

SECTION II: POLICIES

QHP ISSUER PARTICIPATION STANDARDS

SUBJECT: Exchange Certification

PURPOSE: To ensure that all Northeast Delta Dental plans offered on the FFE are certified by the Exchange and are in compliance with FFE processes, procedures, and requirements under Subpart K of Part 155

POLICY: It is Northeast Delta Dental’s policy to ensure that all Northeast Delta Dental plans being sold on the FFE have been certified by the Exchange prior to being offered on the FFE and are in compliance with FFE processes, procedures, and requirements under Subpart K of Part 155 and,.

PROCESS: Northeast Delta Dental reviews and submits their plan offerings on an annual basis for certification by the Exchange. This process includes:

1. Review of the current prescribed benchmark, Letter to Issuers, and HHS Notice of Benefit and Payment Parameters outlining the benefits and requirements of a Pediatric Dental EHB.
2. Review of the applicable state laws.
3. Registering with the Enterprise Identity Management System (EIDM) to gain access to the Health Insurance Oversight System (HIOS) to obtain product and plan IDs.
4. Submitting QHP application for all plans intended to be offered on the FFE, including all required documents (forms, rates, templates, attestations and binders) through SERFF for state approval and in accordance with the timelines set by the applicable state and CMS.
5. Reviewing plan offerings in Plan Preview provided in HIOS.
6. Providing Plan Confirmation and QHP/SADP Certification validation of the final plan list, signing and submitting the Privacy and Security Agreement and Senior Officer Acknowledgement forms to CMS.
7. Awaiting the final countersigned agreement.

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References: [§ 156.200\(a\)](#), [§ 156.200\(b\)\(2\)](#).

QHP ISSUER PARTICIPATION STANDARDS

SUBJECT: Licensure and Good Standing

PURPOSE: To ensure that Northeast Delta Dental has obtained the required licensure and certificate of good standing with the state in which the plans offered on the FFE are being sold.

POLICY: It is Northeast Delta Dental's policy to obtain the required licensure and certificate of good standing with the state in which the plans offered on the FFE are being sold.

PROCESS: Obtain a certificate of good standing from the respective state insurance departments.

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References: [§ 156.200\(b\)\(4\)](#)

QHP ISSUER PARTICIPATION STANDARDS

SUBJECT: Non-Discrimination

PURPOSE: To ensure that all Northeast Delta Dental plans are offered on the FFE without discrimination on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

POLICY: It is Northeast Delta Dental's policy to provide dental plans certified by the Exchange and offered on the FFE without discrimination on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status.

PROCESS: The open enrollment process on healthcare.gov does not question or request criteria related to race, color, national origin, disability gender identity or sexual orientation. Questions related to age are asked for the purpose of determining pediatric plans and questions related to both age and sex are asked for the purpose of determining health trends. Policy underwriting is performed on a group, not an individual, basis, and rates have been filed prior to open enrollment with a guaranteed premium.

Materials available and provided to the consumer during and after enrollment include the following statement pursuant to 45 CFR § 156.200(e):

“Northeast Delta Dental does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status.”

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References: [§ 156.200\(e\)](#)

QHP ISSUER PARTICIPATION STANDARDS

SUBJECT: Agent/Broker Compensation

PURPOSE: To ensure agents and brokers compensated for QHP plans offered through the FFE receive equal pay as the agents and brokers compensated for non-QHP plans offered outside of the FFE.

POLICY: It is Northeast Delta Dental's policy to compensate agents and brokers equal pay regardless of whether or not the plan is sold inside or outside the FFE.

PROCESS: Commission paid to agents and brokers, both on and off the exchange include 10% commission for the sale of an individual plans, as outlined in the Actuarial Memorandum at the time of filing.

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References: [§ 156.200\(f\)](#)

QHP RATE AND BENEFIT INFORMATION

SUBJECT: Rate Increase Justifications

PURPOSE: To submit justifications of rate increases to the Exchange prior to the implementation of the rate increase and prominently posting justifications of rate increases on the QHP Issuer’s website.

POLICY: It is Northeast Delta Dental’s policy to submit rate increase justifications annually to the Exchange prior to the implementation of the rate increase and to prominently post the justification of rate increases on its website.

