

NEW YORK STATE DEPARTMENT OF FINANCIAL SERVICES

Review Standards for

NYSOH and NYSOH-Certified Individual Stand-Alone Dental Insurance

As of 4/15/16

Instructions for SERFF Checklist:

- A. For **ALL** filings, the “General Requirements for All Filings” section must be completed:
- B. For a **FORM** filing, completion of additional sections may be required as follows, depending on the type of form being submitted:
- Policy or contract – Also complete all sections.
 - Application – Also complete the section entitled “Application Forms.”
 - Rider or endorsement – Also complete all items relevant to the form being submitted in all sections.
- C. For filing of initial rates, complete the section entitled “Actuarial Section For New Product Rate Filings Only” in addition to completion of the applicable form sections identified above. For filing of rate changes to existing products (increases, decreases or changes in rate calculation rules or procedures), complete the “Actuarial Section for Existing Product Rate Filings Only” section. For the filing of any other changes to rate or underwriting manuals (e.g. changes in commissions or underwriting), complete the “Actuarial Section for Existing Product Rate Filings Only” section.
- D. For each item, enter in the last column the form number(s), page number(s) and paragraph(s) where the requirement is met in the filing or insert a bookmark connecting to the appropriate location in the filing. All items with shaded boxes must be answered.
- E. Do not make any changes or revisions to this checklist.
- F. **Instructions for Citations:** All citations to Insurance regulations link to the Department of State’s website and an unofficial copy of the NYCRR. Please select title 11 for Insurance regulations. Most of the pertinent form and rate regulations are located in Chapter III Policy and Certificate Provisions, Subchapter A Life, Accident and Health Insurance. All citations to New York Laws (Insurance Laws or other New York laws) link to the public LRS website. To locate the Insurance Laws, please select the link labeled “ISC”.

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Individual Stand-Alone Dental Checklist

LINE OF BUSINESS: **Individual - Dental**

<u>TOI</u>	<u>LINE(S) OF INSURANCE</u>	<u>Sub-TOI</u>
H10I	Individual Health Dental	H10I.001 Health – Pediatric Dental

IF CHECKLIST IS NOT APPLICABLE, OR IF THE SUBMISSION CONTAINS INSERT PAGES, RIDERS OR ENDORSEMENTS AND THE POLICY IN ITS ENTIRETY DOES NOT COMPLY WITH ALL STATUTORY AND REGULATORY PROVISIONS STATED BELOW, PLEASE EXPLAIN:

REVIEW REQUIREMENT	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	LOCATION OF STANDARD IN FILING
GENERAL REQUIREMENTS FOR ALL FILINGS	<i>Note: Unless otherwise noted, all references are to Insurance Law, Insurance Regulations, and Department of Financial Services Circular Letters and OGC opinions</i>	<p><i>Stand-alone dental plans are an excepted benefit under the Affordable Care Act, 42 U.S.C. § 300gg-91 and are generally treated by the Department as limited benefits health insurance under 11 NYCRR 52.10. Certain provisions of the Affordable Care Act apply to the pediatric dental essential health benefit and are indicated in the checklist.</i></p> <p><i>This checklist is intended to provide guidance in the preparation of policy or contract forms for submission and is not intended as a substitute for statute or regulation.</i></p>	Form/Page/ Para Reference
Complete Policy or Contract Submission or Pages/Rider/Endorsement	§ 3201(b)(1) and (c) § 3204 § 3216(d)(1)(A) § 4306(d) and (e)	<p>This submission contains a complete policy or contract form. Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>No statement made by the individual in his or her application for a contract or policy shall avoid the contract or be used in a legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such policy or contract form.</p> <p>No agent or representative of such corporation and no broker, other than officer or officers designated therein, is authorized to change the contract or waive any of its provisions.</p> <p>If this submission contains insert pages, riders or endorsements, then the policy or contract form in its entirety complies with all the statutory and regulatory provisions</p>	

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		<p>stated below. Yes <input type="checkbox"/> No <input type="checkbox"/> (If no is checked, explain in the space provided above.)</p> <p>This rider, insert pages, or endorsements are being attached to a policy or contract that was approved by the Department on _____, submission number _____.</p>	
Form Requirements	11 NYCRR 52.31(b), (d), (e), (f), (l)	<p>Each form in the filing must meet the following requirements:</p> <ul style="list-style-type: none"> • This form contains no strikeouts. § 52.31(b) • This form is designated by a form number made up of numerical digits and/or letters in the lower left-hand corner of the first page. § 52.31(d) • This form is submitted in the form intended for actual use. § 52.31(e) • All blank spaces are filled in with hypothetical data. § 52.31(f) • If the form contains illustrative material, it does so only for items that may vary from case to case, such as names, dates, eligibility requirements, premiums and schedules for determining the amount of insurance for each person. § 52.31(l) • All policy or contract forms must be placed on the Form Schedule tab in SERFF. • In general, variable material is not permitted and should be limited. 	
Flesch Score	§ 3102(c)	Provide Flesch score certification (the Flesch score should be at least 45). The number of words, sentences and syllables in the form should be set forth as part of the certification, which must be signed by an officer of the company.	
SERFF Filing Description or Letter of Submission	11 NYCRR 52.33 Circular Letter No. 33 (1999) Supplement 1 to CL No. 33 (1999)	<p>The filing must include a SERFF filing description or a letter of submission that contains the following:</p> <ul style="list-style-type: none"> • The identifying form number of each form submitted. § 52.33(a) • If the form had previously been submitted for preliminary review, the letter must include a reference to the previous submission and a statement setting out either that the form agrees precisely with the previous submission; or the differences from the form submitted for preliminary review. § 52.33(e) 	
Discrimination	§ 2606, § 2607, § 2608 & 2612	This form does not contain any unfair discrimination provisions because of race, color, creed, national origin, disability (including treatment of mental disability), sex, marital status or status as a victim of domestic violence.	
CONSUMER INFORMATION			Form/Page/ Para Reference
Required Disclosure Form	11 NYCRR 52.54 11 NYCRR 52.59	This filing includes the required disclosure form per § 52.54 or § 52.59 to be incorporated into the policy when delivered OR be delivered to the applicant at the time application is made and receipt is acknowledged.	

