Department of Consumer and Business Services
Oregon Division of Financial Regulation
P.O. Box 14480
Salem, Oregon 97309-0405
Phone (503) 947-7983

Standard Provisions for Exchange Certified Pediatric Dental (ACA compliant) Forms (Individual and Small Group)

This checklist must be submitted with your filing, in compliance with OAR 836-010-0011(2). This list includes national standards, statutes, rules, and other documented positions to enforce ORS 731.016. This checklist is intended to provide guidance in the preparation of policy or contract forms for submission and is not intended as a substitute for statute or regulation. The standards are summaries and review of the entire statute or rule will be necessary. Complete each item to confirm that diligent consideration has been given to each and is certified by the signature on the Certificate of Compliance form. "Not applicable" can be used only if the item does not apply to the coverage being filed. Any line left blank will cause this filing to be considered incomplete. Not including required information or policy provisions may result in disapproval of the filing. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

Insurer name: _____ **Date:** _____

TOI (type of insurance): ☐ H10I Individual Health - Dental ☐ H10G Group Health - Dental

Marketing: ☐ Small Group ☐ Stand Alone

☐ Embedded within medical forms, SERFF no. _____
(this includes pediatric dental only or a family dental plan covering both pediatric and adult dental)

☐ Inside exchange only ☐ Outside exchange only ☐ Both inside and outside exchange

If also filing adult only dental forms, please submit Form 440-3172A in addition to these pediatric dental standards.

To be exchange certified, a carrier must file both a form and binder filing through SERFF.
See pediatric dental binder standards and requirements at:
http://dfr.oregon.gov/rates-forms/health/Pages/dental-binders.aspx.

" * " Does not apply to Health Care Service Contractors.

GENERAL REQUIREMENTS (FOR ALL FILINGS)			
Review requirements	Reference	Description of review standards requirements	Answer
Submission package requirements	OAR 836-010-0011 As required on SERFF or our website	Required forms are located on SERFF or on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx These must be submitted for your filing to be considered complete: 1. Filing description or cover letter. 2. Third party filer's letter of authorization. 3. Certificate of Compliance form signed and dated by authorized persons. 4. Readability certification. 5. Product standards for forms (this document). 6. Forms filed for approval. (If filing revised forms, include a ***highlighted*** copy of the revised form to identify the modification, revision, or replacement language.) 7. Statement of Variability (see "Variability in forms" section).	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
	OAR 836-010-0011(4) Filing description	The filing description or cover letter includes the following: 1. Changes made to previously-approved forms or variations from other approved forms. 2. All previously-approved forms for a similar product and a summary of the differences between the approved similar form and the new form. 3. The differences between in-network and out-of-network. 4. The contact information of two people that can answer questions about this filing.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
Review requested	ORS 742.003(1), OAR 836-010-0011(3)	The following are submitted in this filing for review: 1. New policy and certificate, if applicable. 2. Amendment to an approved form. 3. Endorsements and/or riders being attached to a policy or contract that was approved by DFR on _____, State or SERFF no. _____.	Yes N/A ☐ ☐ ☐ ☐ ☐ ☐
GENERAL FORM REQUIREMENTS (FOR ALL FILINGS)			
Category	Reference	Description of review standards requirements	Answer
Clarity/readability	ORS 742.005(2)	Forms are clear and understandable in presenting premiums, labels, descriptions of contents, title, headings, backing, and other indications (including restrictions) in the provisions. The information is clear and understandable to the consumer and is not ambiguous, abstruse, unintelligible, uncertain, or likely to mislead.	Yes N/A ☐ ☐
	ORS 743.405(5)(a)	The style, arrangement and overall appearance of the policy does not give undue prominence to any portion of the text, and all printed portions of the policy and attached papers printed plainly in not less than 12-point type.	Yes N/A ☐ ☐

Category	Reference	Description of review standards requirements	Answer
Cover page	ORS 742.023*, ORS 743.405(7)* (individual), ORS 742.005, OAR 836-010-0011, National standards	1. The full corporate name of the insuring company appears prominently on the first page of the policy. 2. A marketing name or insurer's logo, if used on the policy, must not mislead as to the identity of the insuring company. 3. The insuring company address, consisting of at least a city and state, appears on the first page of the policy. 4. The signature of at least one company officer appears on the first page of the policy. 5. A form-identification number appears in the lower left hand corner of the forms. The form number is adequate to distinguish the form from all others used by the insurer. 6. The policy contains a brief caption that appears prominently on the cover page and describes the type of coverage (example: Individual Stand Alone Dental).	Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐ Yes ☐ N/A ☐
Form number	OAR 836-010-0011	The policy is filed under one form number and that form provides core coverage with all basic requirements. Basic policy requirements are not bracketed unless an alternative selection is included. Other forms are identified with their unique form number and edition date. (See guidelines on our website: http://dfr.oregon.gov/rates-forms/health/Pages/health.aspx.)	Yes ☐ N/A ☐
Table of contents	ORS 743.103, ORS 743.106(1)(d)	Policy and certificate contains a table of contents or index of the principal sections if longer than 3 pages or 3,000 words.	Yes ☐ N/A ☐
Variability in forms	ORS 742.003, ORS 742.005(2) Variable text	All variable text is indicated by brackets showing language as either in or out of the contract; explains why the language is in, out, or variable; and provides a list of all available options. The specific conditions and circumstances under which each variable item may apply need to be explained in detail. For example: [123 Main, Anytown, ST] - Bracketed if address changes in the future [ABC Benefit] - Bracketed because may be included or excluded depending on policyholder's option	Confirmed ☐
	ORS 742.003, ORS 742.005(2) Variable numbers	Variable data is indicated by brackets and is limited to numerical values showing ranges (minimum to maximum benefit amounts) and all reasonable and realistic ranges are identified for each item. For example: Dollar ranges - $[10 to 100] Percentages - [70 to 100]% Time frames - [30-180]days *If the full numerical range is encompassed within the brackets (as shown above), the explanations do not need to be listed on the SOV or through drafter's notes.*	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Variability in forms, continued	ORS 742.003, ORS 742.005(2) Ways to explain variability	**The following are acceptable ways to explain variability in forms:** 1. DRAFTER'S NOTES: Drafter's notes are embedded in the form and provide a full explanation for all variable text and data. Drafter's notes should be *highlighted or shaded* in embedded form and placed either directly before or after variable text. 2. STATEMENT OF VARIABILITY (SOV): An SOV requires a unique form number on the lower left hand corner and submitted under the Form Schedule tab. The SOV must follow the bracketed sections in sequential order of the forms and provide detailed explanation of variability.	Confirmed ☐
	ORS 742.003, ORS 742.005(2) Vague explanations not allowed	Vague and non-descript explanations, such as "to allow for future changes", is unacceptable and will not be allowed. Our responsibility is to review and approve all language and options; therefore, all ranges and/or options must be disclosed.	Confirmed ☐
	ORS 742.003, ORS 742.005(2) Certification included	The filing also should include a certification that any change or modification to a variable item outside the approved ranges is submitted for prior approval of the change or modification.	Page: Paragraph or Section:

APPLICABILITY

Category	Reference	Description of review standards requirements	Answer
Advertisements	ORS 742.009, OAR 836-010-0011, OAR 836-020-0200 to 305,	If filing a new dental product, Form 440-3308H (*Standards for Health Advertisements*) is or will be filed prior to issuance. The DFR uses the following standards to evaluate compliance. Sales materials for insurance products shall not be false, deceptive, or misleading.	Yes ☐ N/A ☐
Applicability	Health Care Service Contractors (HCSC)	Statute references followed by an asterisk (*), may be marked "N/A" in the answer column if filed for a HCSC. These standards do not apply to HCSCs per ORS 750.055.	
Application	ORS 742.003(1), Form 440-2442H	If filing includes an application form, Form 440-2442H (*Standards for Health Applications*) is included.	Yes ☐ N/A ☐
Associations, trusts, or discretionary groups	ORS 731.098, ORS 731.486*, ORS 743.522, ORS 743.524 (group)	If filing includes group plans through associations, trusts, union trusts, or discretionary groups, carrier must file the group's qualifications and applicable documents contained in Form 440-2441A before any coverage is issued.	Yes ☐ N/A ☐

BENEFIT REQUIREMENT REFERENCES

Covered and non-covered services	The link provides the details of the required pediatric dental services (D code list): http://www.oregon.gov/oha/healthplan/tools/Covered%20and%20Non-Covered%20Dental%20Services,%20Effective%20January%201,%202017.pdf *Last year, we required carriers to list every D code in their policy or certificate. Now, we are not requiring every D code be listed in the policy and instead we are asking for a self-certification that all D codes covered by the CHIP plan will also be covered in this pediatric dental form filing.*	Confirmed ☐