PROCESS: The following is the process for submitting rate justifications and prominently posting them on the website:

1. File rate increase justifications annually, as required with Exchange filings, prior to the implementation of the rate increase.
2. Actuary will provide VP, Sales & Marketing the justification of rate increases.
3. Marketing will format the text to prepare it for display on our corporate website.
4. The VP, Sales & Marketing will ensure the justification is added to the corporate website in the Health Insurance Marketplace Plans section.

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References: [§ 156.210\(c\)](#)

TRANSPARENCY IN COVERAGE

SUBJECT: Claims payment policies and practices.

PURPOSE: To provide information on claims payment policies and practices to the Exchange, HHS, the State Insurance Commissioner/Superintendent and to the public in plain language and in a timely and efficient manner.

POLICY: It is Northeast Delta Dental's policy to provide information on claims payment policies and practices to the Exchange, HHS, the State Insurance Commissioner/Superintendent and to the public in plain language and in a timely and efficient manner.

PROCESS: Northeast Delta Dental will provide, in plain language and in a timely and efficient manner, information regarding payment of claims policies and practices, to the Exchange, HHS, the State Insurance Commissioner/Superintendent and to the public as required by 45 CFR § 156.220.

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References: [§ 156.220\(a\)\(1\)](#), [§ 156.220\(b\)](#), [§ 156.220\(c\)](#)

QHP MARKETING AND BENEFIT DESIGN

SUBJECT: Enrollment of individuals with significant health needs.

PURPOSE: To ensure Northeast Delta Dental's marketing practices or benefit designs do not have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

POLICY: It is Northeast Delta Dental's policy to encourage enrollment of individuals regardless of health needs. It is further Northeast Delta Dental's policy to prohibit marketing practices or benefits designs that will have the effect of discouraging the enrollment of individuals with significant health needs.

PROCESS: The open enrollment process on healthcare.gov does not question or request criteria related to health conditions. Policy underwriting is performed on a group, not an individual, basis and rates have been filed prior to open enrollment with a guaranteed premium. Waiting periods on policies are consistent for all persons and not specific to particular individuals.

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References: [§ 156.225\(b\)](#)

DELEGATED DOWNSTREAM ENTITIES

SUBJECT: Compliance with standards applicable to delegated and downstream entities

PURPOSE: To ensure compliance with standards applicable to delegated and downstream entities to prevent marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in QHPs. To further ensure that a compliant delegation agreement has been signed with all delegated and downstream entities.

POLICY: It is Northeast Delta Dental's policy to ensure compliance with standards applicable to delegated and downstream entities to prevent marketing practices or benefit designs that will have the effect of discouraging enrollment of individuals with significant health needs in QHPs and to ensure that a compliant delegation agreement has been signed with all delegated and downstream entities.

PROCESS: All downstream and delegated entities are required via contract to comply with Northeast Delta Dental's QHP Policies and Procedures. All contracts with downstream and delegated entities shall:

- (1) Specify the delegated activities and reporting responsibilities;
- (2) Provide for revocation of the delegated activities and reporting standards or specify other remedies in instances where HHS or the QHP issuer determines that such parties have not performed satisfactorily;
- (3) Specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under 156.340(a); and
- (4) Specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period.

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References: [§ 156.225](#); [§ 156.340\(a\)\(1\)](#); [§ 156.340\(b\)](#)

AFFILIATED AGENT/BROKER STANDARDS

SUBJECT: Affiliated agent/broker compliance

PURPOSE: To ensure that affiliated agents/brokers are in compliance with standards for downstream and delegated entities pursuant to 45 CFR § 156.340.

POLICY: It is Northeast Delta Dental's policy to ensure compliance by its affiliated agents/brokers, as downstream and delegated entities, with the standards for downstream and delegated entities set forth in 45 CFR § 156.340 including the following:

- Satisfying applicable FFE registration and training requirements
- Maintain licensure and good standing in each state in which the agent/broker participates in an FFE
- Executing the FFE Privacy/Security Agreement(s) and (if applicable) the General Marketplace Agreement
- If an agent/broker non-FFE website is used to complete QHP selection, the website must prominently display the required disclaimers

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References: [§ 156.340\(a\)\(3\)](#); [§ 155.220\(c\)\(3\)\(i\)\(A\)](#)

PROVIDER DIRECTORY STANDARDS

SUBJECT: Provider Directory Standards

PURPOSE: To ensure access to the provider directory, identify providers that are accepting new patients, and publicize online and make available in hard copy upon request.