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		<i>Note: This is filed under the Supporting Documents tab in SERFF.</i>	
APPLICATION FORMS		<i>Coverage offered inside the New York State of Health (NYSOH) must use the application provided by the NYSOH.</i>	Form/Page/ Para Reference
Authorization	11 NYCRR 420.18(b)	If the application includes an authorization to disclose non-public personal health information, the authorization specifies the length of time the authorization will remain valid. The maximum allowable period is 24 months.	
Fraud Warning Statement	§ 403(d) 11 NYCRR 86.4	All applications must contain the prescribed fraud warning statement. The fraud warning statement must be printed directly above the signature line and printed in such a way that is conspicuous to the insured.	
Health Questions	11 NYCRR 52.51(b)	Any question of past or present health of any person that refers to a specific disease or general health must be asked “to the best of the applicant’s knowledge and belief”. <i>Note: Does not apply to questions about factual information such as doctor visits or hospital confinements.</i>	
Investigative Consumer Report	§ 380-c of the General Business Law	If an Investigative Consumer Report will be prepared or procured, a notice complying with § 380-c of the General Business Law is included in the application OR separate form.	
Limited Benefits Statement	11 NYCRR 52.16(k)(1)	If the policy or contract form for which this application is used is offered to persons age 65 and older the application contains a statement that complies with § 52.16(k)(1).	
Medical Information Exchange Center	§ 321	If a Medical Information Exchange Center (such as a Medical Information Bureau) will be used, the insurer complies with § 321 of the Insurance Law.	
Multiple Applications for One Policy	§ 4224(b)	If more than one application is used to apply for a policy, attach a full explanation of the objective criteria used to determine who completes each application. <i>Note: Objective criteria are necessary to avoid unfair discrimination.</i>	
Pre-Existing Conditions	11 NYCRR 52.51(j)	If the application is used with a policy that contains a “pre-existing conditions” provision, a statement describing the provision is included in the application OR the statement is included in the disclosure statement required by § 52.54 that is delivered at the time of the application. <i>NOTE: A PRE-EXISTING CONDITION EXCLUSION MAY NOT APPLY TO THE PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT.</i>	

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Prohibited Questions and Provisions	§ 3204 11 NYCRR 52.51	The application does NOT contain: <ul style="list-style-type: none"> • Questions about the applicant’s race. • A provision that changes the terms of the policy to which it is attached. • A statement that the applicant has not withheld any information or concealed any facts. • An agreement that an untrue or false answer material to the risk will render the policy void. • An agreement that acceptance of any policy or contract form issued upon the application will constitute a ratification of any changes or amendments made by the insurer and inserted in the application, except to conform to § 3204(d). 	
Telephone or In-Person Interview	§ 3204 Article III, NY Technology Law	If a telephone or in-person interview will be used with this application, the interview is conducted in the following manner: <ul style="list-style-type: none"> • Any question raised during the interview are limited to those questions appearing on the application (i.e., questions over the phone would be no different than those being asked in the application). • The applicant will have an opportunity to review and make corrections to those statements that were attributed to him/her in the interview. • Any information obtained in the interview that will be used in the underwriting process will be reduced to writing, signed by the applicant and attached to the policy in compliance with § 3204. • If an electronic signature is used, it must comply with the Electronic Signatures and Records Act (Article III of the Technology Law). • If a telephone application is being used, please provide a description of the procedure for taking a telephonic application. Any scripts used in the telephone interview must be filed for reference. 	
POLICY OR CONTRACT FORM PROVISIONS			Form/Page/ Para Reference
COVER PAGE Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
Insurer name		This policy or contract form contains the name and full address of the issuing insurer on the front or back cover.	
Signature of Company		The signature of company officer(s) appears prominently on the policy or contract form	

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Officer		(such as on the cover).	
Free Look Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(c)(10) § 4306(h) Model Language	The policy or contract form provides that the insured can return the policy or contract within 10 days from receipt provided they do so in writing. Any premium, fees or charges paid will be refunded.	
Brief Statement Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4306(m) Model Language	This policy or contract form contains a brief description of the contract on its first page.	
Table of Contents Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3102(c)(1)(G) Model Language	A table of contents is required.	
Renewability Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.17(a) 11 NYCRR 52.40(b)(1) Model Language	The form meets the following requirements: <ul style="list-style-type: none"> • The cover indicates whether the policy is renewable or nonrenewable. § 52.17(a)(1) • The cover indicates the renewability provision OR briefly describes and references the policy renewability provision. § 52.17(a)(2) • If the policy is “non-cancellable” or “non-cancellable and guaranteed renewable”, the renewability provision complies with § 52.17(a)(5) • If the policy is “guaranteed renewable”, the renewability provision complies with § 52.17(a)(6) and (7). • If the rates are level premium, the policy is “Guaranteed Renewable”, “Non-cancelable” or provides that non-renewable is subject to the approval of the Superintendent. § 52.40(b)(1) 	
Disclosure Statement Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.54, 52.59 Model Language	The policy or contract contains the following disclosure statement: “The insurance evidenced by this [Contract; Policy] provides DENTAL insurance ONLY.”	
Limited Benefits Statement	11 NYCRR 52.16(k)(2)	If the policy or contract form is offered to persons age 65 or older, the cover contains a statement that complies with § 52.16(k)(2).	
Reduction in Benefits	11 NYCRR 52.17(a)(3) Model Language	If benefits are reduced due to attainment of an age limit or benefit reduction period, such reduction is referenced on the cover page or schedule page of the policy or contract form.	

