

## State of New Hampshire Insurance Department

### CHECKLIST FOR CERTIFIED STAND ALONE DENTAL- INDIVIDUAL

#### LINE OF BUSINESS: DENTAL INDIVIDUAL

TOI CODES: H10I

**As additional guidance is forthcoming from the US Department of Health and Human Services, and the New Hampshire Insurance Department, those changes will be incorporated into this checklist.**

Stand Alone Dental plans to be utilized outside the Marketplace only to supplement medical plans, such that the medical plans will comply with federal requirements to offer all ten Essential Health Benefits outside the Marketplace as required under the Public Health Services Act, must follow the Marketplace certification filing process as described within [Bulletin Ins 16-009-AB](#).

#### INSTRUCTIONS FOR SERFF FILINGS CHECKLIST:

- A. For ALL filings, the [Submissions Requirements Checklist](#) MUST be completed and attached to the supporting documentation tab.
- B. For a FORM/RATE filing, the completion of additional sections below must be completed, depending on the forms submitted.
  - a. Policy
  - b. Riders, endorsements or amendments
  - c. Applications
  - d. Advertising and marketing
  - e. Annual Actuarial Certification
- C. RATES are required to be filed in accordance with [NHCAR Part Ins 401.12 \(o\)](#) and [NHCAR Part Ins 4100](#). Additional requirements may be necessary, depending on the Type of Insurance (TOI).

This checklist **MUST** be completed to assist in the submission and review of forms submitted to the New Hampshire Insurance Department. It is not intended to be an all inclusive listing of required provisions, rather guidance for areas of frequent questions and areas needing special attention. All New Hampshire Statutes and Rules are available at:

[http://www.gencourt.state.nh.us/rules/state\\_agencies/ins.html](http://www.gencourt.state.nh.us/rules/state_agencies/ins.html)  
<http://www.gencourt.state.nh.us/rsa/html/NHTOC/NHTOC-XXXVII.htm>

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All individual stand-alone dental submissions to NH for certification must be made via SERFF through the Form/Rate Filing and Plan Management modules. Plan Binders must be complete submissions, as no partial or incomplete submissions will be accepted. Corresponding forms filings must be referenced in the Associate Schedule Items. Please see [SERFF Plan Management instructions](#) for further instructions on binder submission.

CMS has published detailed instructions for the completion and validation of templates. It is the issuer's responsibility to accurately and thoroughly complete the templates. Issuers are reminded to consult the [2017 Plan Year QHP Issuer Bulletin](#), as issuers are required for 2017 to submit an attestation that all CMS QHP tools have been run and errors resolved prior to submission of data templates. NHID will require the state generated attestation form at the time of filing found [here](#), and will not be reviewed until such time as attestations are received noting satisfactory results. If the tool results are not met, then the screen shot as well as the justification must be provided. Both the attestation form, and screen shots should be uploaded to the Supporting Documents tab in SERFF.