POLICY: It is Northeast Delta Dental's policy to publish its up-to-date, accurate, and complete provider directory, which identifies providers that are not accepting new patients, as well as the provider's location, contact information, and specialty for a QHP available to the FFE online or in hard copy upon request.

PROCESS: The following is the process by which the provider directory is updated and maintained:

- 1.) Northeast Delta Dental requests, at least annually, that participating providers advise whether they are accepting new patients.
- 2.) Northeast Delta Dental updates the provider website and provider availability frequently.

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References: [§ 156.230\(b\)\(1\)](#); [§ 156.230\(b\)\(2\)](#)

PROVIDER DIRECTORY STANDARDS

SUBJECT: Provider Directory Standards

PURPOSE: To ensure enrollees receive sufficient written notice of discontinuation of a provider and an option to continue active treatment with the terminated provider based on the below policy provisions.

POLICY: It is Northeast Delta Dental's policy to make a good faith effort to provide written notice to impacted enrollees of discontinuation of a provider thirty (30) days prior to the effective date of the change and to allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for ninety (90) days, whichever is shorter, at in-network cost-sharing rates, if a provider is terminated without cause.

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References: [§ 156.230\(d\)\(1\)](#), [§ 156.230\(d\)\(2\)](#)

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

SUBJECT: Out-of-Network Liability and Balance Billing

DESCRIPTION: Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or any amounts that may remain on a deductible.

POLICY: It is Northeast Delta Dental's policy to prohibit balance billing for services performed by an in-network PPO provider.

PROCESS: The dental plan's payment is based on the "allowed charge" for a covered service. The allowed charge is determined by whether the provider of the services is a Delta Dental PPO Dentist, a Delta Dental Premier Dentist, or does not participate with Delta Dental.

If the Dentist is a **Delta Dental PPO Dentist**, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the area in which the services were provided. The enrollee's responsibility will be any Deductible, Co-Payment and Coinsurance. The Dentist cannot receive in total more than Delta Dental's allowance for PPO Dentists.

If the Dentist is a **Delta Dental Premier Dentist**, the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for PPO Dentists in the area in which the services were provided. The enrollee's responsibility will be any Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and Delta Dental's allowance for Premier Dentists in the area in which the services were provided. The Premier Dentist cannot receive more than the allowance for Premier Dentists and has agreed not to bill the enrollee for more than that amount.

If the Dentist is a **Non-Participating Dentist** or Other Dental Provider (ODP), the allowed charge will be the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the area in which the services were provided. The enrollee's responsibility will be any Deductible, Co-Payment, and Coinsurance, and any difference between your plan's payment and the provider's charge for this service. The enrollee should discuss what the charge will be before receiving the service as a Non-Participating Dentist can set a higher charge for a service than a Participating in-network Dentist.

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ESSENTIAL COMMUNITY PROVIDERS

SUBJECT: Essential Community Providers

PURPOSE: To ensure a sufficient number and geographic distribution of essential community providers to provide reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

POLICY: It is Northeast Delta Dental's policy to ensure a sufficient number and geographic distribution of essential community providers to provide reasonable and timely access to providers in accordance with the Exchange's network adequacy standards, including an ongoing, proactive process for contracting with new providers.

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References: [§ 156.235\(a\)](#), [§ 156.235\(b\)](#)

PROVIDER TRANSITION NOTICES

SUBJECT: Compliance with federal provider transition notice requirements.

PURPOSE: To ensure that all Northeast Delta Dental (NEDD) enrollees receive adequate notification when their primary oral health provider is no longer a network participant or to allow an enrollee to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates, if a provider is terminated without cause.

POLICY: It is Northeast Delta Dental's policy to ensure that NEDD's business practices comply with the Provider Transition Notice requirement.

