

State of New Hampshire Insurance Department

**CHECKLIST FOR CERTIFIED STAND ALONE DENTAL - SMALL GROUP**

**LINE OF BUSINESS: DENTAL - GROUP**

**TOI CODES: H10G**

**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
  - 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-XXXV>

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- **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, SADPs 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.
- NH Network templates and instructions are found at:  
<http://www.nh.gov/insurance/lah/NewHampshireInsuranceDepartment2017PlanYearQHPs.htm>



REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ASSUMPTIONS/ MERGERS/ REDOMESTICATIONS AND DEMUTUALIZATION, ETC		Coordination with NHID Examinations Division is required. Forms must be filed for approval.	YES: NO:  PAGE # OR IF NO:
COVER PAGE (Form Number)	<a href="#">NHCAR Part Ins 401.03 (a)</a>	Form number in lower left hand corner of face page	YES: NO:  PAGE # OR IF NO:
READABILITY NON-ENGLISH POLICIES		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.	YES: NO:  PAGE # OR IF NO:
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>Standard Employee Enrollment Periods</b> Annual enrollment periods for SHOP are on a rolling basis for a 12 month period, as per <a href="#">45 CFR 155.725</a>, and amended by <a href="#">81 FR 12347</a>. As stated in 45 CFR 155.725(e), employees must have access to a standard enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period. The SHOP must notify the enrollee of that enrollment period prior to the start of that period. Newly-qualified employees who become qualified outside of the standard enrollment period may seek coverage beginning on the first day in which the employee is eligible.</p> <p><b>Special Employee Enrollment Periods</b> Employees who experience certain life events as outlined in <a href="#">45 CFR 155.725 (j)</a> and <a href="#">45 CFR 155.420 (d)</a>, must be given access to special enrollment periods of either 30 or 60 days from the date of a triggering event, with effective dates consistent with 45 CFR 155.725 (j) (3). Issuers are urged to consult new guidance from CMS regarding SEP's: <a href="https://www.healthcare.gov/sep-list/">https://www.healthcare.gov/sep-list/</a>.</p>	<p>YES: NO:  PAGE # OR IF NO:</p> <p>YES: NO:  PAGE # OR IF NO:</p> <p>YES: NO:  PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
<b>SECTION 2 APPLICATIONS</b>			
APPLICATION	<a href="#">NHCAR Part Ins 401.12 (l)</a>  <a href="#">NHCAR Part Ins 1901.07 (a) (2)</a>	<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>	YES: NO: PAGE # OR IF NO:
HOME OFFICE BOX	<a href="#">RSA 415:11</a>	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.	YES: NO: PAGE # OR IF NO:
<b>SECTION 3 POLICY FORM</b>			
DISCLOSURE COVER PAGE REQUIREMENT	<a href="#">NHCAR Part Ins 1901.07 (a)(23)</a>	<p>All dental plan policies and certificates 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] [certificate] the following:</p> <p><b>"Notice to Buyer: This [policy] [certificate] provides dental benefits only."</b></p>	YES: NO: PAGE # OR IF NO:
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</p>	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		<p>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>FREE LOOK</b>	<a href="#">NHCAR Part Ins 1901.07 (a) (11)</a>	All policies and certificates, except single-premium nonrenewable policies and as otherwise provided in this paragraph, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificateholder is not satisfied for any reason.	<b>YES: NO: PAGE # OR IF NO:</b>
<b>RENEWABILITY</b>	<a href="#">NHCAR Part Ins 1901.07 (a) (4)</a>	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.	<b>YES: NO: PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PHYSICAL EXAMINATION OR AUTOPSY	<a href="#">RSA 415:18 I (k)</a>	A provision that the insurer shall have the right and opportunity to examine the person of the insured when and so often as it may reasonably require during the pendency of claim under the policy and also the right and opportunity to make an autopsy in case of death where it is not prohibited by law.	YES: NO: PAGE # OR IF NO:
GRACE PERIOD	<a href="#">RSA 415:18 I (p)</a>  <a href="#">45 CFR 156.270</a>	A provision that the policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage 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:
LEGAL ACTION	<a href="#">RSA 415:18 I (n)</a>	A provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within 2 years from the expiration of the time within which proof of loss is required by the policy.	YES: NO: PAGE # OR IF NO:
CONTESTABILITY	<a href="#">RSA 415:18 I (r)</a>	A provision that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by a person shall be used in contesting the validity of the insurance, unless it is contained in a written instrument signed by the person making such statement.  A 30 day advance notice is required.	YES: NO: PAGE # OR IF NO:
PART-TIME EMPLOYEES	<a href="#">RSA 415:18 I (q)</a>	A provision that the insurer shall not exclude part-time employees. A part-time employee shall be any employee who regularly works a minimum of at least 15 hours per week.	YES: NO: PAGE # OR IF NO:
CLAIM NOTICE	<a href="#">RSA 415:18 I (h)</a>	A provision that written notice of sickness or of injury must be given to the insurer within 20 days after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PROOF OF LOSS	<a href="#">RSA 415:18 I (i)</a>	Proofs of Loss: Written proof of loss must be furnished to the insurer within 90 days after the date of such loss in the case of any other group accident and health insurance policy or certificate. Failure to furnish such proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.	YES: NO: PAGE # OR IF NO:
TIME PAYMENT OF CLAIM	<a href="#">RSA 415:18-k</a>	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:
DISABLED DEPENDENT	<a href="#">RSA 415:18 V (a)</a>	The coverage of any dependent of any employee or member of the group insured by such policy, pursuant to paragraph IV, 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 group policy as long as such incapacity continues and as long as said dependent remains chiefly financially dependent on the employee or member of the group 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..	YES: NO: PAGE # OR IF NO:
NEWBORN	<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</p>	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		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.	