POLICY PROVISIONS			
Category	Reference	Description of review standards requirements	Answer
Annual or lifetime limits on EHBs prohibited	PHSA §2711, 75 Fed Reg 37188, 45 CFR §§ 147.126 and 155.1065(a)(2)	No annual or lifetime limits on the dollar value of essential health benefits (EHBs) are allowed.	Confirmed ☐
Arbitration	ORS 36.600, ORS 36.740	If the policy provides for arbitration if claim settlement cannot be reached, the parties may elect arbitration by mutual agreement at the time of the dispute after the claimant has exhausted all internal appeals and mutually agreed arbitration can be binding. One party may initiate arbitration proceedings; however, if there is no mutual agreement the resulting arbitration is binding only on the party who demanded arbitration. Arbitration proceedings take place under the laws of Oregon and are held in the insured's county or another county in this state if agreed upon.	Page: Paragraph or Section:
Cancellation and nonrenewal	ORS 743.495, ORS 743.498	A non-cancelable or guaranteed-renewable policy includes the statement required by ORS 743.498 or similar language explaining the guaranteed or cancelable periods.	Page: Paragraph or Section:
Claim forms	ORS 743.426*, ORS 743.028, OAR 836-080-0225(4)	The “claim forms” statement in ORS 743.426 or a similar statement is included in the policy, providing that if claim forms are required and are not furnished within 15 days after the claimant gives notice of claim, the claimant shall be deemed to have complied with the requirement of the policy.	Page: Paragraph or Section:
Claim notice	ORS 743.423(1)*, OAR 836-080-0210(6)	The “notice of claim” statement in ORS 743.423(1), or a similar statement, is included in the policy, explaining that written notice of claim is given to the insurer within 20 days after occurrence or commencement of any loss covered by the policy or as soon thereafter as is reasonably possible.	Page: Paragraph or Section:
Claim payment	ORS 743.432*, OAR 836-080-0220	A “time payment of claims” statement similar to that in ORS 743.432 is included in the policy, stating that indemnities payable will be paid immediately upon receipt of due written proof of loss or stating the intervals of periodic payment of benefits.	Page: Paragraph or Section:
	OAR 836-080-0225(1)	Not later than the 30th day after receipt of notification of claim, acknowledge the notification or pay the claim. An appropriate and dated notation of the acknowledgment shall be included in the insurer's claim file.	Page: Paragraph or Section:
	ORS 743B.460* (group)	A group health insurance policy may, on request by the group policyholder, provide that all or any portion of any indemnities provided by such policy on account of hospital, nursing, medical or surgical services may, at the insurer’s option, be paid directly to the hospital or person rendering such services.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Claim procedures	ORS 746.230, OAR 836-080-0230, OAR 836-080-0235	If the policy includes claim procedures, the procedures and timelines comply with fair claim practice requirements.	Page: Paragraph or Section:
Coordination of benefits	ORS 743B.475, OAR 836-020-0770 -0806	Coordination of benefits complies with ORS 743B.475 and OAR 836-020-0770 to 0806.	Page: Paragraph or Section:
		Reduction of benefit payments on the basis of other insurance for the insured individual is in full accordance with coordination-of-benefits rules.	Page: Paragraph or Section:
Definition of class	ORS 742.005(6), ORS 743.018	If the insurer uses class for the purpose of rating, the policy includes a definition of class that is consistent with the actuarial basis.	Page: Paragraph or Section:
Dependent coverage	ORS 743B.470(6) Children	Policy covers children not residing with the parent, not claimed as dependents on parents' federal tax return, born out of wedlock, or residing in the insurer's service area.	Page: Paragraph or Section:
	ORS 106.300 to 340, Bulletin 2008-2 Domestic partners	The Oregon Family Fairness Act (ORS 106.300 to 106.340) recognizes and authorizes domestic partnerships in Oregon. A domestic partnership is defined in ORS 106.310 as "a civil contract entered into in person between two individuals of the same sex who are at least 18 years of age, who are otherwise capable and at least one of whom is a resident of Oregon." Requirements beyond this are not allowed for same sex domestic partners. Any time that coverage is extended to a spouse it must also extend to a domestic partner.	Page: Paragraph or Section:
	OAR 105-010-0018 Same-sex marriages performed in other states	Oregon recognizes the marriages of same-sex couples validly performed in other jurisdictions to the same extent that they recognize other marriages validly performed in other jurisdictions.	Page: Paragraph or Section:
Discretionary clauses prohibited	ORS 742.005(3),(4)	Discretionary clauses put insured Oregonians in the difficult situation of having to prove an insurer is being arbitrary and capricious when challenging the insurer's contractual interpretations (including claim determinations). Therefore, discretionary clauses are determined to be prejudicial, unjust, unfair, and inequitable.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Discrimination	ORS 746.015	No person shall make or permit any unfair discrimination between individuals of the same class and equal expectation of life, or between risks of essentially the same degree of hazard, in the availability of insurance, in the application of rates for insurance, in the dividends or other benefits payable under insurance policies, or in any other terms or conditions of insurance policies.	Confirmed ☐
	ORS 746.015(4) Domestic violence	This contract complies with ORS 746.015(4) by not cancelling, refusing to issue, or renew this policy on the basis of the fact that an insured or prospective insured is or has been a victim of domestic violence.	Confirmed ☐
	ORS 746.015(2) Physical disability	This contract complies with ORS 746.015(2) by not discriminating in its underwriting standards and or rates solely on an individual's physical disability.	Confirmed ☐
	ORS 743A.084, ORS 746.015 Unmarried women and their children	The policy does not discriminate between married and unmarried women or between children of married and unmarried women.	Confirmed ☐
Effective dates of coverage	45 CFR §§ 155.410(e)(2-3), Annual open enrollment (individual only)	The annual open enrollment periods in the individual market: • For benefit years starting Jan. 1, 2016 through 2017, annual open enrolment begins Nov. 1 of preceding year and extends through Jan. 31 of benfit year. • For the benefit years beginning on or after January 1, 2018, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.	Confirmed ☐
	45 CFR §§ 155.410(d) (2-3), 155.725(h) (2)(i-ii) Annual open enrollment, rolling enrollment (small group only)	For plan selections received between the 1st and 15th day of the month, coverage is effective on the first day of the following month. For plan selections received between the 16th and the last day of the month, coverage is effective on the first day of the second following month.	Confirmed ☐
	45 CFR §§ 155.420(b)(2)(i), and 155.725 Special enrollment periods	For birth, adoption, or placement for adoption, coverage is effective ON the date of the triggering event. For marriage or loss of minimum essential coverage, coverage is effective on the first day of the following month.	Confirmed ☐
Eligibility	OAR 836-053-0012(1)(g)	Pediatric dental benefits are payable to persons under 19 years of age.	Confirmed ☐
	ORS 743B.470(2) Medicaid	Eligibility for benefits is not based on eligibility for Medicaid.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Emergency care	ORS 742.005 OAR 410-123-1060(13)(a)(A-E)	Dental Emergency Services must be defined within the policy definition section: • Emergency Services - Covered services for an emergency dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. This includes services to treat the following conditions: ○ Acute infection; ○ Acute abscesses; ○ Severe tooth pain; ○ Unusual swelling of the face or gums; or ○ A tooth that has been avulsed (knocked out).	Page: Paragraph or Section:
	OAR 410-123-1060(13)(b) OAR 410-123-1060(2) OAR 410-123-1260(3)(a)(C)	• The treatment of an emergency is limited only to covered services. • Prior authorization is not required for outpatient or inpatient services related to life-threatening emergencies. • For urgent or emergent problems, code D0140 is used for the initial exam, and D0170 for subsequent follow-up exams (these codes not to be used for routine dental visits)	Page: Paragraph or Section:
Enrollment periods	26 CFR §54.9801-6(a)(3)(i) through (iii); 45 CFR §155.725 Annual open enroll-ment (small group only)	Issuers must permit a qualified small employer to purchase coverage at any point during the year, provided that the small employer meets minimum contribution and group participation requirements.	Page: Paragraph or Section:
	26 CFR §54.9801-6(a)(3)(i) through (iii); 45 CFR §155.725 Special enrollment (individual only)	For SADPs, 60 day Special Enrollment Periods (SEP) available from the date of: • Birth, adoption, or placement for adoption • Marriage • Loss of minimum essential coverage • Individual becomes a citizen, a national, or lawfully present (for QHPs only) • Unintentional enrollment or non-enrollment in a QHP • Violation by QHP of a material contract provision • New eligibility determination, access to a new QHP through a permanent move • Native Americans may change one time per month (for QHPs only) • Other exceptional circumstances as defined by the Exchange (for QHPs only)	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Enrollment periods, (cont.)	26 CFR §54.9801-6(a)(3)(i) through (iii); 45 CFR §155.725 Special enrollment (small group inside the exchange only)	For SADPs offered in the SHOP, special enrollment periods available for 30 days from the date of the following: • Birth, adoption, or placement for adoption • Marriage • Loss of minimum essential coverage • Unintentional enrollment or non-enrollment in a QHP • Violation by QHP of a material contract provision • New eligibility determination, access to a new QHP through a permanent move • Native Americans may change one time per month • Other exceptional circumstances as defined by the Exchange	Page: Paragraph or Section:
	26 CFR §54.9801-6(a)(3)(i) through (iii); 45 CFR §155.725 Special enrollment (small group outside the exchange only)	For SADPs offered outside the SHOP, special enrollment periods available for 30 days from the date of the following: • Birth, adoption, or placement for adoption • Marriage • Loss of coverage due to death, employment termination, reduction of hours, divorce or legal separation, loss of dependent status, or bankruptcy (retirees only)	Page: Paragraph or Section:
	26 CFR §54.9801-6(a)(3)(i) through (iii); 45 CFR §155.725 Special enrollment periods by circumstance	Special enrollment periods available for 60 days from the date of the following: • Newly eligible for premium assistance under Medicaid or CHIP • Loss of minimum essential coverage: ○ Loss of eligibility for coverage (coverage is not COBRA continuation coverage); ○ Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment; ○ Loss of coverage because no longer in service area; ○ Loss of coverage because plan no longer offers any benefits to the class of similarly situated individuals; ○ Termination of employer contributions; ○ Exhaustion of COBRA continuation coverage. ○ Loss of minimum essential coverage does not include failure to pay premiums on a timely basis, including a failure to pay COBRA premiums, or situations allowing for a rescission.	Page: Paragraph or Section:
Entire contract	ORS 742.016*, ORS 743.411*	The “entire contract” statement in ORS 743.411 or similar statement is included in the policy, explaining that the contract, including the endorsements and attached papers, if any, constitutes the entire contract of insurance.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Essential health benefits	ACA section 1302(b)(1)(J)	The pediatric dental essential health benefits listed in the policy or certificate are substantially equal to the benefits offered in the Oregon benchmark (CHIP) plan.	Confirmed ☐
Examination of contract	ORS 743.492	There is a provision printed on the face of the policy or attached thereto entitling the prospective insured to a 10-day period in which to examine and return the policy for a refund of any premium paid, including any policy fees or other charges. If returned, the policy is considered void from the beginning and the parties are in the same position as if no policy had been issued.	Page: Paragraph or Section:
Fraud statements	ORS 742.013, Bulletin 2010-03	If a fraud statement is included in the contract, it should be within the guidelines delineated in Bulletin 2010-03. The statement must be general in nature, using "may be" guilty of fraud and "may be" subject to civil or criminal penalties if intentional and material to the risk.	Page: Paragraph or Section:
Grace period	ORS 743.417* (individual), ORS 743B.320	Provision states that a minimum 10-day grace period is granted for the payment of each premium falling due after the first premium, during which the policy shall continue in force.	Page: Paragraph or Section:
Inducements not specified in policy	ORS 746.035	No person shall permit, offer to make or make any contract of insurance, or agreement as to such contract, unless all agreements or understandings by way of inducement are plainly expressed in the policy issued thereon.	Page: Paragraph or Section:
Legal action	ORS 743.441*	Provision states that no action at law or in equity is 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 policy. No action shall be brought after the expiration of 3 years after the time written proof of loss is required.	Page: Paragraph or Section:
Out of pocket maximum (OOPM) (inside exchange only)	Federal final rule 3/11/14, 45 CFR §156.150(a)	Cost sharing for a stand alone dental plan covering pediatric dental may not exceed $350 for one child and $700 for two or more children.	Page: Paragraph or Section:
Pediatric dental benefits	OAR 836-053-0012(2)(g)	"Pediatric dental benefits" means the benefits described in the children's dental provisions of the State Children's Health Insurance Plan as set forth at the following website:https://www.insurekidsnow.gov/coverage/or/index.html. Pediatric dental benefits are payable to persons under 19 years of age.	Confirmed ☐
Physical examination/ autopsy	ORS 743.438*	The "physical examinations and autopsy" statement in ORS 743.438 or a similar statement is included in the policy, explaining that the insurer at its own expense shall have the right and opportunity to examine the insured when and as often as it may reasonably require while a claim is pending.	Page: Paragraph or Section:

Category	Reference	Description of review standards requirements	Answer
Proof of loss	ORS 743.429*	The "proof of loss" statement in ORS 743.429 or a similar statement that proof of loss is due to the insurer within 90 days of the loss or, in the case of continuing loss for which the insurer is obligated to make periodic payments, 90 days after the end of the period of insurer liability. (*If it is not reasonably possible for the policyholder to meet this requirement, the claim shall not be invalidated or reduced if proof of loss is provided as soon as is reasonably possible and not later than one year after the date proof is otherwise required, except in the absence of legal capacity*.)	Page: Paragraph or Section:
Provider non-discrimination	PHSA 2706	Benefits do not discriminate against providers based on provider type.	Confirmed ☐
Provider reimbursement	ORS 743A.032* Dentist	Coverage provides reimbursement for surgical services that is within the lawful scope of practice of a licensed dentist, if policy provided benefits when a physician performed the service.	Page: Paragraph or Section:
	ORS 743A.028* Denturist	Policies for dental health that provide reimbursement for services of a denturist reimburse for the same services, if performed by a licensed dentist.	Page: Paragraph or Section:
	ORS 743A.034 Expanded practice dental hygienist	If a policy covering dental health provides for coverage for services performed by a dentist, the policy must also cover the services when they are performed by an expanded practice dental hygienist, as defined in ORS 679.010(9).	Page: Paragraph or Section:
	ORS 743A.010 State hospital or state approved program	Policy pays benefits for covered services when provided by any hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.	Page: Paragraph or Section:
Rebate prohibition	ORS 746.045	No person shall personally or otherwise offer, promise, allow, give, set off, pay or receive, directly or indirectly, any rebate of or rebate of part of the premium payable on an insurance policy or the insurance producer's commission thereon, or earnings, profit, dividends or other benefit founded, arising, accruing or to accrue on or from the policy, or any other valuable consideration or inducement to or for insurance on any domestic risk, which is not specified in the policy.	Page: Paragraph or Section:
Reinstatement	ORS 743.420*	A provision states that if the renewal premium has not been paid within the time granted but an insurer or authorized agent subsequently accepts a premium the policy shall be reinstated. The only exception is an application for reinstatement required to be submitted by the enrollee and accepted by the insurer.	Page: Paragraph or Section:
Stand alone dental	ACA section 1311(d)(2)(B)(ii)	Requires all exchange stand-alone dental plans to cover the pediatric dental essential health benefits.	Confirmed ☐

