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 Individual Contract Worksheet

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

Legend: CFR=Refers to 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 Office with 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.				
	Policy Cover Page				
69O-154.001	Policy statement instructing the policyholder to read the application attached to the policy and inform the company within 10 days of any incomplete or incorrect information, or if any past medical history has been omitted.				
69O-154.003	Right to Return Policy. Policy must notify the policyholder of the right to review the policy or contract and return it within 10 days of delivery for a full refund of premium paid if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason				
69O-154.105(1)	Renewability provision. Each individual or family policy of accident and health insurance shall include a renewal, continuation or nonrenewal provision consistent with the type of contract to be issued (e.g., noncancellable and guaranteed renewable, guaranteed renewable, renewable at the option of the insurer, single term nonrenewable, etc.). Such provision must be appropriately captioned and commence or be referenced on the first page of the policy and must clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.				
627.602(2)	Deductible statement. Must appear in 18-point font on the policy				
627.416	Execution of policies: every form shall contain the signature of a company official.				

	Required Policy Contents				
69O-154.104	Definitions shall be contained in the contract.				
69O-154.105(2)	Conditions of eligibility.				
627.413(1)(a)	The names of the parties to the contract.				
627.413(1)(b)	The subject (type) of insurance. Policy must have a title.				
627.413(1)(c) 627.4295 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)	The risk insured against. (Benefits.) Pediatric dental (GP) Dental procedures for children: If the contract provides coverage for general anesthesia and hospitalization services, such services must be provided for dental care to persons less than 8 years of age. 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. 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.				
627.413(1)(e)	The premium (may be located on the application or schedule of benefits, if application/schedule is made part of the policy).				
627.602(1)(a)	The monetary and other consideration to be expressed therein.				
627.413(1)(f)	The conditions pertaining to the insurance. Qualification of the benefits.				
627.413(1)(g)	The form numbers and edition dates of all endorsements attached to the policy, only at time of original issue.				
627.602(1)(f)	All contracts and related forms shall contain a form number in the lower left-hand corner.				
627.4131	Contact information. Telephone number required for policyholders and certificate holders to present inquiries or obtain information about coverage				

627.606	The entire contract: list all forms that apply.				
627.607	The time limit on certain defenses: 2-year maximum.				
627.608 CFR 156.270(d)	Grace period. The policy shall contain a minimum grace period of no less than 7 days for a weekly premium policy, 10 days for a monthly premium policy, or 31 days for all other policies. IF SOLD ON EXCHANGE ONLY (NGP). Individuals who receive an advanced premium tax credit and lose coverage due to non-payment of premium must be provided a 3-month grace period. The QHP must cover all allowable claims for the first month and may pend subsequent claims in the second and third months. During the grace period, a QHP issuer will continue to collect subsidy payments on the delinquent enrollee's behalf and return payments of the premium tax credit for the second and third months if the enrollee exhausts the grace period.				
627.609	Reinstatement.				
627.610	Notice of claims: minimum of 20 days or as soon as reasonably possible.				
627.611	Claim Forms: company must provide within 15 days.				
627.6044	Claims methodology.				
627.612	Proof of loss: minimum of 90 days or as soon as reasonably possible within 1 year.				
627.6044	Claims payment methodology.				
627.6131 627.662(6)	Claims payments.				
627.613	Time of payment of claims: company must pay or deny within 45 days.				
627.602(1)(c)	Must identify who is covered. This may be located in the outline of coverage or schedule of benefits if they are made part of the policy.				
627.6131	Payment of claims.				
627.614	Payment of claims: maximum of $3,000 to person who cannot execute a valid release.				
627.6141	Denial of claims				
627.602(1)(e) 627.411 69O-154.105(7)(c)	Exceptions and reductions must be listed. Exceptions, exclusions and reductions must be clearly expressed as a part of the benefit provision to which such applies, or if applicable to more than one benefit provision, shall be set forth as a separate provision and appropriately captioned. They must be clearly stated and unambiguous.				