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Termination of Benefits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(c)(11) § 4306(i) Model Language	If the policy or contract form contains an age limit, date or period after which the coverage will not be effective or renewed, the age limit, date or period after which the coverage will not be effective or renewed must be stated on the cover page in (must select one): (1) The renewability provision; (2) A separate provision with an appropriate caption; or (3) A brief description in at least 14 point type.	
DEFINITIONS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217 Model Language	<i>Definitions included in the policy or contract form must comply with the Model Language. For a complete listing of the required definitions click on the adjacent Model Language link.</i>	Form/Page/ Para Reference
HOW THIS COVERAGE WORKS			Form/Page/ Para Reference
Selecting a Primary Care Dentist			
Selecting, Accessing and Changing Participating Providers Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(9) § 3217-a(a)(10) § 4324(a)(9); (10) Model Language	Where applicable, this policy or contract form includes a description of the procedures for insureds to select, access, and change primary and specialty care providers, including notice of how to determine whether a participating provider is accepting new patients.	
Designation of Primary Care Dentist (PCD) Does this product require a PCD to be designated? Yes <input type="checkbox"/> No <input type="checkbox"/> Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-e § 4306-d Model Language	If the policy or contract form requires the designation of a primary care dentist (“PCD”), this policy or contract form permits an insured to designate any participating PCD who is available to accept the insured.	
Preauthorization			
Preauthorization Requirements Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3217-a(a)(2) § 3238 § 4324(a)(2) Model Language	This policy or contract form includes a description of all preauthorization or other notification requirements for treatments and services. A preauthorization or notification penalty of either 50% of the allowable amount for services rendered or \$500.00, whichever is less, is permissible. If the policy or contract form requires a gatekeeper, the preauthorization requirements may not be imposed on the insured for in-network services.	

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Medical Necessity			
Definition of Medical Necessity	§ 3217-a(a)(1) § 4324(a)(1)	This policy or contract form includes a definition of “medical necessity” used in determining whether benefits will be covered.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
Contact Information	§ 3217-a(a)(16) § 4324(a)(16)	This policy or contract form includes all appropriate mailing addresses and telephone numbers to be utilized by insureds seeking information or authorization.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
ACCESS TO CARE AND TRANSITIONAL CARE			
Referral or Authorization to Non-Participating Providers	§ 3217-a(a)(11) § 4324(a)(11) § 4801(c) § 4804(a)	If a policy or contract form is a managed care product as defined in Insurance Law § 4801(c), such as a gatekeeper insurance product, it must describe how an insured may obtain a referral or authorization to a dental care provider outside of the insurer’s network when the insurer does not have a dental care provider with appropriate training and experience in the network to meet the dental care needs of the insured and the procedure by which the insured can obtain such referral or authorization.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
Specialty Care Provider as PCD	§ 3217-a(a)(13) § 3217-d(b) § 4324(a)(13) § 4306-c(b) § 4801(c) § 4804(b)	If this policy or contract form is a managed care product, as defined by Insurance Law § 4801(c), such as a gatekeeper insurance product, and it requires (i) the designation of a PCD, and (ii) that specialty care must be provided pursuant to a referral from a PCD, then it must include a notice that an insured with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized dental care over a prolonged period of time, is permitted to request that a specialist be designated as their PCD to provide or coordinate the insured’s dental care and describe the procedure for requesting and obtaining a specialist as a PCD.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
Standing Referrals	§ 3217-a(a)(12) § 3217-d(b) § 4324(a)(12) § 4306-c(b) § 4801(c) § 4804(c)	If this policy or contract form is a managed care product, as defined by Insurance Law § 4801(c), such as a gatekeeper insurance product, and it requires (i) the designation of a PCD, and (ii) that specialty care must be provided pursuant to a referral from a PCD, it must include a notice that an insured with a condition which requires on-going care from a specialist, may request a standing referral to such specialist and describe the procedure for requesting and obtaining such a standing referral.	
Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language		
Transitional Care When A	§ 3217-d(c)	If this policy or contract form is a managed care product, as defined by Insurance Law §	

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<p>Provider Leaves the Network</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4306-c(c) § 4801(c) § 4804(e)</p> <p>Model Language</p>	<p>4801(c), such as a gatekeeper insurance product, and the insured is in an ongoing course of treatment when a provider leaves the network, the policy or contract form must describe how an insured may continue to receive treatment for the ongoing treatment from the former participating provider for up to 90 days from the date the provider's contractual obligation to provide services was terminated.</p>	
<p>Transitional Care For A New Member in a Course of Treatment</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-d(c) § 4306-c(c) § 4801(c) § 4804(f)</p> <p>Model Language</p>	<p>If this policy or contract form is a managed care product, as defined by Insurance Law § 4801(c), such as a gatekeeper insurance product, and the insured is in an ongoing course of treatment with a non-participating provider when the insured's coverage becomes effective for a life-threatening disease or condition or a degenerative and disabling condition or disease, the policy or contract form must describe how the insured may continue to receive care for the ongoing course of treatment from the non-participating provider for up to 60 days from the effective date of the insured's coverage.</p>	
<p>COST-SHARING EXPENSES AND ALLOWED AMOUNT</p>			<p>Form/Page/ Para Reference</p>
<p>Cost of Service</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3201(c)(3) 11 NYCRR 52.1(c)</p> <p>Model Language</p>	<p>If the cost of the service is less than the copayment for the service, the patient is responsible for the lesser amount.</p>	
<p>Maximum Out-of-Pocket Limit for the Pediatric Essential Health Benefit</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.150</p> <p>Model Language</p>	<p>For 2017, there must be an in-network out-of-pocket limit on the pediatric dental essential health benefit of \$350 (or less) for one (1) member under age 19 and \$700 (or less) for two (2) or more members under age 19.</p>	
<p>Non-Participating Providers and Non-Authorized Services</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(6) § 4324(a)(6)</p> <p>Model Language</p>	<p>This policy or contract form includes a description of the insured's financial responsibility for payment when services are provided by a dental care provider who is not part of the insurer's network of providers or by any provider without the required authorization or when a procedure, treatment or service is not a covered dental care benefit.</p>	
<p>Reimbursement of Providers</p>	<p>§ 3217-a(a)(4)</p>	<p>This policy or contract form includes a description of the types of methodologies the</p>	