- **Important Notes:**

- Stand-Alone Dental Plan (SADP) Issuers must submit their form filings by **April 8, 2016**. SADP Issuers must submit their rate filings and binders with templates by **April 8, 2016**. SADP plans must comply with the NH dental benchmark plan: [FEDVIP pediatric dental](#).
- Stand-alone dental plans are not subject to the insurance market reform provisions of the Affordable Care Act such as guaranteed availability and renewability of coverage. Dental carriers will be able to make premium adjustments upon consumer enrollment, but must indicate that rates are not guaranteed for SADPs offered on the FFM.
- Stand-alone dental are excluded from cost-sharing reduction (CSR) requirements.
- For plan year 2017, SADP are not required to be accredited or submit accreditation information.
- Variability is not permitted within cost sharing schedules. Please submit one schedule for a high option and/or one schedule for a low option with no variability.
- Child-only policies must be submitted to provide coverage for children under the age of 19. Coverage must continue until the end of the calendar year in which the child turns 19.
- NH Network templates can be found at:  
<http://www.nh.gov/insurance/lah/NewHampshireInsuranceDepartment2017PlanYearQHPs.htm>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
<b>SECTION 1 GENERAL REQUIREMENTS</b>			
ADVERTISING	<a href="#">NHCAR Part Ins 2600</a>  <a href="#">Federal Health Insurance Marketplace Branding Guide</a>  <a href="#">Bulletin Ins 14-015-AB</a>	<p>Advertising Guidelines</p> <p>Health Insurance Marketplace branding guides and logo.</p> <p>All issuers and plans must comply with state laws and regulations regarding marketing by health insurance issuers. QHP issuers must inform consumers in QHP marketing materials that the QHP is certified by the Marketplace. The QHP issuer cannot inform consumers that the certification of a QHP implies any form of further endorsement or support of the QHP.</p> <p>NHID will require prior approval of plan marketing material and an attestation that the issuer meets all Marketing Standards. If NHID determines through its regulatory efforts that unfair or discriminatory marketing is occurring, NHID will enforce through use of state remedies, including decertification for QHPs.</p> <p>Advertising and Marketing rules for Health Insurance and HMOs can be found in <a href="#">NHCAR Part Ins 2601</a>. Statutory authority for HMO advertising is found at <a href="#">RSA 420-B:8 VI</a>.</p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>
DISCLOSURE	<a href="#">Final Letter to Issuers</a>	<p>Marketing materials distributed to enrollees and to prospective enrollees, contain a clause such as the following:</p> <p>“[Insert plan’s legal or marketing name] does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.”</p>	