627.602(1(b) 627.413(1)(d)	Effective dates of Coverage for 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. <u>Annual enrollment periods.</u>				
CFR 147.104(b)(iii)	Individual market coverage must become effective consistent with the dates in CFR 155.410.				
CFR 155.410(f)(2)	Coverage effective dates applicable both inside and outside the Exchange: For the benefit year beginning on January 1, 2016, the Exchange must ensure that coverage is effective— • 1/1/16, for QHP selections received by the Exchange on or before 12/15/15. • 2/1/16, for QHP selections received by the Exchange from 12/16/15 through 1/15/16. • 3/1/16, for QHP selections received by the Exchange from 1/16/15 through 1/31/16.				
CFR 147.104(b)(5)	<u>Special enrollment periods</u>. Coverage must become effective consistent with the dates in CFR 155.420. Coverage effective dates applicable both inside and outside the 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.				
CFR 155.420(B)(3)	An Exchange may set earlier effective dates for certain special enrollment periods.				
69O-154.105(4)	Non-duplication of coverage.				

	Policy Standards				
	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/Annual open enrollment period.				
CFR 155.410(a) CFR 155.420(a)	The Exchange must provide enrollment periods for qualified individuals to enroll in or change QHPs.				
CFR 155.410(e)	Annual open enrollment period for non-grandfathered policies in the individual market, both inside and outside of the Exchange, for the 2016 Plan Year beginning on or after January 1, 2016, is November 1, 2015 through January 31, 2016.				
	Enrollment/Special enrollment periods. **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				
155.420(c), (d)(1)-(10) & (e)	The Exchange must provide special enrollment periods for qualified individuals to enroll in QHPs and enrollees to change QHP (or SADP) upon				

80 FR 10798	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.				

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.				
627.616; 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.				
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.				
CFR 147.104(f)	Policy period (NGP). An issuer that offers coverage in the individual market, or in a merged market in a State that has elected to merge the individual market and small group market risk pools, must ensure that such coverage is offered on a calendar year basis with a policy year ending on December 31 of each calendar year.				
627.6045 CFR 148.220(b)(1) CMS QHP Webinar Series	Pre-existing condition provisions not applicable to supplemental products. 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. (Per CMS Webinar 4/29/13: Stand-alone dental plans are not subject to Public Health Service Act § 2704.				

4/29/13	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.)				
CFR 155.400(e)	Premium payment dates. FFE EXCHANGE ONLY. To effectuate enrollment, the FFE requires payment of the first month (or binder payment) premium. For coverage being effectuated under regular coverage effective dates, FFE premium payment deadlines must be no earlier than the coverage effective date, but no later than 30 calendar days from the coverage effective date. For coverage being effectuated under special effective dates, premium payment deadlines must be 30 calendar days from the date the issuer receives the enrollment transaction.				
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 147.106(f)	Renewal of coverage. An issuer in the individual market renewing a NGP, or uniformly modifying a NGP, must provide to each individual written notice of the renewal before the date of the first day of the next annual open enrollment period in a form and manner specified by the HHS Secretary.				
69-154.005(3) CFR 155.430(b)(1), (d)(1)-(2) 80 FR 10800	Termination of coverage by the insured Termination of coverage by the insured (including member) for ON-EXCHANGE non-grandfathered plans. <u>Exchange-only products</u> The Exchange must permit an enrollee to terminate 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 (not just cancel) 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 by the insurer.				
627.6043	Insurers must give the policyholder at least 45 days' advance notice of cancellation, expiration, nonrenewal, or a change in rates. Such notice shall be mailed to the policyholder's last address as shown by the records of the insurer. However, if cancellation is for nonpayment of premium, at least 10 days' written notice accompanied by the reason therefor shall be given. Written notice of cancellation for nonpayment of premium shall not be required for health insurance policies under which premiums are payable monthly or more frequently and regularly collected by a licensed agent. If the insurer fails to provide the required notice, the coverage shall remain in effect at the existing rates until 45 days after the notice is given or until the effective date of replacement coverage obtained by the insured, whichever occurs first.				
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).				
CFR 147.106(h)	Medicare eligibility or entitlement is not a basis for nonrenewal or termination of an individual's health insurance coverage in the individual market.				