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4324(a)(4) Model Language	insurer uses to reimburse providers.	
WHO IS COVERED			Form/Page/ Para Reference
Person to Whom Contract is Issued Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(c)(3) § 4304(d) Model Language	This policy or contract form provides coverage for the person to whom the contract is issued. The policy or contract form can only insure one person, except a policy or contract may insure members of a family as defined by section § 3216(a)(3) upon the application of an adult member of the family who shall be deemed the policyholder.	
Spouse Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(3) § 3216(c)(3) § 4304(d) Circular Letter No. 27 (2008) Model Language	For spouse and/or family coverage, this policy or contract form provides coverage for the lawful spouse, unless there is a divorce or annulment of the marriage. This includes marriages between same-sex partners.	
Dependents Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(3) § 3216(a)(4) § 4304(d) 11 NYCRR 52.17(a)(10) Model Language	For parent and child/children and/or family coverage, this policy or contract form provides coverage of children until age 19. <i>Note: Family members may provide a new contestable period for each new member added, but cannot provide for a new contestable period for the policy. See 11 NYCRR § 52.17(a)(10).</i> <i>Note: Pursuant to § 2608-a of the Insurance Law, an insurer may not deny enrollment to a child under the health coverage of the child's parent on the ground that the child was born out of wedlock, the child is not claimed as a dependent on the parent's federal income tax return, or the child does not reside with the parent or in the insurer's service area.</i>	
Unmarried Students Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(4)(A)(ii) § 4304(d) Model Language	For parent and child/children and/or family coverage, any unmarried student at an accredited institution of learning may be considered a dependent child until attaining age 23.	
Unmarried Students on	§ 3237	For parent and child/children and/or family coverage, coverage for dependent children	

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<p>Medical Leave of Absence</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4306-a</p> <p>Model Language</p>	<p>who are full-time students (if covered to a higher age than other dependent children), shall have coverage continue when such dependent takes a medical leave of absence from school due to illness or injury for a period of 12 months from the last day of attendance at school, provided however, that coverage of a dependent student is not required beyond the age at which coverage would otherwise terminate. To qualify for such coverage, the insurer may require that the medical necessity of the leave be certified to by the student's attending physician who is licensed to practice in the state of New York.</p>	
<p>Unmarried Disabled Children</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(a)(4)(A)(i) § 3216(c)(4)(A) § 4304(d)</p> <p>Model Language</p>	<p>For parent and child/children and/or coverage, this policy or contract form provides coverage for any unmarried dependent child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, or mental retardation as defined in the Mental Hygiene Law, or physical handicap and who became so incapable prior to the age at which dependent coverage would otherwise terminate.</p> <p><i>Note: Such coverage shall not terminate while the coverage remains in effect and the dependent remains in such condition and is chiefly dependent on the insured for support and maintenance, if the insured has within 31 days of such dependent's attainment of the limiting age submitted proof of such dependent's incapability.</i></p>	
<p>Newborn Infants</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(c)(4)(C) § 4304(d)</p> <p>45 C.F.R. § 155.420</p> <p>Model Language</p>	<p>For parent and child/children and/or family coverage, this policy or contract provides coverage of newborn infants, including newly born infants adopted by the insured if the insured takes physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to § 115-c of the Domestic Relations Law within 60 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked. Coverage shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.</p> <p><i>Note: In the case of individual or individual and spouse coverage, the insurer must permit the insured to elect such coverage of newborn infants from the moment of birth. If notification and/or payment of an additional premium is required to make coverage effective for a newborn infant, the coverage may provide that such notice and/or payment be made within no less than 60 days of the day of birth to make coverage effective from the moment of birth.</i></p>	
<p>Adopted Children and Step-Children</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.17(a)(30), (31)</p> <p>Model Language</p>	<p>For parent and child/children and/or family coverage, this policy or contract form provides that adopted children and stepchildren are eligible for coverage on the same basis as natural children. Further, a policy or contract form covering a proposed adoptive parent, on whom the child is dependent, shall provide that such child be eligible for coverage on the same basis as a natural child during any waiting period prior to the</p>	

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		finalization of the child’s adoption.	
<p>Domestic Partners</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>OGC Opinion 01-11-23</p> <p>Model Language</p>	<p>If coverage for domestic partners is provided, the policy or contract form should require the applicant to provide the following:</p> <ul style="list-style-type: none"> • Registration as a domestic partner, where such registry exists, or an affidavit of domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months; • Proof of cohabitation; and • Proof of financial interdependency by evidence of two (2) or more of the following: joint bank account; joint credit or charge card; joint obligation on a loan; status as authorized signatory on the partner’s bank account, credit card or charge card; joint ownership or holding of investments; joint ownership of residence; joint ownership of real estate other than residence; listing of both partners as tenants on lease; shared rental payments; shared household expenses; shared household budget for purposes of receiving government benefits; joint ownership of major items of personal property; joint ownership of a motor vehicle; joint responsibility for child care; shared child-care expenses; execution of wills naming each other as executor and/or beneficiary; designation as beneficiary under the other’s life insurance policy or retirement benefits account; mutual grant of durable power of attorney; mutual grant of authority to make health care decisions; affidavit by creditor or other individual able to testify to partners’ financial interdependence; or other items of sufficient proof to establish economic interdependency under the circumstances of the particular case. 	
<p>Enrollment Periods</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 C.F.R. § 155.410 45 C.F.R. § 155.420</p> <p>Model Language</p>	<p>This policy or contract form must provide for an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.</p> <p>A policy or contract form issued outside the NYSOH may use a continuous open enrollment period.</p>	
DENTAL CARE		<i>The pediatric dental care essential health benefit must be included in the policy. The other benefits listed are optional.</i>	Form/Page/ Para Reference
<p>Pediatric Dental Care Essential Health Benefit</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>45 CFR § 156.150 45 CFR § 155.1065</p> <p>Model Language</p>	<p>This policy or contract form provides coverage for the pediatric dental care essential health benefit including the following dental care services for members up to age 19: emergency dental care; preventive dental care; routine dental care; endodontics; periodontics; prosthodontics; oral surgery; and orthodontics used to help restore oral structures to health and function and to treat serious medical conditions.</p>	