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
TRANSPARENCY IN COVERAGE	<a href="#">45 CFR 156.220</a>	<p>In accordance with 45 CFR 156.220, a QHP issuer must submit, in an accurate and timely manner, the following information to the Exchange, HHS and the State insurance commissioner, as well as to the public:</p> <ul style="list-style-type: none"> <li>(1) Claims payment policies and practices;</li> <li>(2) Periodic financial disclosures;</li> <li>(3) Data on enrollment;</li> <li>(4) Data on disenrollment;</li> <li>(5) Data on the number of claims that are denied;</li> <li>(6) Data on rating practices;</li> <li>(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and</li> <li>(8) Information on enrollee rights under Title I of the Affordable Care Act.</li> </ul>	<p>YES: NO: PAGE # OR IF NO:</p>
ASSUMPTIONS/ MERGERS/ REDOMESTICATIONS AND DEMUTUALIZATION, ETC		<p>Coordination with NHID Examinations Division is required. Forms must be filed for approval.</p>	<p>YES: NO: PAGE # OR IF NO:</p>
COVER PAGE (Form Number)	<a href="#">NHCAR Part Ins 401.03 (a)</a>	<p>Form number in lower left hand corner of face page</p>	<p>YES: NO: PAGE # OR IF NO:</p>
READABILITY NON-ENGLISH POLICIES		<p>English version of forms must be approved. If there is a discrepancy between the foreign language form and the English version, the approved English version will control.</p>	<p>YES: NO: PAGE # OR IF NO:</p>
ENROLLMENT PERIODS		<p>As named in the final Notice of Benefit and Payment Parameters for 2017, the annual open enrollment period for the FFM now begins on November 1, 2016 and extends through January 31, 2017.</p> <p><b>Special Enrollment Periods</b> As stated in 45 CFR 155.420, enrollees in the individual market must be given access to special enrollment periods of 60 days from the date of a triggering event, with effective dates consistent with 45 CFR 155.420(b).</p>	<p>YES: NO: PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
<b>SECTION 2 APPLICATIONS</b>			
APPLICATION	<p><a href="#">NHCAR Part Ins 401.12 (I)</a></p> <p><a href="#">NHCAR Part Ins 1901.07 (a) (2)</a></p>	<p>Federal Marketplace application must be attached to the supporting documentation tab for informational purposes.</p> <p>Off-Marketplace filings must include the company's application form attached to the form schedule tab for review and approval. Disclosure is required, as per NHCAR Part Ins 1901.07 (a) (2) All applications for dental plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:</p> <p><b>"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."</b></p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>
HOME OFFICE BOX	<a href="#">RSA 415:11</a>	<p>H.O. Box - No alteration of any written application for insurance, by erasure, insertion or otherwise, shall be made by any person other than the applicant without his written consent, and the making of any such alteration without the consent of the applicant shall be a misdemeanor.</p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>
<b>SECTION 3 POLICY FORM</b>			
DISCLOSURE COVER PAGE REQUIREMENT	<p><a href="#">NHCAR Part Ins 1901.07 (a)(23)</a></p>	<p>All dental plan policies shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy the following:</p> <p><b>"Notice to Buyer: This policy provides dental benefits only."</b></p>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
JURISDICTION AND ID CARDS	<a href="#">RSA 400-A:15-c</a>  <a href="#">NHCAR Part Ins 1901.09</a>	<p><b>Identification of Health Coverage Under the Jurisdiction of the Insurance Commissioner.</b> – All health coverage as defined in RSA 420-G:2, IX and prescription drug and dental benefits offered separately as described in RSA 420-G:2, IX(j) shall be identified as being under the jurisdiction of the insurance commissioner. Such identification shall be clearly printed on a member's identification card and the policy issued to an insured after January 1, 2010. The commissioner shall adopt rules, pursuant to RSA 541-A, designating the form and manner of the identification required under this section.</p> <p>(c) Identify, on all member identification cards or benefit guarantee cards, that the benefit plan represented on the card is under the jurisdiction of the New Hampshire insurance commissioner pursuant to RSA 400-A:15-c, so that the term "insured" shall be printed on the member identification card so that it is:</p> <ol style="list-style-type: none"> <li>(1) Clearly visible; and</li> <li>(2) In a font size no less than the member's name on the member identification card.</li> </ol>	<b>YES: NO:</b>  <b>PAGE # OR IF NO:</b>
FREE LOOK	<a href="#">NHCAR Part Ins. 401.05 (b) (11)</a>	<p>The following provision shall appear in a conspicuous place on the face page of all accident and health policies except for nonrenewable travel insurance policies written for terms of less than one year:</p> <p>"This policy may, at any time within 30 days after its receipt by the policyholder, be returned by delivering it or mailing it to the company or the agent through whom it was purchased. Immediately upon such delivery or mailing, the policy will be deemed void from the beginning, and any premium paid on it will be refunded."</p>	<b>YES: NO:</b>  <b>PAGE # OR IF NO:</b>
RENEWABILITY	<a href="#">NHCAR Part Ins 1901.07 (a) (4)</a>	<p>Each policy of individual accident and health insurance or group supplemental accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall 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.</p>	<b>YES: NO:</b>  <b>PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