PROCESS: When a PPO provider has left a dental practice location or terminates his/her participation in the PPO network:

- 1) Provider Services will research whether or not that practice location has other PPO providers at that location.
 - a. If there are other PPO providers at the practice location, no further action is required.
 - b. If there are no PPO providers at the practice location, or the location closes, Provider Services must open an ad hoc report request to identify enrollees who must be notified. Enrollees should receive a written notice of discontinuation of a provider 30 days prior to the effective date of change, or otherwise as soon as practicable.
- 2) The report must identify the following:
 - a. Any active individual covered through the FFE who has been seen at least one time by the PPO provider in the last 12 months.
 - b. Mailing address and email Address
- 3) If there is an email address on file, individual will be notified via email.
- 4) If there is no email address on file, individual will be notified via mail.

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References: § 156.230(d)(1), § 156.230(d)(2)

MEANINGFUL ACCESS TO QHP INFORMATION

SUBJECT: Applications and Notices – Accessibility and Readability Requirements

PURPOSE: To ensure information provided to applicants and enrollees are provided in plain language and in a manner that is accessible and timely.

POLICY: It is Northeast Delta Dental’s policy to provide information to applicants and enrollees in plain language and in a manner that is accessible and timely.

PROCESS: Information is provided in the following:

1. The use of a single, streamlined application to determine eligibility and collect information necessary for enrollment and advance payments of premium tax credit.
2. Offer the tools to file an application via internet web site, telephone, mail and in person.
3. For individuals with limited English proficiency, Northeast Delta Dental contracts with language interpretation services at no cost to the individual.
4. For individuals with disabilities, Northeast Delta Dental provides accessible Web sites and auxiliary aids and services at no cost to the individual.

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References: [§ 156.250](#) , [§ 155.230\(b\)](#), [§ 155.335\(c\)](#), [§ 155.405](#), [§ 155.205\(c\)](#)

RATING VARIATIONS

SUBJECT: Coverage Cost Parity

PURPOSE: To charge the same premium rate without regard to whether the plan is offered through an Exchange, directly from the issuer, or through an agent.

POLICY: It is Northeast Delta Dental's policy to combine experience rating for Exchange certified QHP plans sold on the FFE and Exchange certified non-QHP plans sold on the FFE to ensure the same premium rates.

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References: [§ 156.255\(b\)](#)

ENROLLMENT PERIODS FOR QUALIFIED INDIVIDUALS

SUBJECT: Enrollment for Individuals

PURPOSE: To ensure enrollment of individuals during initial and annual open enrollment periods as described in § 155.410(b) and (e) and to make available, at a minimum, special enrollment periods as described in § 155.420(d) in accordance with the effective dates of coverage established by the Exchange pursuant to § 155.410(c) and (f) and § 155.420(b).

POLICY: It is Northeast Delta Dental's policy to ensure enrollment of individuals during the initial and annual open enrollment periods and to make available, at a minimum, special enrollment periods in accordance with the effective date of coverage established by the Exchange.

PROCESS: Individual enrollment:

1. Individuals seeking dental plans will visit www.HealthCare.gov for:
 - a. Selection of dental plan
 - b. Number of dependents
 - c. Effective date
 - d. Rate information.
2. Enrollment information is then sent to Encara (Third Party Administrator) for fulfillment of plan materials.
3. Enrollment information is simultaneously sent to Northeast Delta Dental via secured EDI file from Encara for entering into the claims administration system.

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References: [§ 155.260\(a\)](#), [§ 155.410\(b\) \(c\) \(e\) and \(f\)](#), [§ 155.420\(b\) and \(d\)](#)

ENROLLMENT PROCESS FOR QUALIFIED INDIVIDUALS

SUBJECT: Enrollment for Individuals

PURPOSE: To ensure enrollment of individuals is performed through the Exchange rather than direct enrollment with the QHP Issuer, enrollment information is safeguarded with respect to personally identifiable information, in compliance with the premium payment rules established by the Exchange and information packages for new enrollees meets readability and accessibility standards for individuals with disabilities or limited English proficiency.