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		Such coverage may be subject to deductibles, copayments and/or coinsurance. If the policy or contract form includes additional pediatric dental care beyond the essential health benefit requirement, please provide an explanation of coverage in the box below.	
<u>Additional Pediatric Dental Benefit explanation:</u>			
Adult Dental Care		This policy or contract form may provide coverage for adult dental care. If providing coverage for adult dental care, please provide an explanation of coverage in box below.	
<u>Adult Dental Benefit explanation:</u>			
PERMISSIBLE EXCLUSIONS AND LIMITATIONS		<i>No policy or contract form shall limit or exclude coverage by type of illness, accident, treatment or medical condition with the exception of the following exclusions.</i> <i>The following exclusions are permissible. A plan does not need to include all of the exclusions. However, if an exclusion is included the language below must be used.</i>	Form/Page/ Para Reference
Aviation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(4)(iii) Model Language	This policy or contract form excludes coverage for services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.	
Convalescent and Custodial Care Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(11) Model Language	This policy or contract form excludes coverage of services related to rest cures, custodial care or transportation. Custodial care means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.	
Cosmetic Services	11 NYCRR 52.16(c)(5)	This policy or contract form excludes coverage for cosmetic services or surgery, except	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>that cosmetic surgery does not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.</p>	
<p>Coverage Outside of the United States, Canada or Mexico</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(12)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for care or treatment provided outside of the United States, its possessions, Canada or Mexico.</p>	
<p>Experimental or Investigational Treatment</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4303(z) Article 49</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for any health care service, procedure, treatment or device that is experimental or investigational. However, coverage will be provided for experimental or investigational treatments, including, treatment of rare diseases, or patient costs for the insured's participation in a clinical trial, when the denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, no coverage will be provided for the costs of any investigational drugs or devices, non-health services required for the insured to receive the treatment, the costs of managing the research, or costs that would not be covered under the policy or contract form for non-investigational treatments.</p>	
<p>Felony Participation</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(4)(i)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for any illness, treatment or medical condition due to participation in a felony, riot or insurrection.</p>	
<p>Foot Care</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(6)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet.</p>	
<p>Government Facility</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.</p>	
<p>Medical Services</p>	<p>Model Language</p>	<p>This policy or contract form excludes coverage for medical or dental services that are medical in nature, including any hospital or prescription drug charges.</p>	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>			
<p>Medically Necessary Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3201(c)(3) Article 49 Model Language</p>	<p>This policy or contract form generally excludes coverage for any dental service, procedure, treatment, test, or device that is determined to not be medically necessary; however, coverage will be provided when the denial of services is overturned by an external appeal agent certified by the State.</p> <p>Any denial of coverage should be treated as a medical necessity denial unless the denial is based on a benefit limit that is described in the policy or contract form.</p>	
<p>Medicare or Other Governmental Program Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) Model Language</p>	<p>This policy or contract form excludes coverage for services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).</p>	
<p>Military Service Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(4)(i) Model Language</p>	<p>This policy or contract form excludes coverage for an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.</p>	
<p>No-Fault Automobile Insurance Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8) Model Language</p>	<p>This policy or contract form excludes coverage for any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even the insured does not make a proper or timely claim for the benefits available under a mandatory no-fault policy.</p>	
<p>Pre-Existing Condition Exclusion</p>	<p>§ 3232 § 4318 11 NYCRR 52.17(a)(27), (28)</p>	<p>This policy or contract form excludes conditions for which medical advice was given, treatment was recommended or received from a physician within 6 months before the enrollment date.</p> <ul style="list-style-type: none"> • Coverage cannot be excluded or reduced for a loss due to a pre-existing condition for a period of greater than 12 months following the enrollment date. • When the contract or policy is issued to an individual aged 65 or older this is reduced to a period no greater than 6 months following the enrollment date. • The 12 month exclusionary period must be shortened by the time the insured was covered under creditable coverage if the insured was enrolled in the prior coverage within 63 days prior to enrolling in this coverage. 	

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		<ul style="list-style-type: none"> Genetic information shall not be considered a pre-existing condition in the absence of a diagnosis of the condition related to such information. <p><i>Note: Waiting periods of benefits are viewed as pre-existing exclusions. Waiting periods for benefits or “phase in” of full benefits cannot be longer than 1 year.</i></p> <p>NOTE: A PRE-EXISTING CONDITION EXCLUSION MAY NOT APPLY TO THE PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT.</p>	
Services Not Listed Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c)(3) Model Language	This policy or contract form excludes coverage for services that are not listed in the policy form as being covered.	
Services Provided by a Family Member Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services performed by a member of the insured’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister, or brother of the insured or the insured’s spouse.	
Services Separately Billed by Hospital Employees Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services rendered and separately billed by employees of hospitals, laboratories or other institutions.	
Services With No Charge Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(8) Model Language	This policy or contract form excludes coverage for services for which no charge is normally made.	
Temporomandibular Joint Dysfunction (TMJ)	OGC Opinions 92-49 & 06-08-08	This policy or contract excludes coverage for treatment of temporomandibular joint dysfunction (TMJ) when it is medical in nature. <p><i>Note: This contract or policy form may not exclude the treatment of TMJ that is dental in nature, unless a medical necessity determination is made and the insured receives all utilization review and external appeal rights under Article 49.</i></p>	
Vision Services Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	11 NYCRR 52.16(c)(10)	This policy or contract form excludes coverage for the examination or fitting of eyeglasses or contact lenses.	

