment of premium must be provided a three-month grace period. The QHP must cover all allowable claims for the first month of the three-month grace period and may pend subsequent claims in the second and third months of the grace period. During the grace period, a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return such payments of the premium tax credit for the second and third months of the grace period if the enrollee exhausts the grace period.				
627.616 95.11(2)(b)	Legal action: no legal action within 60 days after written proof of loss given; 5-year statute of limitations.				

PHSA 2702(c) CFR 156.230 80 FR 10830	Network adequacy Provider network consists of only providers contracted as in-network. The general availability of out-of-network providers may not be counted for purposes of meeting network adequacy requirements. (Applicable to QHP in FFE.) Reasonable access standard adopted in the *2015 Letter to Insurers in the Federally-facilitated Marketplaces (March 14, 2014)*. All services must be accessible without unreasonable delay consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act. (Applicable to QHP in FFE.) A provider directory is easily accessible when the general public is able to view all current providers on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and the general public is able to easily discern which providers participate in which plans and which provider networks, where there are multiple networks. (Applicable to QHP in FFE.) For Plan Years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible.				
69O-154.105(4)	Non-duplication of coverage.				
CFR 144.103	Plan and product defined. A “plan” is defined as “the pairing of health insurance coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.” The “product” comprises all plans offered with those characteristics and the combination of the service areas for all plans offered within a product constitutes the total service area of the product. The plan will be considered the same plan if it has the same cost-sharing structure as before the modification, or any variation is solely related to changes in cost of utilization, or is to maintaion the same metal tier; continues to cover a majority of the same service area and provider network. A state may permit greater changes to the cost-sharing structure, or designate a lower thresahold for maintenance of the same provider network or service area to still be considered the same plan.				
627.6561 PHSA 2704 CFR 146.145 CMS QHP Webinar Series FAQ 4/29/13	Pre-existing conditions. Provisions limiting pre-existing condition exclusion are not applicable to SADP. The prohibition against pre-existing condition exclusions does not apply to limited scope dental benefits if the benefits are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of a group health plan (i.e., participants may elect not to receive coverage for the benefits and the participant must pay additional premium to receive coverage for the benefits). (Per CMS Webinar 4/29/13: Stand-alone dental plans are not subject to Public Health Service Act § 2704 - Prohibition of Preexisting Condition Exclusions or Other Discrimination Based on Health Status. Therefore, for the purposes of Exchange certification, CMS will not be publishing guidance on look-back periods; rather, applicable Federal and State laws apply.)				

627.65625 CFR 146.145	Prohibiting discrimination against individual participants and beneficiaries based on health status. Limited-scope dental benefits (if they are provided under a separate policy, certificate or contract of insurance, or are otherwise not an integral part of a group health plan) are excepted from the prohibition against discrimination against participants and beneficiaries based on a health factor.				
627.657(3) 627.612	Proof of loss. Minimum of 90 days or as soon as reasonably possible within 1 year.				
627.4145 CFR 155.205	Readable language in insurance policies. Minimum score of 45 on Flesch reading ease test. Plain language requirement (Exchange standard). Issuers must provide applicants and enrollees information in plain language and in a manner that is accessible and timely. Required notices must meet certain specified standards.				
  CFR 155.430(b)(1), (d)(1)-(2) 80 FR 10800	Termination of coverage by the insured Termination of coverage by the insured for NGP. Exchange-only products The Exchange must permit an enrollee to terminate his or her enrollment in a QHP, including termination as a result of obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP. To the extent an enrollee may terminate under existing state laws, including "free look" cancellation laws, the enrollee may do so in accordance with such laws. The termination date is the date specified by the enrollee, if the enrollee provides reasonable notice. If the If the enrollee does not provide reasonable notice, the last day of coverage is 14 days after the date the enrollee requests termination. "Reasonable notice" is defined as notice occurring 14 days before the requested effective date of termination. If the enrollee requests an earlier termination date and the enrollee's QHP issuer agrees to termination in fewer than 14 days, then the date of termination is on or after the date requested by the enrollee.				

	Termination of coverage by insurer				
627.6645	Insurers must give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates.				
CFR 147.106(a)-(b)	Market-wide (not applicable to GP) *Exceptions to guaranteed renewability*. An issuer may nonrenew or discontinue health insurance coverage: • for nonpayment of premium, fraud or intentional misrepresentation of a material fact, violation of participation or contribution rules, by the plan sponsor or individual; • if discontinuing a particular product or all coverage in a given market or all markets: • if no enrollees under the plan still live, reside, or work in the service area of the issuer (or in the area for which the issuer is authorized to do business); or • for coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly.				
CFR 155.430(b)(2) CFR 156.270 CFR 55.430(b)(2)(vi)	Exchange-only products Termination of coverage by the Exchange or insurer for NGP. The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances with the following termination dates: • The enrollee is no longer eligible for coverage. In this case, the termination date is the last day of QHP coverage or eligibility; • Non-payment of premium, and the 3-month grace period required by 45 CFR 156.270 for advance payment of premium tax credits or any other applicable grace period has expired. In this case, the termination date is the last day of the first month of the 3-month grace period. • Non-payment of premium, and some other applicable grace period has been exhausted. In this case, the termination date is the date consistent with existing state laws regarding grace periods. • The enrollee changes plans during an open or special enrollment period. In this case, the last day of coverage in the prior QHP is the day before the effective date of coverage in the new QHP, including any retroactive enrollments/termination dates. • Death of the enrollee, with the effective date being the date of death. • The enrollee's coverage has been rescinded per 147.128 because the individual (or a person seeking coverage on behalf of the individual) performs an act, practice, or omission that constitutes fraud, or the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the plan or coverage. In this case, the issuer must provide a 30-day advance notice to each participant per 45 CFR 147.128(a). • The QHP terminates or is decertified by the Exchange. • Any of the reasons for termination of coverage under CFR 147.106 (i.e., exceptions to guaranteed renewability).				
CFR 156.270(b)	If a QHP issuer terminates an enrollee's coverage in accordance with				