POLICY: It is Northeast Delta Dental's policy to ensure enrollment of individuals is performed through the Exchange and not directly with Northeast Delta Dental and that all personally identifiable information regarding enrollment is safeguarded. It is further Northeast Delta Dental's policy to be in compliance with the premium rules established by the Exchange and with the readability and accessibility standards for individuals with disabilities or limited English proficiency.

PROCESS:

1. Individuals requesting enrollment directly through the issuer are directed to HealthCare.gov.
2. Enrollment information received is sent to Encara using an 834 EDI file onto a secure FTP server.
3. Premiums offered on Healthcare.gov are guaranteed and approved by the state and federal government prior to the sale.
4. Premium payments are transmitted to Encara (Third Party Administrator) using a secured 820 EDI File.
5. Encara sends a 999 Acknowledgement file to CMS upon receipt of the 820 file.
6. Encara sends policy documents and welcome letter to individuals on behalf of Northeast Delta Dental.
7. Documents provided to the individuals are written in English and with an approved Flesch Score readability. Individuals speaking a different language are assisted by means of a translation service contracted by Northeast Delta Dental.

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References: [§ 156.265\(b\)](#); [§ 156.265\(c\)](#); [§ 156.265\(d\)](#); [§ 156.265\(f\)](#); [§ 156.265\(g\)](#); [§ 156.1250](#).

ENROLLEE CLAIMS SUBMISSION

SUBJECT: Enrollee Claims Submission

DESCRIPTION: An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

POLICY: It is Northeast Delta Dental's policy to process claims submitted by the subscriber with the same consideration as that of a claim submission by a provider.

PROCESS: When visiting a Non-Participating Dentist or ODP (Other Dental Provider), an enrollee may be required to submit the claim and pay for services at the time they are provided. Claim forms are available at <http://www.nedelta.com/Patients/Patient-Forms> and should be submitted to **Northeast Delta Dental, PO Box 2002, Concord, NH 03302-2002**. Payment will be made directly to the enrollee. Some states may require that assignment of benefits be honored. In these instances, payment will be made directly to the Non-Participating Dentist or ODP when written notice of an assignment is made on the claim. In either case, payment for treatment by a Non-Participating Dentist or ODP will be limited to the lesser of the submitted charge or Delta Dental's allowance for Non-Participating Dentists or ODPs in the area in which services were provided. It is the enrollee's responsibility to make full payment to the Dentist or ODP. When there is not enough fee information available, Delta Dental will determine an appropriate payment amount.

A completed claim (or satisfactory written proof acceptable to Delta Dental) must be furnished to Delta Dental at its principal office within twenty-four (24) months from the date the Dentist or ODP provided Dental Care. No payment will be made on claims with dates of service in excess of the twenty-four (24) month limitation except for a demonstrated reason preventing submission within the twenty-four (24) month period.

The enrollee or someone in the dental office must fill in the patient information portion of the claim form. Please be sure information is complete and accurate to ensure the prompt and correct payment of your claim.

For questions regarding claims submission, please contact our Customer Service at 603-223-1234 or toll-free at 1-800-832-5700. For TTY, please call 711.

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RETROACTIVE DENIALS

SUBJECT: Retroactive Denials

DESCRIPTION: A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment.

POLICY: It is Northeast Delta Dental's policy to adjust history of a claim paid in error and to follow the appropriate process as outlined below.

PROCESS: Claims payment errors can be avoided by reviewing the information on the claim prior to signing and submitting to Northeast Delta Dental.

If a claim was paid due to an error made by Northeast Delta Dental, the claim history will be adjusted but no recoupment of payment will be made from the dentist or the enrollee.

If a claim was paid due to an error made by the provider, Northeast Delta Dental will adjust the claim and recoup payment made to the provider, but the enrollee is not responsible for that payment.

If a claim was paid due to an error made by the enrollee, Northeast Delta Dental will adjust the claim and the enrollee is responsible for reimbursement of payment to Northeast Delta Dental. An enrollee can avoid retroactive denials by paying premiums on time and in full, and making sure you talk to your provider about whether the service being performed is a covered benefit. An enrollee can also avoid retroactive denials by obtaining services from a Participating Dentist.

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ENROLLEE RECOUPMENT OF OVERPAYMENTS

SUBJECT: Enrollee Recoupment of Overpayments

DESCRIPTION: The refund of a premium overpayment made by the enrollee due to the over-billing by the issuer.