	Termination of coverage by the insured (continued). Exchange-only products Termination of enrollment in a QHP through the Exchange (distinct from termination of coverage with the issuer outside the Exchange) 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 tax credits or 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 woith 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 effectiove date of coverage in the new QHP, including any retroactive enrollments/termination dates. • Death of the enrollee, with effective date being 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, issuer must provide 30-day advance notice to each participant per 45 CFR 147.128(a) o The QHP terminates or is decertified by the Exchange. o Any of the reasons for termination of coverage under CFR 147.106 o (i.e., exceptions to guaranteed renewability). A QHP issuer must establish a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium as permitted by the Exchange.				
CFR 155.430(b)(2) CFR 156.270(a) 80 FR 10-801					
CFR 156.270(b) FR 80 10809 CFR 155.430(c)	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.				
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.				
CFR 147.116(b)	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."				
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				
627.634	Age limit: if a contract will terminate when a covered person attains a certain age; if the premium is paid and accepted after such date, the coverage will continue until the end of the period for which the premium was paid.				
CFR 156.150(b)	Actuarial value. Insurer must demonstrate that the stand-alone pediatric dental plan offers 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 2707 PHSA 2711 CFR 147.126 CFR 155.1065(a)(2) CMS QHP Webinar Series FAQ 4/29/13	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). (CMS QHP Webinar Series FAQ 4/29/13) No lifetime limits on the dollar value of EHB, but 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 on the dollar value of EHB. The SADP must cover at least the pediatric dental EHB.				
627.419(9)	Appeals. Each claimant, or dentist acting for a claimant, who has had a claim denied as not medically or dentally necessary or who has had a claim payment based on an alternate dental service in accordance with accepted dental standards for adequate and appropriate care must be provided an opportunity for an appeal to the insurer's licensed dentist who is responsible for the medical necessity reviews under the plan or is a member of the plan's peer review group. The appeal may be by telephone, and the insurer's dentist must respond within a reasonable time, not to exceed 15 business days.				

627.617	Beneficiary. Change of beneficiary: unless irrevocable.				
627.627	Conformity with statutes.				
	Co-payment features (if any)				
CFR 156.150(a)	Cost-sharing annual limitation. 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.) Issuers are not prohibited from excluding all benefits for a condition. However, if any benefits are provided for a condition, then the provisions related to annual and lifetime limits apply. Other requirements of Federal or State law may require coverage of certain benefits.				
CFR 147.140	Individual health insurance coverage that on March 23, 2010, did not impose an overall annual or lifetime limit on the dollar value of all benefits ceases to be a GP if the plan or health insurance coverage imposes an overall annual limit on the dollar value of benefits.				
PPACA 1402	Cost sharing includes deductibles, coinsurance, co-payments, or similar charges; and any other expenditure required of an insured individual which is a qualified medical expense for EHB covered under the plan. Defines "qualified medical expense."				
627.602(1)(c); 627.6562	Dependent Coverage. If dependent coverage is included, the policy must insure a dependent child at least until the end of the calendar year in which the child reaches the age of 25.				
627.6041	Attainment of Limiting Age: Coverage does not terminate if the child continues to be: incapable of self-sustaining employment by reason of mental retardation of physical handicap and is chiefly dependent on the member for support or maintenance.				
PPACA 1251(a)(4)(A)(iv) PHSA 2714 CFR 147.120	(GP, NGP) Requires all plans offering dependent coverage to allow dependent children to remain on their parent's plan until age 26. Eligible children are defined based on their relationship with the participant such as financial dependency, residency, student status, employment, eligibility for other coverage and marital status. Adult children up to age 26 may not be defined for purposes of eligibility other than in terms of the relationship between the child and insured. The policy term s for dependent coverage cannot vary based on the age of a child. Coverage of grandchildren not required.				
FEDVIP	"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.				
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.				
627.620	Misstatement of age.				