	§155.430(b)(2)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination. When a primary subscriber and his or her dependents live at the same address, a separate notice need not be sent to each dependent at that address, so long as the notice sent to each primary subscriber at that address contains all the required information about the termination for that primary subscriber and each of his or her dependents at that address. QHP issuers must maintain records of termination of coverage and send termination information to HHS, promptly and without undue delay.				
80 FR 10809					
CFR 155.430(c)					
627.411(f)2	Terrorism exclusion. Terrorism cannot be excluded; companies must pay benefits to policyholders injured or killed by terrorist acts.				
69O-125.003	Unfair discrimination of travel plans. No insurer may refuse to issue or refuse to continue any policy because of the intent of the applicant to engage in future or past lawful foreign travel unless the insurer can demonstrate that insured's who have traveled or intend to travel are a separate actuarially supportable class who risk of loss is different from those who have not and will not travel. At present, only Iraq and Afghanistan may be excluded.				
627.602(1)(b) 69O-154.105(6)	Waiting period (or probationary period) is the period of time after a policy is issued before coverage is effective. Defined as "that period of time which may be specified in the policy and which must follow the date a person is initially insured under the policy before the coverage or coverages of the policy shall become effective as to such person." It must not exceed 30 days, subject to exceptions. No express limit on length of waiting periods in the individual market. Defines "waiting period" in a group context as "the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period."				
CFR 147.116(b)					
FEDVIP	Waiting period for orthodontic services. The dependent child receiving orthodontic services must be enrolled in the same plan option for an entire and continuous 24-month waiting period to receive orthodontic coverage.				
	Additional Provisions				
CFR 156.150(b)	Actuarial value. Pediatric SADP must offer the pediatric dental EHB at either a high level (85% actuarial value) or a low level (70% actuarial value), but not both, and within a de minimis variation of +/- 2 percentage points. [Actuarial value compares the cost of a plan after cost-sharing is taken into account against the same plan assuming 100% payment for all covered dental services.] Coverage levels must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.				
PHSA 2711 CFR 147.126 CFR155.1065(a)(2) (CMS QHP Webinar Series	Annual and lifetime Limits. Pediatric dental EHB offered by SADP certified to be offered in the Exchanges must be offered without annual and lifetime limits. This includes orthodontia services to the extent they are considered part of the pediatric dental EHB (i.e., medically necessary).				

FAQ 4/29/13)	Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB or from excluding all benefits for a non-covered condition for all covered people. If any benefits are provided for a condition, then no lifetime limit requirements apply. No annual limits may be imposed on the dollar value of EHB. The SADP must cover at least the pediatric dental EHB.				
CFR 156.150(a)	Annual limitation on cost sharing. Cost sharing under a SADP covering pediatric dental EHB under 45 CFR 155.1065 may not exceed $350 for one covered child ("individual" limit) and $700 for two or more covered children ("family" limit). (Reduced cost sharing does not apply to SADPs.)				
627.662(8) 627.6471	Alternative rates of payment contracts (optional). An insurer may enter into contracts for alternate rates of payment with licensed health care providers and may limit payment under such policies and may offer the benefits alternative to insureds.				
682	Arbitration. If included, arbitration must be on a voluntary basis. Two or more parties 'may' agree in writing; cannot have binding arbitration in contracts.				
627.664	Assignments. No provision shall be construed to prohibit and insured from making an assignment of all or any part of his or her incidents of ownership in the policy.				
627.6562(1) FEDVIP	Dependent coverage. If dependent coverage is included, the contract must comply with s. 627.6562 for dependents up to the end of the calendar year when the child reaches the age of 25. Eligible family members include your spouse and unmarried dependent children under age 22. This includes legally adopted children and recognized natural children who meet certain dependency requirements. This also includes stepchildren and foster children who live with you in a regular parent-child relationship. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.				
627.6699(3)(h) (small group) 627.6563 (small and large groups) 29 U.S.C. 1002, as referenced by 42 U.S.C. s. 300gg-91(d)(5)	"Eligible Employee" means an employee who works full time, having a normal workweek of 25 or more hours, and who has met any applicable waiting period requirements. "Employee" is defined as an individual employed by an employer.				
CFR 148.220(1)	Guaranteed issue (availability) and guaranteed renewability of coverage does not apply to limited scope dental benefits if the benefits are provided under a separate policy, certificate or contract of insurance.				
627.6615 627.6699(12)(b)4.g. Small Group	Handicapped children. A child incapable of self-sustaining employment due to mental retardation or physical handicap and chiefly dependent on the policyholder for support and maintenance may continue to be covered.				
627.662(5) 627.640	Rates must be filed with the Office for approval. If there is no rate impact with the filing, the insurer must provide an actuarial certification that the risks covered by the products proposed within this filing are funded on an annual basis without any pre-funding of future risk. If this certification cannot be provided, justification of all rates is required.				

627.6699(3)(v) CFR 144.103	"Small Employer" definition required. Employed at least 2 but not more than 50 employees on business days during the preceding calendar year and employs at least 2 employees on the first day of the plan year.				