POLICY: It is Northeast Delta Dental's policy to refund or provide credit for overpayments made by enrollees due to overbilling by Northeast Delta Dental.

PROCESS: If you believe you have paid too much for your premium and should receive a refund, please call Customer Service at 1-800-832-5700.

If the policy is active and there is an overpayment, the next billing cycle will contain an adjustment of the overpaid premium resulting in a lower premium amount due reflected in that cycle's bill.

If the enrollee cancels the policy, Delta Dental or its third party service provider shall return any unearned portion of the premium within thirty (30) days. The earned premium shall be computed on a pro-rata basis.

In the event of termination by Delta Dental, Delta Dental or its third party service provider will return the unearned portion of any policy premium within thirty (30) days. The earned premium shall be determined on a pro-rata basis.

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TERMINATION OF COVERAGE FOR QUALIFIED INDIVIDUALS

SUBJECT: Notice of termination to individuals

PURPOSE: To ensure notice of termination of coverage of an individual, including the effective date of termination, is sent to the individual promptly and without undue delay.

POLICY: It is Northeast Delta Dental's policy to notify individuals of termination of coverage, and to provide the effective date of and reason for such termination, to the individual promptly and without undue delay.

PROCESS: The following is the process for notifying individuals of termination:

1. Encara receives 834 file from CMS, which notifies Encara of terminated individuals.
2. Encara transmits the 834 file to Northeast Delta Dental.
3. Northeast Delta Dental promptly notifies individual of termination, including the effective date of and reason for such termination.
4. Termination records are retained electronically at Northeast Delta Dental.

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References: [§ 156.270\(a\)](#); [§ 156.270\(b\)](#)

TERMINATION OF COVERAGE FOR QUALIFIED INDIVIDUALS (GRACE PERIODS AND CLAIMS PENDING)

SUBJECT: Termination for Non-Payment of Premium

PURPOSE: To ensure compliance with the termination of coverage for non-payment of premiums requirements set forth by § 155.430.

POLICY: It is Northeast Delta Dental's policy to include grace period consideration of three (3) consecutive months for enrollees receiving advance payments of the premium tax credits and enrollees in similar circumstances under the condition that the enrollee has previously paid at least one full month's premium during the benefit year. The grace period is for enrollees who fail to pay their premium by the due date but before coverage is terminated. Northeast Delta Dental extends this policy to include the payment of all appropriate claims for services rendered to the enrollee during the first month of the grace period with the understanding that claims in the second and third months of the grace period may have a pending status. Those claims with a pending status will be the enrollee's responsibility unless all outstanding premiums are paid by the end of the grace period.

PROCESS: When it is determined that an enrollee enters the three (3) month grace period for non-payment of premium, Northeast Delta Dental will:

- 1.) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period.
 - a. During the second and third months of the grace period, claims will be held in a pending status.
- 2.) Notify HHS and the enrollee of the delinquency of premium.
- 3.) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.
- 4.) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the Department of Treasury.
 - a. Collected advance payments of the premium tax credit paid on behalf of the enrollee for the second and third months of the grace period must be returned; and the enrollee must be terminated if the enrollee exhausts the grace period without paying all outstanding premiums.
 - b. The termination date for an enrollee that has exhausted the grace period without paying all outstanding premiums will be the last day of the first month of the three month grace period in accordance with [§ 155.430\(d\)\(4\)](#).
- 5.) Maintain records of termination in accordance with § 155.430(c).

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References: [§ 156.270\(c\)](#); [§ 156.270 \(d\)](#), [§ 156.270 \(e\)](#), [§ 156.270\(f\)](#); [§ 156.270 \(g\)](#); [§ 156.270\(h\)](#); [§ 156.270\(i\)](#), [§ 155.430\(d\)](#)

MEDICAL NECESSITY, PRIOR AUTHORIZATION AND PREDETERMINATION OF BENEFITS

SUBJECT: Medical Necessity, Prior Authorization and Predetermination of Benefits

PURPOSE: To ensure transparency with enrollees regarding Medical Necessity, Prior Authorization and Predetermination of Benefits.