Category	Reference	Description of review standards requirements	Answer
Time limit on certain defenses	ORS 743.414(1)(3)*	• A provision states that after two years from the date of issue of the policy no misstatements, except fraudulent misstatements, made by the applicant shall be used to void the policy or to deny a claim. • "After this policy has been in force for a period of two years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."	Page: Paragraph or Section:
Usual, customary, or reasonable, defined	ORS 742.005	Filing includes a definition for "usual, customary, and reasonable" (UCR) that fully discloses how UCR benefits are determined.	Page: Paragraph or Section:

ESSENTIAL HEALTH BENEFITS FOR PEDIATRIC DENTAL (Benefits from the benchmark CHIP plan)

To be an exchange certified pediatric dental plan, the policy must cover the minimum benefits as listed below. The policy may have more generous coverage than this, but must at least cover the minimums below. Also, required coverage is only for insureds under 19 (unless otherwise stated).

Category	Subcategory/Reference	Description of benefit requirements	Answer
DIAGNOSTIC SERVICES	Exams OAR 410-123-1260(2)(a)(A)(i)	Exams (D0120, D0145, D0150, or D0180) a maximum of twice every 12 months with the following limitations: • D0150: once every 12 months when performed by the same practitioner; • D0150: twice every 12 months when performed by different practitioners; • D0180: once every 12 months.	Page: Paragraph or Section:
	OAR 410-123-1260(2)(a)(C)	For each emergent episode, use D0140 for the initial exam. Use D0170 for related dental follow-up exams.	Page: Paragraph or Section:
	OAR 410-123-1260(2)(a)(D)	Covers oral exams by medical practitioners when they are oral surgeons.	Page: Paragraph or Section:
	Radiographs OAR 410-123-1260(2)(b)(A-B)	• Routine radiographs once every 12 months. • Bitewing radiographs for routine screening once every 12 months.	Page: Paragraph or Section:
	OAR 410-123-1260(2)(b)(C), (H)	Maximum of six radiographs for any one emergency, but more can be added if dentally necessary	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
DIAGNOSTIC SERVICES (cont.)	OAR 410-123-1260(2)(c)(D)(i-ii)	For insureds under age six, radiographs may be billed separately every 12 months as follows: • D0220 — once • D0230 — a maximum of five times	Page: Paragraph or Section:
	OAR 410-123-1260(2)(c)(D)(iii)(E)	D0270 — a maximum of twice, or D0272 once; for panoramic (D0330) or intra-oral complete series (D0210) once every five years, but both cannot be done within the five-year period	Page: Paragraph or Section:
	OAR 410-123-1260 (2)(c)(F)(i-ii)	Insureds must be minimum of age 6 to bill intra-oral complete series (D0210). The minimum standards for reimbursement of intra-oral complete series are: • For insureds age six through 11 - a minimum of 10 periapicals and two bitewings for a total of 12 films • For insureds ages 12 and older - a minimum of 10 periapicals and four bitewings for a total of 14 films.	Page: Paragraph or Section:
PREVENTIVE SERVICES	Prophylaxis OAR 410-123-1260(3)(a)(A) OAR 410-123-1260(3)(a)(C)	• Limited to twice per 12 months. • Additional prophylaxis benefit provisions may be available for persons with high risk oral conditions due to disease process, pregnancy, medications or other medical treatments or conditions, severe periodontal disease, rampant caries and/or for persons with disabilities who cannot perform adequate daily oral health care.	Page: Paragraph or Section:
	OAR 410-123-1260(3)(a)(D) (i-ii)	Coded using the appropriate Current Dental Terminology (CDT) coding: • D1110 (Prophylaxis – Adult) – Use for insureds age 14 and older • D1120 (Prophylaxis – Child) – Use for insureds under age 14	Page: Paragraph or Section:
	Topical fluoride treatment OAR 410-123-1260(3)(b)(B)	Limited to twice every 12 months for children under age 19.	Page: Paragraph or Section:
	OAR 410-123-1260(3)(b)(D) (i-v)	Additional topical fluoride treatments may be available, up to 4 treatments per insured within 12-month period when high-risk conditions or other oral health factors are clearly documented in chart notes for the following insureds who: • Have high-risk oral conditions due to disease process, medications, other medical treatments or conditions, or rampant caries; • Are pregnant; • Have physical disabilities & cannot perform adequate, daily oral health care; • Have a developmental disability or other severe cognitive impairment that cannot perform adequate, daily oral health care; or • Are under age 7 with high-risk oral health factors such as poor oral hygiene, deep pits & fissures (grooves) in teeth, severely crowded teeth, poor diet, etc.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
PREVENTIVE SERVICES, (cont.)	Sealants (D1351) OAR 410-123-1260(3)(c)(A)B)(i-ii)	• Covered only for children under 16 years of age. • Limits coverage to: ○ Permanent molars; and ○ Only one sealant treatment per molar every five years, except for visible evidence of clinical failure.	Page: Paragraph or Section:
	Space management OAR 410-123-1260(3)(e)(A-B)	Covers fixed and removable (but not lost or damaged) space maintainers (D1510, D1515, D1520, and D1525).	Page: Paragraph or Section:
RESTORATIVE SERVICES	Restorations (amalgam and composite) OAR 410-123-1260(4)(a)(A)	Resin-based composite crowns & restorations on anterior teeth (D2390) covered for clients under age 21	Page: Paragraph or Section:
	OAR 410-123-1260(4)(a)(D-E)	Limits payment of covered restorations to the maximum restoration fee of four surfaces per tooth, once every five years.	Page: Paragraph or Section:
	OAR 410-123-1260(4)(a)(H)	Surface once in each treatment episode regardless of the number or combination of restorations.	Page: Paragraph or Section:
	OAR 410-123-1260(4)(a)(I)	The restoration fee includes payment for occlusal adjustment and polishing of the restoration.	Page: Paragraph or Section:
	Crowns and related services OAR 410-123-1260(4)(b)(A)(i)	The fee for the crown includes payment for preparation of the gingival tissue.	Page: Paragraph or Section:
	OAR 410-123-1260(4)(b)(A)(iv)	Retention pins (D2951) is per tooth, not per pin.	Page: Paragraph or Section:
	OAR 410-123-1260(4)(b)(D)(i)	Prefabricated plastic crowns (D2932) – allowed only for anterior teeth, permanent or primary.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
RESTORATIVE SERVICES, (cont.)	OAR 410-123-1260(4)(b)(D)(ii-iii)	• Stainless steel crowns (D2930/D2931) -– allowed only for anterior primary teeth and posterior permanent or primary teeth. • Prefabricated stainless steel crowns with resin window (D2933) – allowed only for anterior teeth, permanent or primary.	Page: Paragraph or Section:
	OAR 410-123-1260(4)(b)(A)(iii), (D)(iv)	• Covers core buildup for retainer (D2950) only when necessary to retain a cast restoration due to extensive loss of tooth structure and only when done in conjunction with a crown. • Prefabricated post and core in addition to crowns (D2954/D2957).	Page: Paragraph or Section:
	OAR 410-123-1260(4)(b)(D)(v)(I-IV)	Permanent crowns (resin-based composite - D2710 and D2712, and porcelain fused to metal (PFM) - D2751 and D2752) as follows: • Limited to teeth numbers 6-11, 22 and 27 only, if dentally appropriate; • Limited to four (4) in a seven-year period. • Only for insureds at least 16 years of age; and • Rampant caries are arrested and the insured demonstrates a period of oral hygiene before prosthetics are proposed.	Page: Paragraph or Section:
	OAR 410-123-1260 (4)(b)(E)(i-iii)	Crown replacement: • Permanent crown replacement limited to once every seven years; • All other crown replacement limited to once every five years; and • Possible exceptions to crown replacement limitations due to acute trauma, based on the following factors: o Extent of crown damage; o Extent of damage to other teeth or crowns; o Extent of impaired mastication; o Tooth is restorable without other surgical procedures; and o If loss of tooth would result in coverage of removable prosthetic.	Page: Paragraph or Section:
ENDODONTIC SERVICES	Pulp capping OAR 410-123-1260(5)(a)(A-B)	Includes direct and indirect pulp caps in the restoration fee; direct caps are a separate service because restorations are not a covered benefit under CHIP.	Page: Paragraph or Section:
	Endodontic therapy OAR 410-123-1260(5)(b)(A)	Pulpal therapy on primary teeth (D3230 and D3240)	Page: Paragraph or Section:
	OAR 410-123-1260(5)(b)(B)(i-ii)(I)	For permanent teeth: • Anterior and bicuspid endodontic therapy (D3310 and D3320) is covered for all insureds; and • Molar endodontic therapy (D3330) covered only for 1st & 2nd molars.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
ENDODONTIC SERVICES, (cont.)	Endodontic retreatment and apicoectomy/ periradicular surgery OAR 410-123-1260(5)(c)(B)(i-iii)	Limits either a retreatment or an apicoectomy (but not both procedures for the same tooth) to symptomatic anterior teeth when: • Crown-to-root ratio is 50:50 or better; • The tooth is restorable without other surgical procedures; or • If loss of tooth would result in the need for removable prosthodontics.	Page: Paragraph or Section:
	OAR 410-123-1260(5)(c)(C)	Retrograde filling (D3430) is covered only when done in conjunction with a covered apicoectomy of an anterior tooth.	Page: Paragraph or Section:
	OAR 410-123-1260(5)(e)	Covers endodontics if the tooth is restorable within the benefit coverage package.	Page: Paragraph or Section:
	Apexification/ recalcification & pulpal regeneration OAR 410-123-1260(5)(f)(A-B)	• Limits payment for apexification to a maximum of five treatments on permanent teeth only. • Apexification/recalcification and pulpal regeneration procedures are covered.	Page: Paragraph or Section:
PERIODONTIC SERVICES	Surgical periodontal services OAR 410-123-1260(6)(a)(A-B)	• Gingivectomy/Gingivoplasty (D4210 and D4211) – limited to coverage for severe gingival hyperplasia where enlargement of gum tissue occurs that prevents access to oral hygiene procedures, e.g., Dilantin hyperplasia; and • Includes six months routine postoperative care.	Page: Paragraph or Section:
	Non-surgical periodontal services OAR 410-123-1260(6)(b)(A)(i & iii)	Periodontal scaling and root planing (D4341 and D4342): • Allowed once every two years; • A maximum of two quadrants on one date of service is payable, except in extraordinary circumstances;	Page: Paragraph or Section:
	Full Mouth Debridement Periodontal Maintenance OAR 410-123-1260(6)(b)(B)(i), (c)(A)	• Full mouth debridement (D4355) allowed once every 2 years • Periodontal Maintenance (D4910) allowed once every six months	Page: Paragraph or Section:
REMOVABLE PROSTHODONTIC SERVICES	OAR 410-123-1260(7)(a) OAR 410-123-1260(7)(c)	• Insureds age 16 years and older are eligible for removable resin base partial dentures (D5211-D5212) and full dentures (complete or immediate, D5110-D5140). • The fee for the partial and full dentures includes payment for adjustments during the six-month period following delivery to insureds.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
REMOVABLE PROSTHODONTIC SERVICES, (cont.)	Resin partial dentures (D5211-D5212) OAR 410-123-1260(7)(d)(A-B)	• May not approve resin partial dentures if stainless steel crowns are used as abutments. • The insured must have one or more anterior teeth missing or four or more missing posterior teeth per arch with resulting space equivalent to that loss demonstrating inability to masticate. Third molars are not a consideration when counting missing teeth.	Page: Paragraph or Section:
	Replacement of removable partial or full dentures OAR 410-123-1260(7)(e)(A & C)	• Replacement of removable full or partial dentures, when it cannot be made clinically serviceable by a less costly procedure (e.g., reline, rebase, repair, tooth replacement), is limited to the following: • For insureds at least 16 years and under 19 years of age - shall replace full or partial dentures every 10 years, but only if dentally appropriate. • The 10-year limitations apply to the insured regardless of the insured's enrollment status at the time insured's last denture or partial was received.	Page: Paragraph or Section:
	Replacement of removable partial or full dentures (cont.) OAR 410-123-1260(7)(e)(D)	• Replacement of partial dentures with full dentures is payable 10 years after partial denture placement. Exceptions to this limitation may be made in cases of acute trauma or catastrophic illness such as cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant replacement.	Page: Paragraph or Section:
	OAR 410-123-1260(7)(g)(A)	Replacement of all teeth & acrylic on cast metal framework (D5670-D5671) covered for insureds age 16 and older a maximum of once every 10 years, per arch.	Page: Paragraph or Section:
	Denture rebase procedures OAR 410-123-1260(7)(h)(A-B, D)	• Covers rebases only if a reline may not adequately solve the problem. • Limits payment for rebase to once every three years. • May make exceptions to this limitation in cases of acute trauma or catastrophic illness such as cancer and periodontal disease resulting from pharmacological, surgical and/or medical treatment for aforementioned conditions. Severe periodontal disease due to neglect of daily oral hygiene may not warrant rebasing.	Page: Paragraph or Section:
	Denture reline procedures OAR 410-123-1260(7)(i)(A & C)	• Limits payment for reline of complete or partial dentures to once every three years. • May make exceptions to this limitation under the same conditions warranting replacement.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
REMOVABLE PROSTHODONTIC SERVICES, (cont.)	Laboratory relines OAR 410-123-1260(7)(i)(D)(i-ii)	• Are not payable prior to six months after placement of an immediate denture; and • Limited to once every three years.	Page: Paragraph or Section:
	Interim partial dentures or "flippers" (D5820-D5821) OAR 410-123 1260(7)(j)(A-B)	• Allowed if the insured has one or more anterior teeth missing; and • Reimburse for replacement of interim partial dentures once every 5 years, but only when dentally appropriate.	Page: Paragraph or Section:
	Tissue conditioning OAR 410-123-1260(7)(k)(A-B)	• Allowed once per denture unit in conjunction with immediate dentures; • Allowed once prior to new prosthetic placement.	Page: Paragraph or Section:
MAXILLOFACIAL PROSTHETIC SERVICES	OAR 410-123-1260(8)(a-b)	• Fluoride gel carrier (D5986) is limited to those patients whose severity of oral disease causes the increased cleaning and fluoride treatments allowed in rule to be insufficient. The dental practitioner must document failure of those options prior to use of the fluoride gel carrier. • All other maxillofacial prosthetics (D5900-D5999) are medical services.	Page: Paragraph or Section:
ORAL SURGERY SERVICES	Tooth Re-implantation OAR 410-123-1260(9)(g) OAR 410-123-1260(9)(h)	• Covers payment for tooth re-implantation only in cases of traumatic avulsion where there are good indications of success. • Biopsies collected are reimbursed as a dental service. Laboratory services of biopsies are reimbursed as a medical service.	Page: Paragraph or Section:
	Extractions OAR 410-123-1260(9)(j)	Includes local anesthesia and routine postoperative care, including treatment of a dry socket if done by the provider of the extraction. Dry socket is not considered a separate service.	Page: Paragraph or Section:
	Surgical Extractions OAR 410-123-1260(9)(k)(A-B)	• Includes local anesthesia & routine post-operative care. • Limits payment for surgical removal of impacted teeth or removal of residual tooth roots to treatment for only those teeth that have acute infection or abscess, severe tooth pain, and/or unusual swelling of the face or gums.	Page: Paragraph or Section:
	OAR 410-123-1260(9)(k)(D)	Alveoplasty is covered without a corresponding extraction (D7320-D7321) only for members under age 19.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
ORAL SURGERY SERVICES, (cont.)	OAR 410-123-1260(9)(l) (A-C)	Covers frenulectomy (D7960) & frenuloplasty (D7963) in the following situations: • Once per lifetime per arch; • Maxillary labial frenulectomy only for insureds age 12 through 19; • When the insured has ankyloglossia; • When the condition is deemed to cause gingival recession; or • When the condition is deemed to cause movement of the gingival margin when the frenum is placed under tension.	Page: Paragraph or Section:
	OAR 410-123-1260(9)(m)	Covers excision of pericoronal gingival (D7971).	Page: Paragraph or Section:
ORTHODONTIA SERVICES	OAR 410-123-1260(10)(a) (A-C)	Limits orthodontia services and extractions to eligible insureds: • With the ICD-9-CM diagnosis of cleft palate or cleft palate with cleft lip; • Whose orthodontia treatment began prior to age 19; or • Whose surgical corrections of cleft palate or cleft lip were not completed prior to age 19.	Page: Paragraph or Section:
	OAR 410-123-1260(10)(d)	Payment for appliance therapy includes the appliance and all follow-up visits.	Page: Paragraph or Section:
	OAR 410-123-1260(10)(e)	Orthodontists evaluate orthodontia treatment for cleft palate/cleft lip as two phases. Stage one is generally the use of an activator (palatal expander) and stage two is generally the placement of fixed appliances (banding). Reimburse each phase separately.	Page: Paragraph or Section:
ADJUNCTIVE GENERAL AND OTHER SERVICES	OAR 410-123-1260(11)(a)	Fixed partial denture sectioning (D9120) is covered only when extracting a tooth connected to a fixed prosthesis and a portion of the fixed prosthesis is to remain intact and serviceable, preventing the need for more costly treatment.	Page: Paragraph or Section:
	Anesthesia OAR 410-123-1260(11)(b) (A)	Only use general anesthesia or IV sedation for those insureds with concurrent needs: age, physical, medical or mental status, or degree of difficulty of the procedure (D9220, D9221, D9241 and D9242).	Page: Paragraph or Section:
	OAR 410-123-1260(11)(b) (B)(i-ii)	Reimburses providers for general anesthesia or IV sedation as follows: • D9220 or D9241: First 30 minutes; • D9221 or D9242: Each 15-minute period represents a quantity of one, up to 3 hours on same day of service.	Page: Paragraph or Section:

Category	Subcategory/Reference	Description of benefit requirements	Answer
ADJUNCTIVE GENERAL AND OTHER SERVICES, (cont.)	OAR 410-123-1260(11)(b)(C)	Reimburses administration of Nitrous Oxide (D9230) per date of service, not by time.	Page: Paragraph or Section:
	OAR 410-123-1260(11)(b)(D)(i-iii)	Oral pre-medication anesthesia for conscious sedation (D9248): • Limited to insureds under 13 years of age; • Limited to four times per year; • Includes payment for monitoring and Nitrous Oxide.	Page: Paragraph or Section:
	OAR 410-123-1260(11)(b)(F)	Limits payment for code D9630 to those oral medications used during a procedure and is not intended for "take home" medication.	Page: Paragraph or Section:
	OAR 410-123-1260(11)(c)	Limits reimbursement of house/extended care facility call (D9410) only for urgent or emergent dental visits occurring outside of a dental office. Code is not reimbursable for preventive services or for services provided outside of the office for the provider or facilities' convenience.	Page: Paragraph or Section:
	Oral devices / appliances (E0485, E0486) OAR 410-123-1260(11)(d)(A)	Oral devices/appliances may be placed or fabricated by a dentist or oral surgeon, but are considered a medical service.	Page: Paragraph or Section:

REQUIREMENTS FOR RATES ***(Individual stand alone plans only—if your pediatric dental benefits are embedded in the medical contract, this portion does not need to be filled out and your pediatric dental rate information should be included in the medical rate filing.)***			
Review requirements	Reference	Description of review standards requirements	Answer
Filing request	OAR 836-010-0011	The following review is requested: 1. New rate filing. 2. Rate change.	Check one: ☐
Combined classes	ORS 742.041*	Filing includes classes of combined life and health insurance (no other classes are combined in this filing in which insurer's liability for unearned premiums or reserve for unpaid, deferred, or undetermined loss claims is estimated in a different manner.)	Yes ☐ No ☐
Premium changes	ORS 742.005(6), ORS 743.018	Premium changes are subject to prior approval and should not be filed more than once in a 12-month period.	Yes ☐
Renewability	ORS 742.023*, ORS 743.018	A premium change or renewability provision provides for premium changes only when such changes apply to all policies of this form, are issued to persons in the same class in this state, and have been approved by the Oregon Division of Financial Regulation.	Yes ☐ No ☐
Ratemaking	OAR 836-010-0011	Appendix A (Form 440-2462) is included, all columns completed with support of the requested rate change; it includes actual and projected experience and company's overall Oregon and national loss ratio.	Yes ☐
		A complete actuarial memorandum, signed by an accredited actuary, is included containing a description of all policy benefits and the actuarial assumptions used to develop each of the benefits. (Include a description of the risk and the assumptions used in developing the cost.)	Yes ☐
		The expected experience of the new rate or existing rate for the projected calculating period over which the actuary expects the premium rates to remain adequate is based on estimated future experience without expected rate increases.	Yes ☐
		The source of the data; information about new or experimental benefits; and explanation of the reliability of projections, abrupt changes in the experience, and substantial differences between actual and expected experience are included.	Yes ☐
		A statement that the grouping of policy forms has not changed or an explanation of the changes is included. Experience of forms must be grouped according to similar types of benefits, claims experience, reserves, margins for contingencies, expenses and profit, renewability, underwriting, and equity between policyholders.	Yes ☐

Review requirements	Reference	Description of review standards requirements	Answer
Ratemaking, cont.	OAR 836-010-0011, cont.	The premium structure, as defined by the classification of insureds in the policy, is not changed at the time of rate increase (e.g., changes from issue-age to attained-age basis).	Yes ☐
	ORS 733.030	Filing identifies how reserving assumptions (including specific company experience) take into account any expected adverse mortality and lapses that are reflected in the pricing.	Yes ☐
Loss ratios	OAR 836-010-0021(1)	**Rate changes**. Successive generic policy forms of similar benefits covering generations of policyholders must be combined in the calculation of premium rates and loss ratios.	Yes ☐
Underwriting	OAR 836-010-0011	Mark the type of health underwriting filed for the forms included in this rate request: • Full underwriting. • Simplified underwriting. • No underwriting	Check one: ☐ ☐ ☐
Affordable Care Act	45 CFR Part 156, §156.135, §156.470	**Pediatric Dental Essential Health Benefits and Actuarial Value:** • Describe how the actuarial value was determined for the pediatric dental EHB portion of benefits. • The actuarial value should be 70% (plus or minus 2%) to be marketed as a “Low” plan or 85% (plus or minus 2%) to be marketed as a “High” plan. • Describe the allocation of the claims and premium amounts between pediatric dental EHB and non-EHB coverage. • A member of the American Academy of Actuaries must certify the actuarial values and the allocations. • A stand alone dental plan may also provide benefits in addition to the pediatric dental EHB benefits. The plan may also cover adults. • Provide separate rate tables for the pediatric EHB and non-EHB coverage provided.	Confirmed ☐ ☐ ☐ ☐ ☐ ☐

Review requirements	Reference	Description of review standards requirements	Answer
Affordable Care Act, cont.	45 CFR Part 156, §156.135, §156.470	**Rating Factors:** • Limited to permitted factors by the ACA for medical plans (not required to use all factors): o Age o Tobacco o Geographic area (defined by ZIP code) The standard age curve does not apply, but discrete values are needed for each age band provided in the CMS Rate Tables template included in the plan filing (same rate can be entered for multiple ages, if necessary). • CMS Rate Table templates accept only a single value for ages 0-20. • Compliance with 3:1 age ratio and 1.5:1 tobacco use ratio not required. **Family Rates:** • Calculated based on the "per member" additive methodology • Per member rating includes a maximum of 3 children under age 21 **Notes**: § CMS Rate Data template is required for binder filings only (not required for rate filings). Rate information must show that rates are guaranteed, not estimated. § All exchange certified stand alone dental plans must include the pediatric dental essential health benefits (EHB). § Rating restrictions and EHB requirements do not apply to stand alone dental plans not being certified by exchange to provide pediatric dental EHB.	Confirmed ☐ ☐ ☐ ☐ ☐ ☐