Illinois Division of Insurance
Review Requirements Checklist

320 West Washington Street
Springfield, IL 62767-0001

Updated 3/2016

Line(s) of Insurance:

ACA Group Stand Alone Dental (SADP)
ACA Individual Stand Alone Dental (SADP)

(All State Mandates Apply)

Line(s) of Business:

Affordable Care Act Benchmark Requirements
Individual and Small Group Stand Alone Dental Products using either a PPO or Indemnity delivery platform

Contact Person:

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ELECTRONIC REFERENCES

Federal References Link:
Code of Federal Regulations
United States Code

Illinois References Link:
Illinois Insurance Code
Administrative Regulations Online
Illinois Company Bulletins

GENERAL REQUIREMENTS			
Review Requirements	**Reference**	**General Filing Requirements**	**Location of Standard in Filing**

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Review Requirements Checklist	Go to Review Requirements Checklists on DOI web site. See next column	Each filing must include a completed Review Requirements Checklist that must contain a completed "Location of Standard in Filing" column for each required element of the filing. Please indicate the proper page # and form # for each entry.	
Cover Letter and Letter of Submission	50 IL Adm. Code 1405.20 (e) 50 IL Adm. Code 2001.30 (a)(3) 50 IL Adm. Code 916.40 (b)	In addition to referencing any previously approved form number(s) as required by 50 IL Adm. Code 1405.20(e), those references must also include the filing number and SERFF tracking number (if applicable and available) for the referenced forms. Letters of submission must generally describe the intent and use of the form being filed and, if applicable, how it will be used with any previously approved form(s). . **The Filing Description field in the General Information Tab in SERFF may be used in place of a cover letter.**	
Entire Contract	215 ILCS 5/367(2)(a)	The policy, including the application and any amendments and riders, constitutes the entire contract of insurance and no change is valid unless approved by an executive officer of the company and unless such approval be endorsed hereon or attached hereto.	
Time Limit on Certain Defenses	215 ILCS 5/357.3 215 ILCS 5/367(2)	A policy is incontestable two years from the date of issue except for fraudulent misstatements made by the applicant on the application.	
Timely Payment of Claims	215 ILCS 5/357.9	Claims shall be paid within 30 days following receipt of written due proof of loss. Failure to pay within such period shall entitle the insured to interest at the rate of 9 per cent per annum from the 30th day.	

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Coordination of Benefits	215 ILCS 5/367(11a &b) 50 IL Adm Code 2009	Based on same premise as NAIC Model with some language variance. **Applicable to Small Group Only**	
Dental Care Patient Protection Act	215 ILCS 109/25	The Act requires Managed Care Dental plans to file a written consumer summary information description. The insurer must also file its grievance procedure and its list of participating providers.	
Spousal continuation	215 ILCS 5/367.2	Spousal and dependent continuation rights in case of death, divorce or retirement. **Applicable to Small Group Only**	
Dependent continuation	215 ILCS 5/367.2-5	Continuation rights for an insured's dependent child in the event of the death of the insured and the child is not eligible for coverage as a dependent under 215 ILCS 5/367.2. **Applicable to Small Group Only**	
Non-Participating Provider Services	215 ILCS 5/356z.3a	A notice must be provided to consumers explaining that a larger out-of-pocket expense may occur if non-participating providers are used. Provision must use same language as in statute, but may be modified to suit insurer terminology.	
Assignment of Benefits	215 ILCS 5/370a	No provision of the Illinois Insurance Code, or any other law, prohibits an insured from making an assignment of all or any part of his/her rights and privileges under the policy.	
Benefit	**Benchmark Requirement**	**Conditions for Coverage or Limitations**	
Pediatric Dental	PHSA §2711 (75 Fed Reg 37188, 45 CFR §147.126) CFR 45 §155.1065(a)(2) ACA 1302(b)(1)(J)	Coverage for children who have not achieved the age of 19.	
Diagnostic			
X-Rays	Yes		

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Routine Exams/Evaluations	Yes	Every 6 months per dentist in an office setting. Every 12 months in a school setting.	
Preventative Services			
Cleanings	Yes	Every 6 months	
Fluoride Treatment	Yes	Annually	
Sealants	Yes		
Space Maintenance	Yes		
Restorative Services			
Amalgams	Yes		
Resins	Yes		
Crowns	Yes		
Sedative Fillings	Yes		
Endodontic Services			
Pulpotomy	Yes		
Root Canals	Yes		
Periodontal Services			
Gingivectomy	Yes		
Scaling and Root Planing	Yes		
Removable Prothodontic Services	Yes		
Complete Denture (upper and lov	Yes		
Partial Denture (upper and lower)	Yes		
Denture Relines	Yes		
Maxillofacial Prosthetics	Yes		
Fixed Prosthetic Services	Yes		
Bridge	Yes		
Oral and Maxillofacial Services			
Extractions	Yes		

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Surgical Extractions	Yes		
Alveoloplasty	Yes		
Orthodontic Services			
Orthodontia (coverage limited to children meeting or exceeding a score of 42 from the Modified Salzmann Index or meeting criteria for medical necessity)	Yes		
Adjunctive General Services			
General anesthesia	Yes		
IV Sedation	Yes		
Nitrous Oxide	Yes		
Conscious Sedation	Yes		
Therapeutic Drug Injection	Yes		
Enrollment Periods	45 CFR § 156.260 155.310 155.410 155.420	This policy or contract form must provide for an annual open enrollment period, and special enrollment periods, including those special enrollment periods that allow for the addition of a new family member.	
Annual Limitation on Cost Sharing	45 CFR § 156.150(a)	A stand-alone dental plan covering the pediatric dental EHB must demonstrate that it has a reasonable annual limitation on cost-sharing as determined by the Exchange. Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services.	

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Minimum Actuarial Value	45 CFR § 156.150(b)	Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefits at either: · A low level of coverage with an AV of 70 percent; or · A high level of coverage with an AV of 85 percent; and · Within a de minimis variation of +/−2 percentage points. · The level of coverage must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.	