POLICY: It is Northeast Delta Dental's policy to ensure transparency with enrollees regarding Medical Necessity, Prior Authorization and Predetermination of Benefits.

Northeast Delta Dental will determine Medical Necessity of services in accordance with an enrollee's benefit plan. Medical necessity is care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. Some services may be subject to review for medical necessity.

Prior authorization is required for certain procedures including Medically Necessary Orthodontics. This is a review of the dentist's treatment plan before the services can be performed. If an enrollee fails to obtain the proper Prior Authorization, it can result in the denial of services.

Separate from a Prior Authorization, Northeast Delta Dental encourages enrollees to request a Predetermination of Benefits for any procedure that is considered to be other than brief or routine. A Predetermination of Benefits provides an estimate of what Northeast Delta Dental will pay for the services based on information available at the time the Predetermination of Benefits is completed. A Predetermination of Benefits is NOT the same as a Prior Authorization and it is not a guarantee of payment as the benefit information may change between the time the Predetermination of Benefits is completed and the time the service is performed.

PROCESS: MEDICAL NECESSITY AND PRIOR AUTHORIZATION

- The dentist performing services will request a Prior Authorization for certain treatment including orthodontics.
- Northeast Delta Dental will review the request and any provided documentation supporting Medical Necessity.
- Northeast Delta Dental may request additional supporting documentation, x-rays and charting in order to determine Medical Necessity.
- Northeast Delta Dental will send to the subscriber and the dental office an approval or denial of the Prior Authorization based on the determination of Medical Necessity no later than fifteen days after all required information is received.

PROCESS: PREDETERMINATION OF BENEFITS

- The dentist performing services will request a Predetermination of Benefits for services other than brief or routine to determine the cost of services being paid by both Northeast Delta Dental and by the enrollee.
- Northeast Delta Dental will review the request and any provided documentation.
- Northeast Delta Dental may request additional supporting documentation, x-rays and charting as needed.

Northeast Delta Dental QHP Compliance Plan

- Northeast Delta Dental will send to the subscriber and the dental office the Predetermination of Benefits based on the information available at the time the Predetermination of Benefits is completed.
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LAST REVIEWED: SEPTEMBER 5, 2019; MARCH 10, 2020; JULY 15, 2020; MARCH 30, 2021; April 20, 2022

NON-RENEWAL AND DISCONTINUATION OF QHPs

SUBJECT: Non-renewal and Discontinuation of QHP Certified Plans

PURPOSE: To ensure compliance with the notification standards for non-renewal or discontinuation of QHP Certified plans, in accordance with 45 CFR § 156.290.

POLICY: It is Northeast Delta Dental's policy to adhere to and be in compliance with notification standards for non-renewal or discontinuation of QHP Certified plans as outlined below.

PROCESS: When Northeast Delta Dental no longer offers a QHP Certified plan, it will notify the Exchange of non-renewal or discontinuation by:

1. Sending notification to the Exchange of its decision prior to the beginning of the recertification process and procedures adopted by the exchange in accordance with §155.1075.
2. Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year.
3. Fulfill data reporting obligations from the last plan or benefit year of the certification.
4. Provide notice to enrollees in accordance with § 156.290.
5. Terminate coverage for enrollees in the QHP in accordance with § 156.270:
 - a. If decertification is initiated by the Exchange, enrollees are terminated only after the enrollees have an opportunity to enroll in other coverage.

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References: [45 CFR § 156.290](#); [§ 156.1255](#)

MAINTENANCE OF RECORDS

SUBJECT: Record Maintenance for Federally Facilitated Exchanges

PURPOSE: To maintain all financial records and documents relating to plans and plan benefits and communications with enrollees (whether paper, electronic, or other media) for a period of ten (10) years.

POLICY: It is Northeast Delta Dental's policy to maintain all documents and records (whether paper, electronic, or other media) relating to financial records, plan benefits documents and communications with enrollees for a period of ten (10) years.