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<p>War</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(4)(i)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for an illness, treatment or medical condition due to war, declared or undeclared.</p>	
<p>Workers' Compensation</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>11 NYCRR 52.16(c)(8)</p> <p>Model Language</p>	<p>This policy or contract form excludes coverage for services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.</p>	
<p>CLAIM DETERMINATIONS</p>			<p>Form/Page/ Para Reference</p>
<p>Notice of Claim</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(d)(1)(E)</p> <p>Model Language</p>	<p>This policy or contract form provides that the insured has to provide the insurer with written notice of claim as applicable. A claim may be submitted electronically. However, failure to give notice within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such notice and the notice was provided as soon as reasonably possible.</p>	
<p>Submission of Claim</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(d)(1)(G) § 4306(n)</p> <p>Model Language</p>	<p>This policy or contract form must provide that the insured has a minimum of 120 days to provide the insurer with proof of loss after the date of such loss. However, failure to give proof within the specified time frame does not reduce or invalidate a claim if it was not reasonably possible to give such proof and the proof was provided as soon as reasonably possible.</p> <p><i>For commercial insurers:</i> In no event, except in the absence of legal capacity may a claim be filed more than one year from the time the claim was required to be filed.</p>	
<p>UTILIZATION REVIEW & EXTERNAL APPEAL</p>			<p>Form/Page/ Para Reference</p>
<p>Grievance Procedure</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4801(c) § 4802</p> <p>Model Language</p>	<p>If this policy or contract form is a managed care product, as defined by Insurance Law §4801(c), such as a gatekeeper insurance product, the grievance procedure must be consistent with Insurance Law §4802.</p>	
<p>Utilization Review Policies and Procedures</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(3) § 4324(a)(3)</p> <p>29 CFR § 2560.503-1 45 CFR § 147.136</p> <p>Model Language</p>	<p>This policy or contract form includes a description of the utilization review policies and procedures, including:</p> <ul style="list-style-type: none"> • The circumstances under which utilization review will be undertaken; • The toll-free telephone number, the hours available and the availability of an after-hours answering service of the utilization review agent; • The timeframes under which utilization review decisions must be made for prospective, retrospective and concurrent decisions; • The right to reconsideration; • The right to appeal, including the expedited and standard appeals processes and the 	

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		<p>timeframes for such appeals;</p> <ul style="list-style-type: none"> • The right to designate a representative; • A notice that all denials of claims will be made by qualified clinical personnel and that all notices of denials will include information about the basis of the decision; • A notice of the right to an external appeal, together with a description, jointly promulgated by the Commissioner of Health and the Superintendent, of the external appeal process and the timeframes for such appeals; and • Further appeal rights, if any. <p><i>Note: If this policy or contract form has a provision which states that the insurer will review certain services before they are performed and, if determined by the insurer, will pay benefits for a lower cost alternative service, then the denial of the requested service is treated as an adverse determination subject to internal and external appeal rights contained in Article 49 of the Insurance Law.</i></p>	
<p>External Appeal Procedures</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 4801(c) Article 49</p> <p>45 CFR § 147.136</p> <p>Model Language</p>	<p>This policy or contract form includes a description of the external appeal procedures, including:</p> <ul style="list-style-type: none"> • Instructions on how to request an external appeal; • The circumstances under which an external appeal may be pursued, including a service denied as: <ul style="list-style-type: none"> ○ not medically necessary; ○ experimental/investigational, including clinical trials and treatment for rare diseases; ○ for a managed care product, as defined in Insurance Law § 4801(c), such as a gatekeeper insurance product, an out-of-network denial when the service is not available in-network and the insurer recommends an alternate treatment; ○ for a managed care product, as defined in Insurance Law § 4801(c), such as a gatekeeper insurance product, an out-of-network referral denial on the basis that the insurer has a health care provider in-network with appropriate training and experience to meet the particular health care needs of the insured, and who is able to provide the service; and ○ formulary exception denials. • § The timeframe for submitting an external appeal. 	
TERMINATION OF COVERAGE		<p><i>The following are the only termination provisions permissible under the Insurance Law.</i></p> <p><i>The model language must be used for each of the following termination provisions.</i></p>	Form/Page/ Para Reference
Termination upon Death of Subscriber	Model Language	This policy or contract form provides that upon the subscriber’s death, the coverage will terminate unless there are dependents covered. If there is coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been	

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Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>		paid.	
Termination for Spouses in Cases of Divorce Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides that in cases of divorce, coverage for the spouse shall terminate as of the date of the divorce.	
Termination by Subscriber Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	This policy or contract form provides that termination will occur at the end of the month during which the subscriber provides written notice requesting termination or on such later date requested for such termination by the notice.	
Termination for Failure to Pay Premiums Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(d)(1)(C) § 4304(c)(2)(A) § 4306 45 CFR 156.270(g) Model Language	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has failed to pay premiums or contributions within 30 days of when premiums are due in accordance with the terms of the contract or policy form if the insurer has not received timely premium payments. Note: For NYSOH coverage insurers must provide a grace period of at least three (3) consecutive months for subscribers receiving advance payments of the premium tax credit if the subscriber has previously paid at least one (1) full month's premium during the benefit year.	
Termination for Fraud Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4304(c)(2)(B) § 3105 Model Language	This policy or contract form includes a provision permitting the insurer to terminate coverage if the subscriber has performed an act or practice that constitutes fraud or made a misrepresentation of material fact in writing on an enrollment application or in order to obtain coverage for a service.	
Rescission Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3105 § 3204 42 USC § 300gg-12 45 CFR § 147.128 Model Language	No misrepresentation shall avoid coverage or defeat any recovery thereunder unless the insured makes a misrepresentation that is material. This policy or contract form may include a provision that in the event a subscriber makes a misrepresentation of material fact in writing upon his/her enrollment application, coverage may be rescinded if the facts misrepresented would have lead the insurer to refuse to issue the coverage. Notification must be given to the insured 30 calendar days prior to cancellation.	
Termination if there are No Longer Insureds in the Insurer's Service Area	§ 4304(c)(2)(D)	This policy or contract form includes a provision permitting the insurer, in regard to a network plan, to terminate coverage if there is no longer any insured who lives or resides in the service area of the insurer, or in the area for which the insurer is authorized to do	