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="#">NH CAR 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 and s. The items included in the outline of coverage shall appear in the sequence prescribed:</p> <p>(1) Read Your [policy] [ certificate ] 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] [ CERTIFICATE ] 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</p>	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.	
<b>MINIMUM STANDARDS</b>	<a href="#">NHCAR Part Ins 1901.06 (I)</a>	(I) Limited Benefit Health Coverage	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>
<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>	<p>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.</p> <p>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 remain at \$350 for one covered child and \$700 for two or more covered children.</p> <p>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.</p>	<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>	<p>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.</p> <p>Dental issuers must meet the standards for network adequacy enforced by the NHID for the 2017 plan year</p>	<b>YES: NO:</b> <b>PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
		QHP review which requires SADP issuers to offer two (2) open panel dental practices per county in the issuer's service area.  For QHPs only, networks must include Essential Community Providers, per 45 CFR 156.230 and 45 CFR 156.235.	
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:
ANESTHESIA	<a href="#">FEDVIP</a>	Deep sedation, general anesthesia and intravenous conscious sedation in conjunction with surgical or operative procedures, regardless of age.	YES: NO: PAGE # OR IF NO:
ESSENTIAL HEALTH BENEFITS	<a href="#">45 CFR 156 Appendix B</a>	Class A (Basic) Services – preventive and diagnostic	YES: NO: PAGE # OR IF NO:
FEDVIP HIGH OPTION DENTAL BENEFITS	<a href="#">FEDVIP Plan Details</a>		
		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:
FLUORIDE TREATMENT	Essential Health Benefit		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:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PATIENT'S BILL OF RIGHTS	<a href="#">RSA 415:18 XIV</a> <a href="#">RSA 151:21</a>	An insurer issuing policies of group insurance shall provide to each new certificate holder who is a resident of this state a copy of the patients' bill of rights law under RSA 151:21.	<b>YES:</b> <b>NO:</b> <b>PAGE # OR IF NO:</b>
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>	<b>YES:</b> <b>NO:</b> <b>PAGE # OR IF NO:</b>
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>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>	<b>YES:</b> <b>NO:</b> <b>PAGE # OR IF NO:</b>
COORDINATION OF BENEFITS	<a href="#">NHCAR Part Ins 1904</a>	This part applies to all group insurance plans subject to RSA 415, RSA 420-A and RSA 420-B.	<b>YES:</b> <b>NO:</b> <b>PAGE # OR IF NO:</b>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PREMIUMS RENEWAL INCREASE	<a href="#">NHCAR Part Ins 401.07 (b) (9)</a>	In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that:  a. A 30 days notice is provided for policies subject to RSA 415;	YES:    NO:  PAGE # OR IF NO:
CONTINUATION RIGHTS	<a href="#">RSA 415:18 XVI</a>	Carriers shall provide continuation of coverage when an individual covered by a plan of group health insurance or a health maintenance organization that provides medical, hospital, dental, and/or surgical expense benefits, loses coverage under the plan. Continuation coverage shall be identical to the coverage provided to other similarly situated members of the group that are still covered by the plan. Periods of coverage shall be as follows: When any individual loses coverage under a group health insurance plan for any reason except dismissal from employment for gross misconduct or carrier termination, coverage shall continue subject to this section for a period of 18 months, unless the individual is eligible for coverage under the following:  Whenever the entire group is terminated, coverage shall continue subject to this section for a period of 39 weeks.  An individual who is determined to be disabled within the first 60 days of the date such individual loses coverage shall be entitled to 29 months of continuation coverage.  Coverage shall continue subject to this section for a period of 36 months if any individual loses coverage under a group health insurance plan for one of the following reasons:  Death of a covered employee, divorce or legal separation of the covered employee or, if the employee's former spouse has been covered pursuant to RSA 415:18 VII-b, the first occurring of any of the following events: The remarriage of the covered employee; the death of the covered employee; the 3-year anniversary of the final decree of divorce or legal separation; or such earlier time as provided by such decree;  A substantial loss of coverage by retirees and dependents within one year of the employer filing for protection under the bankruptcy provisions of Title 11 of the United States Code; or  A dependent child ceasing to be a dependent child.  Surviving spouse age 55 or older – When the surviving spouse, divorced spouse, or legally separated spouse is 55 years of age or older and loses coverage because of the death, divorce or legal separation of the covered employee, coverage shall continue subject to this section until such time as the spouse becomes eligible for participation in another employer-sponsored group plan, or becomes eligible for Medicare.	YES:    NO:  PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SUMMARY PLAN DESCRIPTION OF CONTINUATION RIGHTS	<a href="#">RSA 415:18 XVI (f)</a>	(1) The carrier shall provide, at the time of commencement of coverage under the health benefit plan, a summary plan description to each eligible member or subscriber of the rights provided under this section. (2) Notice of the right to continue coverage also shall be set forth in each master policy and individual certificate of coverage.	YES: NO: PAGE # OR IF NO:

**SECTION 4 RATES**

<p><b>RATE SUBMISSIONS</b></p>	<p><a href="#">NH CAR PART Ins 4100</a></p>	<p>REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS</p> <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 (off-exchange) 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>	<p><b>YES: NO:</b> <b>WHY:</b></p>
<p><b>FEDERALLY REQUIRED FORMS</b></p>	<p><a href="#">Master List</a></p>	<p>Filing and Binder Requirements for Dental Plans</p>	<p><b>YES: NO:</b> <b>WHY:</b></p>

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

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

**REGULATION LINK(S):** NH CAR 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.