

State of New Hampshire Insurance Department

CHECKLIST FOR STAND ALONE DENTAL- GROUP

LINE OF BUSINESS: DENTAL - GROUP

TOI CODES: H10G

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 this Bulletin.

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 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 401.14 \(m\)](#) 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/rsa/html/NHTOC/NHTOC-XXXVII.htm>

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- **Important Notes:**

- **Stand Alone Dental Plan (SADP) Issuers should submit their form filings before May 10, 2020. SADP Issuers must submit their rate filings before May 10, 2020. 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 QHPs offered on the FFM.
- Stand alone dental are excluded from cost-sharing reduction (CSR) requirements.
- **For plan year 2021, SADP are not required to be accredited or submit accreditation information.**
- Variability is not permitted within cost sharing schedules.
- **NH Network templates and instructions are found at: <https://www.nh.gov/insurance/lah/2021-plan-year-qhps.htm>**

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
SECTION 1 GENERAL REQUIREMENTS			
ADVERTISING	<p>NHCAR Part Ins 2600</p> <p>Federal Health Insurance Marketplace Branding Guide</p>	<p>Advertising Guidelines</p> <p>Health Insurance Marketplace branding guides</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 NHCAR Part Ins 2601.</p> <p>Health Insurance Marketplace branding guide and logo for QHPs are found at: http://marketplace.cms.gov/GetOfficialResources/marketplace-brand-guide.pdf</p> <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>	<p>YES: NO:</p> <p>PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
TRANSPARENCY IN CWOVERAGE	45 CFR 156.220	<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"> (1) Claims payment policies and practices; (2) Periodic financial disclosures; (3) Data on enrollment; (4) Data on disenrollment; (5) Data on the number of claims that are denied; (6) Data on rating practices; (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and (8) Information on enrollee rights under title I of the Affordable Care Act. 	YES: NO: PAGE # OR IF NO:
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)	NHCAR Part Ins 401.04 (a)	Form number in lower left hand corner of face page	YES: NO: PAGE # OR IF NO:
READABILITY NON-ENGLISH POLICIES	NHCAR Part Ins 401.04 (p) – (t)	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:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
ENROLLMENT PERIODS		<p>The annual open enrollment period for the FFM now begins on November 1, 2020 and extends through December 15, 2020.</p> <p>Standard Employee Enrollment Periods 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>Special Employee Enrollment Periods Employees who experience certain life events as outlined in 45 CFR 155.725 (j) and 45 CFR 155.420 (d), must be given access to special enrollment periods of <i>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 guidance from CMS regarding SEP's: https://www.healthcare.gov/sep-list/</i></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
SECTION 2 APPLICATIONS			
APPLICATION	NHCAR Part Ins 401.14 (k)	<p>For On-exchange filings Federal Marketplace application must be attached to the supporting documentation tab for informational purposes. Off-exchange application must be attached to the forms schedule tab.</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 6201.05 (c) 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 style="text-align: center;">"The [policy] [certificate] provides dental benefits only. Review your [policy] [certificate] carefully."</p>	<p>YES: NO: PAGE # OR IF NO:</p>