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		business.	
Termination of the class of contracts or policies	§ 4304(c)(2)(C)	This policy or contract form may terminate if the insurer stops offering the class of contracts or policies in which this contract or policy belongs, without regard to claims experience or health related status of this contract or policy. Individual commercial insurers must give 30 days prior written notice. Article 43 insurers must give 5 months prior written notice.	
Renewal	§ 4304(b)(2) 11 NYCRR 52.17(a)(2)	This policy or contract provides that except as specified in § 4304(b)(2) the insurer must renew or continue in force such coverage at the option of the insured. The policy or contract form must specify the conditions under which the insurer may refuse to renew the policy or contract.	
Premiums	§ 4306(a) § 3216(d)(1)(C)	The policy or contract form must provide that premiums are to be paid to the insurer by the subscriber or such other person designated, by the due date, with a grace period as specified.	
LOSS OF COVERAGE			Form/Page/ Para Reference
Extension of Benefits Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3201(c) Model Language	This policy or contract form must provide that upon termination of insurance, whether due to a termination of eligibility or termination of the policy an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before the covered person's coverage ended.	
Suspension of Coverage Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(a)(13) § 4304(i) 11 NYCRR 52.17(a)(9) Circular Letter No. 7 (2003) USERRA, 38 U.S.C. § 4317 Model Language	This policy or contract form provides that: <ul style="list-style-type: none"> • Any covered persons who are also member of a reserve component of the armed forces of the United States, including the National Guard, shall be entitled, upon request, to have their coverage temporarily suspended during a period of active duty and reinstatement of such coverage at the end of active duty if: • The insurer will refund any unearned premiums for the period of suspension. • Persons covered by this policy or contract shall be entitled to resumption of coverage, upon written application and payment of the required premium within 60 days after the date of termination of the period of active duty. • Coverage shall be retroactive to the date of termination of the period of active duty. No exclusion or waiting period may be imposed for any condition unless the condition arose during the period of active duty and the condition has been determined by the Secretary of Veterans Affairs to be a condition incurred in the line of duty or a waiting	

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		period had been imposed and was not completed at the time of suspension.	
GENERAL PROVISIONS			Form/Page/ Para Reference
Assignment Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	Model Language	The policy or contract form should state whether or not assignment of benefits is permitted.	
Incontestability Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4306 § 3216(d)(1)(B) Model Language	The policy contract form must provide that statements by the insured must be in writing and signed in order to be used to reduce benefits or avoid the insurance.	
Who May Change This Contract or Policy Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 4306(e) § 3216(d)(1)(A) Model Language	The policy or contract form must provide that no agent has the authority to change the policy or contract or waive any provisions and that no change shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy or contract, or by amendment to the policy or contract signed by the subscriber and insurer.	
Action in Law or Equity Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	§ 3216(d)(1)(K) Model Language	The policy or contract must provide that no action in law or equity shall be brought to recover on the policy or contract form prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy or contract form and that no such action shall be brought after the expiration of three (3) years following the time such proof of loss is required by the policy.	
Subrogation Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/>	General Obligations Law § 5-335 Civil Practice Law and Rules § 4545(a) Model Language	Although not required, if a subrogation provision is included in this policy or contract form, it must comply with NYS General Obligations Law § 5-335 and Civil Practice Law and Rules § 4545(a).	
Unilateral Modification	11 NYCRR 52.17(a)(25)	Unilateral modifications by an insurer to an existing contract or policy must be made with at least 45 days prior written notice to the policyholder. Unilateral modifications by the	

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<p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>insurer may be made only at the time of renewal. If the policy or contract form requires the subscriber to provide written notice to terminate coverage, the notice of the unilateral modification by the insurer must be provided to the subscriber no less than 14 days prior to the date by which the subscriber is required to provide notice to terminate coverage.</p>	
<p>Non-English Speaking Insureds Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3217-a(a)(15) § 4324(a)(15) Model Language</p>	<p>This policy or contract form includes a description of how the insurer addresses the needs of non-English speaking insureds.</p>	
<p>Reinstatement After Default Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>§ 3216(d)(1)(D) § 4306(f) Model Language</p>	<p>This policy or contract form must provide that after default, subsequent acceptance of payment by an authorized agent or broker will reinstate the contract or policy. With respect to sickness and injury, the reinstated contract; policy will only cover sickness as may be first manifested more than 10 days after the date of acceptance.</p>	
<p>SCHEDULE OF BENEFITS Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Model Language</p>	<p>This policy or contract form must contain a Schedule of Benefits. All services subject to preauthorization and/or referral requirements must be clearly indicated in the Schedule of Benefits.</p>	<p>Form/Page/ Para Reference</p>
<p>Prohibition on Lifetime Dollar Limits</p>	<p>§ 4328 § 4306-e § 3217-f 42 USC § 300gg-11 45 CFR § 147.126</p>	<p>The policy or contract form may not include a lifetime limit on the pediatric dental essential health benefit.</p>	
<p>Limitations on Annual Dollar Limits</p>	<p>§ 4328 § 3217-f § 4306-e 42 USC § 300gg-11 45 CFR § 147.126</p>	<p>The policy or contract form may not impose “restricted” annual dollar limits on the pediatric dental essential health benefit.</p>	
<p>Insured’s Financial Responsibility for Payment</p>	<p>§ 3217-a(a)(5) § 4324(a)(5) 11 NYCRR 52.1(c)</p>	<p>This policy or contract form includes a description of the insured’s financial responsibility for payment of premiums, deductibles, copayments and/or coinsurance, and any other charges, annual limits on an insured’s financial responsibility, caps on payments for covered services and financial responsibility for non-covered dental care procedures,</p>	