REFUND UPON CANCELLATION	<a href="#">RSA 415:6 I (14)</a>	Refund upon cancellation: After the policy has been continued beyond its original term, the insured may cancel the policy at any time by written notice, delivered or mailed to the insurer or the insurer's representative. Such cancellation shall become effective upon receipt by the insurer or the insurer's representative, or on such later date as may be specified in such notice by the insured. If the insured cancels, the insurer shall promptly return any unearned portion of the premium paid, but in any event shall return the unearned portion of the premium within 30 days. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of the cancellation.	YES: NO: PAGE # OR IF NO:
GRACE PERIOD	<a href="#">RSA 415:6 I (3)</a>  <a href="#">45 CFR 156.270</a>	A provision as follows: Grace Period: A grace period of _____ (insert a number not less than "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.  Enrollees receiving advance payment of premium tax credits are allowed a 3-month grace period following nonpayment of premium, subject to the conditions of 45 CFR 156.270.	YES: NO: PAGE # OR IF NO:
INCONTESTABILITY	<a href="#">RSA 415:6 I (2)</a>	A provision as follows: Time Limit on Certain Defenses: (a) After 2 years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such 2-year period.	YES: NO: PAGE # OR IF NO:
LEGAL ACTION	<a href="#">RSA 415:6 I (11)</a>	A provision as follows: Legal Actions: No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.	YES: NO: PAGE # OR IF NO:
ENTIRE CONTRACT	<a href="#">RSA 415:6 I (1)</a>	A provision as follows: Entire Contract; Changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CLAIM NOTICE	<a href="#">RSA 415:6 I (5)</a>	A provision as follows: Notice of Claim: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at _____ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.	YES: NO: PAGE # OR IF NO:
PROOF OF LOSS	<a href="#">RSA 415:6 I (7)</a>	A provision as follows: Proofs of Loss: Written proof of loss must be furnished to the insurer at its office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within one year after the date of such loss in the case of a Medicare supplement insurance policy and within 90 days after the date of such loss in the case of any other accident and health insurance policy. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.	YES: NO: PAGE # OR IF NO:
TIME PAYMENT OF CLAIM	<a href="#">RSA 415:6 (8)</a>  <a href="#">RSA 415:6-h</a>	A provision as follows: Time of Payment of Claims: Indemnities payable under this policy for any loss other than loss for which this policy provides any periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ___ (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.  Clean written claim must be paid in 30 days; clean electronic claim must be paid within 15 days.	YES: NO: PAGE # OR IF NO:
DEPENDENT	<a href="#">RSA 415:5 I (3-a)</a>	In the event a carrier elects to provide coverage for dependent children, the term "dependent child" shall include a subscriber's child <b>by blood or by law</b> , who is under age 26.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
<b>DISABLED DEPENDENT</b>	<a href="#">RSA 415:5 I (3-a) (a)</a>	(3-a)(a) The coverage of any family member insured by such policy, pursuant to subparagraph (3), who is mentally or physically incapable of earning his or her own living on the date as of which such dependent's status as a covered family member would otherwise expire because of age, shall continue under such policy while such policy remains in force or is replaced by another policy as long as such incapacity continues and as long as said dependent remains chiefly financially dependent on the policyholder or the employee or his or her estate is chargeable for the care of said dependent, provided that due proof of such incapacity is received by the insurer within 31 days of such expiration date.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<b>ANESTHESIA</b>	<a href="#">FEDVIP</a>	Deep sedation, general anesthesia and intravenous conscious sedation in conjunction with surgical or operative procedures, regardless of age.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<b>NEWBORN</b>	<a href="#">RSA 415:22</a>	<p>I. All individual and group health insurance policies providing coverage on a provision of service or an expense incurred basis shall also provide that the health insurance benefits applicable for children are payable with respect to a newly born child of the insured or subscriber or a newly born child of a dependent child of the insured or subscriber from the moment of birth.</p> <p>II. Coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.</p> <p>III. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification of birth of a newly born child and payment of the required premium or fee must be furnished to the insurer or nonprofit service or indemnity corporation within 31 days after the date of birth in order to have the coverage continue beyond such 31-day period. Unless the policy or contract specifically provides that grandchildren of the insured or subscriber are eligible for coverage, coverage for newly born children of a dependent child of the insured or subscriber shall not continue beyond the initial 31-day period following birth. Nor shall such newly born children be considered dependents of the insured for any purpose addressed in this title.</p>	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ADOPTIVE	<a href="#">RSA 415:22-a</a>	All individual and group health insurance policies which provide coverage for a family member of the insured shall, as to such family member's coverage, also provide that health insurance benefits applicable for children are payable with respect to any minor from the date such minor is placed in the custody of the insured pursuant to an adoption proceeding under the provisions of RSA 170-B. Such health insurance benefits shall terminate upon dismissal or withdrawal of the petition for adoption.	YES: NO: PAGE # OR IF NO:
WAITING PERIOD		Issuers are allowed to include up to a 24-month waiting period for medically necessary orthodontia services for both stand-alone pediatric dental and embedded medical product that includes pediatric dental.	YES: NO: PAGE # OR IF NO:
OUTLINE OF COVERAGE	<a href="#">NHCAR Part Ins 1901.07 (m)</a>	<p>(m) Dental Plans (Outline of Coverage). An outline of coverage in the form prescribed below shall be used in connection with dental plan policies. The items included in the outline of coverage shall appear in the sequence prescribed:</p> <p>(1) Read Your policy Carefully. This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!</p> <p>(2) A brief specific description of the benefits.</p> <p>(3) A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits described in (2) above.</p> <p>(4) A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.</p>	YES: NO: PAGE # OR IF NO:
MINIMUM STANDARDS	<a href="#">NHCAR Part Ins 1901.06 (l)</a>	(l) Limited Benefit Health Coverage	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
<b>PROHIBITION ON ANNUAL AND LIFETIME DOLLAR LIMITS</b>		Section 2711 of the PHS Act (and its implementing regulations at 45 C.F.R. § 147.126) generally prohibits group health plans and health insurance issuers in the individual and group markets from placing annual or lifetime limits on the dollar value of EHB for any beneficiary. Under 45 C.F.R. § 155.1065 (a)( 2), the pediatric dental EHB offered by stand-alone dental plans certified to be offered in the Exchanges must be offered without annual and lifetime limits.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<b>ANNUAL LIMITS ON COST-SHARING – MAXIMUM OUT-OF-POCKET</b>	<a href="#">Final Rule</a>	As named in the final Notice of Benefit and Payment Parameters for 2015, SADP plans must place an annual limit on the pediatric dental EHB when offered as part of a SADP.  For the 2017 plan year, the national annual limits on cost sharing for the pediatric dental EHB when offered as part of a stand-alone dental plan remains at \$350 for one covered child and \$700 for two or more covered children.  This requirement does not apply to stand alone dental plans not being offered for the purpose of providing a pediatric dental benefit that supplements major medical QHPs to meet the 10 major medical essential health benefits.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<b>COMPANY STANDING/LICENSE</b>		The New Hampshire Insurance Department Certificate of Good Standing (Compliance) and current license must be attached to the supporting documentation tab. An updated license must be attached upon issue in June.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<b>NETWORK ADEQUACY</b>	<a href="#">RSA 420-J:7 I</a>	A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.  <b>Dental issuers must meet the standards for network adequacy enforced by the NHID for the 2017 plan year QHP review which requires SADP issuers to offer two (2) open panel dental practices per county in the issuer's service area.</b>  For certified SADPs, networks must include Essential Community Providers per 45 CFR 156.230 and 45 CFR 156.235.	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SERVICE AREA		NHID will allow the issuers to choose their service area(s), except that requested service areas may not be smaller than a county.	YES: NO: PAGE # OR IF NO:
ESSENTIAL HEALTH BENEFITS  FEDVIP  HIGH OPTION DENTAL BENEFITS	<a href="#">45 CFR 156 Appendix B</a>  <a href="#">FEDVIP Plan Details</a>	Class A (Basic) Services – preventive and diagnostic	YES: NO: PAGE # OR IF NO:
		Class B (Intermediate) Services – includes minor restorative services	YES: NO: PAGE # OR IF NO:
		Class C (Major) Services – includes major restorative, endodontic, and prosthodontic services	YES: NO: PAGE # OR IF NO:
		Class D Services - orthodontic	YES: NO: PAGE # OR IF NO:
DELTA DENTAL	<a href="#">RSA 420-F</a>	Laws specific to Delta Dental	YES: NO: PAGE # OR IF NO:
PATIENT'S BILL OF RIGHTS	<a href="#">RSA 415:6-f</a> <a href="#">RSA 151:21</a>	Any insurer issuing policies of individual insurance shall provide to each new policyholder holder who is a resident of this state a copy of the patients' bill of rights law under RSA 151:21	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
BALANCE BILLING PROHIBITED	<a href="#">RSA 420-J:8</a>	<p>Every contract between a health carrier and a participating provider shall set forth a hold harmless provision specifying protection for covered persons. This provision shall include language substantially as follows:</p> <p>(a) Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services.</p>	YES: NO: PAGE # OR IF NO:
APPEALS PROCESS/ MANAGED CARE	<a href="#">RSA 420-J</a>  <a href="#">NHCAR Part Ins 2703.04</a>	<p>Grievance Procedures, External Review</p> <p>Notice of Right to External Review.</p> <p>(a) Health carriers shall provide to covered persons the insurance department's "<a href="#">Managed Care Consumer Guide to External Appeal</a>" and the insurance department's "<a href="#">Request for Independent External Appeal of a Health Care Decision</a>" in each of the following circumstances:</p> <p>(1) The publications shall be attached to the policy, membership booklet, or other evidence of coverage provided to covered persons;</p>	YES: NO: PAGE # OR IF NO:
PREMIUMS RENEWAL INCREASE	<a href="#">NHCAR Part Ins 401.07 (b) (9)</a>	<p>In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that:</p> <p>a. A 30 days' notice is provided for policies subject to RSA 415;</p>	YES: NO: PAGE # OR IF NO:

## SECTION 4 RATES

<b>RATE SUBMISSIONS</b>	<a href="#">NHCAR PART Ins 4100</a>	REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS <ul style="list-style-type: none"> <li>• Stand alone dental plans are not required to submit the Unified Rate Review Template for rate increase.</li> <li>• Stand alone dental plans are required to offer child-only (under age 19) coverage.</li> <li>• Stand alone dental plans may not use the AV Calculator. Instead, they must demonstrate that the Stand alone dental plan offers the pediatric dental EHB at either a low level of coverage with an AV of 70% or a high level of coverage with an AV of 85%, and with a de minis variation of +/-2%. This must be certified by a member of the American Academy of Actuaries.</li> <li>• No additional age rating may be included for pediatric dental.</li> </ul>	YES:    NO: WHY:
<b>FEDERALLY REQUIRED FORMS</b>	<a href="#">Master List</a>	Filing and Binder Requirements for Dental Plans	YES:    NO:

**[NEW HAMPSHIRE INSURANCE DEPARTMENT DENTAL NOTES:](#)**

STATUTE LINK(S): RSA [415](#), [400](#), [420-F](#), [420-J](#), [INDEX](#)

REGULATION LINK(S): NHCAR PART INS [401](#), [1901](#), [2600](#), [2700](#) & [4100](#), [INDEX](#)

State of New Hampshire

**CERTIFICATION FOR FORM SUBMISSION FOR COMPLIANCE WITH THE AFFORDABLE CARE ACT OF 2010**

I, THE UNDERSIGNED OFFICER OF \_\_\_\_\_  
(Name of Entity)

AM KNOWLEDGEABLE OF HEALTH COVERAGES; HAVE CAREFULLY REVIEWED THE CONTENTS OF THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED ON THE ATTACHED COMPLIANCE FILING AS SUBMITTED TO THE NEW HAMPSHIRE COMMISSIONER OF INSURANCE; HAVE READ AND UNDERSTAND EACH OF THE APPLICABLE NEW HAMPSHIRE LAWS AND REGULATIONS; AM AWARE OF THE PENALTIES WHICH MAY BE ENFORCED FOR CERTIFICATION OF A NONCOMPLYING FORM; AND CERTIFY THAT THE POLICY FORMS, APPLICATIONS, SUBSCRIPTION CERTIFICATES, MEMBERSHIP CERTIFICATES OR OTHER EVIDENCES OF HEALTH CARE COVERAGE IDENTIFIED IN THE SERFF FILING FOR ACA COMPLIANCE FILED WITH THIS CERTIFICATION, PROVIDE ALL REQUIRED BENEFITS AND ARE IN FULL COMPLIANCE WITH ALL NEW HAMPSHIRE INSURANCE LAWS AND REGULATIONS.

\_\_\_\_\_  
(Original Signature of Officer\*)

\_\_\_\_\_  
(Title of Officer\*)

\_\_\_\_\_  
(Printed Name of Officer\*)

\_\_\_\_\_  
(Date)

\* If the individual signing the certification is other than the president, vice president, assistant vice president, corporate secretary, assistant corporate secretary, CEO, CFO, COO, general counsel, or an actuary that is also a corporate officer, documentation must be included that shows that this individual has been appointed as an officer of the organization by the Board of Directors.