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
HOME OFFICE BOX	RSA 415:11	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:
SECTION 3 POLICY FORM			
DISCLOSURE COVER PAGE REQUIREMENT	NHCAR Part Ins 6201.05 (r)	<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>"Notice to Buyer: This [policy] [certificate] provides dental benefits only."</p>	YES: NO: PAGE # OR IF NO:
JURISDICTION AND ID CARDS	RSA 400-A:15-c NHCAR Part Ins 1901.09	<p>Identification of Health Coverage Under the Jurisdiction of the Insurance Commissioner. – 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"> (1) Clearly visible; and (2) In a font size no less than the member's name on the member identification card. 	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
FREE LOOK	NHCAR Part Ins. 6001.06 (c)	The following provision shall appear in a conspicuous place on the cover page of all ancillary accident and health policies and certificates: "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."	YES: NO: PAGE # OR IF NO:
RENEWABILITY	NHCAR Part Ins 6001.06 (d)	Each policy of individual ancillary health insurance or group ancillary 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.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
PHYSICAL EXAMINATION OR AUTOPSY	RSA 415:18 I (k)	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	RSA 415:18 I (p) 45 CFR 156.270	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	RSA 415:18 I (n)	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 3 years from the expiration of the time within which proof of loss is required by the policy.	YES: NO: PAGE # OR IF NO:
CONTESTABILITY	RSA 415:18 I (r)	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	RSA 415:18 I (q)	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:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
CLAIM NOTICE	RSA 415:18 I (h)	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:
PROOF OF LOSS	RSA 415:18 I (i)	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	RSA 415:18-k	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	RSA 415:5 I (3-a)	In the event a carrier elects to provide coverage for dependent children, the term "dependent child" shall include a subscriber's child by blood or by law , who is under age 26.	YES: NO: PAGE # OR IF NO:
DISABLED DEPENDENT	RSA 415:5 I (3-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.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NEWBORN	RSA 415:22	<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>	YES: NO: PAGE # OR IF NO:
ADOPTIVE CHILD	RSA 415:22-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:
OUTLINE OF COVERAGE	NHCAR Part Ins 6201.06	(h) The items included in the outline of coverage shall appear in the following sequence: "[COMPANY NAME]"	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
MINIMUM STANDARDS	NHCAR Part Ins 1901.06 (l)	<p>[TYPE OF ANCILLARY HEALTH COVERAGE] THIS [POLICY] [CERTIFICATE] PROVIDES LIMITED BENEFITS BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES</p> <p>OUTLINE OF COVERAGE</p> <p>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>[Type of Ancillary Health] coverage is designed to provide, to persons insured, [brief description of Type of Ancillary Health coverage], subject to any limitations set forth in the policy or certificate. Coverage is not provided for any benefits other than the specific [Type of Ancillary Health] benefits described and any additional benefit described below:</p>	YES: NO: PAGE # OR IF NO:
PROHIBITION ON ANNUAL AND LIFETIME DOLLAR LIMITS		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. ³⁴ 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.	YES: NO: PAGE # OR IF NO:
ANNUAL LIMITS ON COST-SHARING – MAXIMUM OUT-OF-POCKET	2020 Letter to Issuers	<p>For the 2021 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>	YES: NO: PAGE # OR IF NO:
COMPANY GOOD STANDING/NH LICENSE		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.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
NETWORK ADEQUACY	RSA 420-J:7 I NH CAR Part Ins 2701	<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 2015 plan year QHP review which requires SADP issuers to offer two (2) open panel dental practices per county in the issuer's service area.</p> <p>For QHPs only, networks must include Essential Community Providers, per 45 CFR 156.230 and 45 CFR 156.235.</p>	YES: NO: PAGE # OR IF NO:
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	FEDVIP	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 FEDVIP HIGH OPTION DENTAL BENEFITS	45 CFR 156 Appendix B FEDVIP Plan Details	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 D Services - orthodontic	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
FLUORIDE TREATMENT	Essential Health Benefit	Fluoride treatment as per USPSTF	YES: NO: PAGE # OR IF NO:
DELTA DENTAL	RSA 420-F	Laws specific to Delta Dental	YES: NO: PAGE # OR IF NO:
PATIENT'S BILL OF RIGHTS	RSA 415:18 XIV RSA 151:21	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.	YES: NO: PAGE # OR IF NO:
BALANCE BILLING PROHIBITED	RSA 420-J:8	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: (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.	YES: NO: PAGE # OR IF NO:

REVIEW REQUIREMENTS	REFERENCE	DESCRIPTION OF REVIEW STANDARDS REQUIREMENTS	COMPLIANCE
APPEALS PROCESS/ MANAGED CARE	RSA 420-J NHCAR Part Ins 2703.04	Grievance Procedures, External Review Notice of Right to External Review. (a) Health carriers shall provide to covered persons the insurance department's "Managed Care Consumer Guide to External Appeal" and the insurance department's "Request for Independent External Appeal of a Health Care Decision" in each of the following circumstances: (1) The publications shall be attached to the policy, membership booklet, or other evidence of coverage provided to covered persons;	YES: NO: PAGE # OR IF NO:
COORDINATION OF BENEFITS	NHCAR Part Ins 1904	This part applies to all group insurance plans subject to RSA 415, RSA 420-A and RSA 420-B.	YES: NO: PAGE # OR IF NO:
PREMIUMS RENEWAL INCREASE	NHCAR Part Ins 401.08 (b) (9)	In the event of any renewal rate increase, insurers shall provide policyholders with prior notice of any such increase such that: b. A 60 days notice is provided for policies subject to RSA 420-G;	YES: NO: PAGE # OR IF NO:

<p>CONTINUATION RIGHTS</p>	<p><u>RSA 415:18 XVI</u></p>	<p>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:</p> <p>Whenever the entire group is terminated, coverage shall continue subject to this section for a period of 39 weeks.</p> <p>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.</p> <p>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:</p> <p>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;</p> <p>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</p> <p>A dependent child ceasing to be a dependent child.</p> <p>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.</p>	<p>YES: NO: Page # or If NO:</p>
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SUMMARY PLAN DESCRIPTION OF CONTINUATION RIGHTS	RSA 415:18 XVI (f)	(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:
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SECTION 4 RATES

<p>RATE SUBMISSIONS</p>	<p>NH CAR PART Ins 4100</p>	<p>REQUIREMENTS FOR ACCIDENT AND HEALTH INSURANCE RATE SUBMISSIONS</p> <ul style="list-style-type: none"> • Stand alone dental plans are not required to submit the Unified Rate Review Template for rate increase. • Stand alone dental plans (off-exchange) are required to offer child-only (under age 19) coverage. • No additional age rating may be included for pediatric dental. 	<p>YES: NO: WHY:</p>
<p>FEDERALLY REQUIRED FORMS</p>	<p>Master List</p>	<p>Filing and Binder Requirements for Dental Plans</p>	<p>YES: NO: YES: NO: YES: NO:</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](#), [6000](#), [6100](#), [6200](#), [2600](#), [2700](#) & [4100](#), [INDEX](#)

State of New Hampshire

CERTIFICATION FOR FORM SUBMISSION FOR COMPLIANCE WITH THE PATIENT
PROTECTION AND 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 PPACA 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.