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		<p>treatment or services.</p> <p>Coinsurance values imposed on an insured should not exceed 50%.</p>	
ADDITIONAL COVERAGE			Form/Page/ Para Reference
<p>Out-of-Network Coverage</p> <p>Model Language Used? Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Model Language	<p>If out-of-network coverage has been selected, this policy or contract form provides benefits for covered services that are received from out-of-network providers and have not been approved by the insurer to be covered on an in-network basis.</p> <p><i>Note: The Department will not approve more than a 30% differential between in-network and out-of-network coverage unless supported by scholarly literature or actual claims experience of the insurer.</i></p>	
DENTAL PROVIDER NETWORKS	§ 3241(a)	<p>The NYSOH reviews provider networks used with plans offered inside the NYSOH and the Department of Financial Services reviews provider networks used with NYSOH-certified plans offered outside the NYSOH.</p> <p>A network adequacy submission must be made to the Department of Financial Services for NYSOH-certified plans offered outside the NYSOH. Provide the state tracking number of the network adequacy filing: _____.</p> <p>See the Department of Financial Services’ website for additional guidance relating to the submission of networks for NYSOH-certified coverage offered outside the NYSOH.</p>	Form/Page/ Para Reference
ACTUARIAL SECTION FOR NEW PRODUCT RATE FILINGS ONLY		<p>PLEASE NOTE: An updated set of instructions “Checklist for the Submission of 2017 Premium Rates for Stand Alone Dental” will be posted on the Department website and on SERFF.</p> <p><i>Complete this section for all new product forms filings except those filings where a rate filing is unnecessary because: (select one)</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> <i>The submission contains only application forms, disclosure statements, and/or advertising, OR</i> <input type="checkbox"/> <i>The submission is an out-of-state filing pursuant to Section 3201(b)(2), OR</i> <input type="checkbox"/> <i>The form submission has no premium rate implications and a letter or actuarial memorandum is enclosed that states and justifies this as appropriate.</i> <p><i>For rate changes to existing products, do NOT complete this section – complete the Existing Products-Rate Requirements section below.</i></p>	Form/Page/ Para Reference

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ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(d) 11 NYCRR 52.45(a)	a. Actuarial justification for the use of claim costs and other assumptions. b. Non-claim expense components as a percentage of gross premium. c. Expected loss ratio(s).	
Loss Ratios	11 NYCRR 52.45(a)	Expected loss ratio(s) – with actuarial justification	
Reserve Basis	11 NYCRR 94	Description of bases for unpaid claim liabilities and extra reserves (if any).	
Actuarial Certification	11 NYCRR 52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans” as adopted by the Actuarial Standards Board. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification	11 NYCRR 52.45(a)	The expected loss ratio is: 	
RATE MANUAL	11 NYCRR 52.40(c)(2) 11 NYCRR 52.45(a)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue limits. f. Description of rating classes, factors and premium discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Expected loss ratio(s).	
ACTUARIAL SECTION	<i>Complete this section for all filings of changes in rates (e.g., rate increases/decreases or</i>		

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FOR EXISTING PRODUCT RATE FILINGS ONLY		<i>changes in rate calculation rules or procedures), commissions or underwriting to existing products. (For new products, do NOT complete this section – complete the New Products-Rate Requirements section above instead.)</i>	
ACTUARIAL MEMORANDUM	11 NYCRR 52.40(a)(1)	Actuarial qualifications: a. Member of the Society of Actuaries or member of the American Academy of Actuaries; and b. Meet the “Qualification Standards of Actuarial Opinion” as adopted by the American Academy of Actuaries.	
Justification of Rates	11 NYCRR 52.40(d) 11 NYCRR 52.45(a)	a. Description of proposed changes in coverage, rates, commissions, underwriting rules, etc. b. History of previous New York rate revisions. c. Provide New York and nationwide claims experience respectively, including: (i) Earned premium; (ii) Paid and incurred claims; and (iii) Incurred loss ratios. d. Actuarial justification of proposed rates revision (increase/decrease). e. Non-claim expense components as a percentage of gross premium. f. Impact on rates as a result of each of the changes with actuarial justification. g. Expected loss ratio(s) after the proposed changes.	
Actuarial Certification	11 NYCRR 52.40(a)(1)	a. The filing is in compliance with all applicable laws and regulations of the State of New York. b. The filing is in compliance with Actuarial Standard of Practice No. 8 “Regulatory Filings for Rates and Financial Projections for Health Plans”. c. The expected loss ratio meets the minimum requirements of the State of New York. d. The benefits are reasonable in relation to the premiums charged. e. The rates are not unfairly discriminatory.	
Expected Loss Ratio Certification		The expected loss ratio is: 	
REVISED RATE MANUAL PAGES	11 NYCRR 52.40(c)(2) 11 NYCRR 52.45(a)	a. Table of contents. b. Rate pages. c. Insurer name on each consecutively numbered rate page. d. Identification by form number of each policy, rider, or endorsement to which the rates apply. e. Brief description of benefits, types of coverage, limitations, exclusions, and issue	

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		limits. f. Description of revised rating classes, factors and discounts. g. Examples of rate calculations. h. Commission schedule(s) and fees. i. Expected loss ratio(s).	
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