DATE ISSUED: APRIL 8, 2016

LAST REVISED: APRIL 8, 2016; APRIL 4, 2017

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References: [§156.705\(a\)](#), [§ 156.705\(c\)](#), [§ 155.1210](#)

HANDLING OF HEALTH INSURANCE CASEWORK SYSTEM (HICS)

SUBJECT: Handling of Health Insurance Casework System (HICS)

PURPOSE: To ensure that subscribers receive an expedient resolution to issues related to their enrollment.

POLICY: It is Northeast Delta Dental's policy to investigate HICS cases and provide resolution to issues related to enrollment within the appropriate and required time of 72 hours for Level 1 (urgent) cases and 15 calendar days for Level 2 cases.

PROCESS: When Northeast Delta Dental receives notification from CMS of a HICS case:

1. The NEDD employee assigned to the case will investigate the case in NEDD's system. If NEDD requires additional information, it will contact the subscriber by phone. If NEDD is unable to reach the subscriber by phone during their investigative process, NEDD will send a written request for information by mail and notate the HICS System.
2. If NEDD can resolve the issue upon first investigation, it will resolve the issue and send a mailed notification of the resolution to the subscriber and update the HICS Casework System. If NEDD cannot resolve the issue upon initial investigation, NEDD will reach out to Encara (NEDD's Third Party Administrator) to assist in the investigation.
3. If Encara can resolve the issue, it will either respond to NEDD with instructions on moving forward; or resolve the issue and notify the subscriber by mail and send NEDD a notification of resolution so that NEDD can update the HICS Casework System.
4. If the issue cannot be resolved by either NEDD or Encara, the case is then sent to XOSC Helpdesk through CMS. If no resolution can be accomplished, the case is then referred to first the caseworker and ultimately, the case manager, if necessary.

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LAST REVIEWED: APRIL 8, 2016; APRIL 4, 2017; MARCH 27, 2018; SEPTEMBER 5, 2019; MARCH 10, 2020; MARCH 30, 2021; April 20, 2022

References: [§ 156.1010\(b\)](#); [§ 156.1010\(d\)](#); [§ 156.1010\(f\)](#)

OTHER NOTICES FOR SPECIAL ENROLLMENT PERIODS

SUBJECT: Notice requirements for Special Enrollment Period material or benefit display errors.

PURPOSE: To ensure that enrollees receive notice within 30days of correction of any material or benefit display errors and the enrollee’s eligibility for a Special Enrollment Period.

POLICY: It is Northeast Delta Dental’s policy to notify enrollees within 30days of correction of any material or benefit display errors and the enrollee’s eligibility for a Special Enrollment Period in accordance with 45 CFR § 156.1256.

PROCESS: When there is an error in material or benefit display and the enrollee’s eligibility for a Special Enrollment Period, Northeast Delta Dental will notify the enrollee within 30 days after receiving notice from the FFE that the error has been fixed.

DATE ISSUED: APRIL 10, 2017

LAST REVISED: APRIL 10, 2017; MARCH 27, 2018

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References: [§ 156.1256](#)

Information on Explanations of Benefits (EOBs)

SUBJECT: Information on Explanations of Benefits (EOB)

DESCRIPTION: An Explanation of Benefits (EOB) is a statement an issuer sends to the enrollee to explain what treatments and/or services were paid or denied on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

POLICY: It is Northeast Delta Dental's policy to provide an Explanation of Benefits (EOB) to the subscriber in response to a claim received and adjudicated in accordance with the plan's benefit design. Northeast Delta Dental will remit such Explanation of Benefits within thirty (30) days of receipt of clean written claims and within (15) days of clean electronic claims.

PROCESS: In reviewing your Explanation of Benefits, please review from top to bottom and left to right:

- The *Subscriber Name* and *Subscriber ID Number*, which should match what is on your identification card;
- The *Total Fee Submitted* reflects the total cost of services charged to Northeast Delta Dental by the dentist.
- The *Total Patient Payment to Provider* reflects the amount you owe to the dentist.
- The *Total Plan Payment* reflects the amount Northeast Delta Dental paid to the dentist on your behalf.
- The *Group Number* and *Sublocation Number* identify the group with which you are associated.
- The *Notices* describes important information about requesting a review of denied claims and the dispute process.
- The *Claim Information* gives a detailed breakdown of services performed. The top line of this section describes the claim number assigned to the claim, the patient's name (the member of the family who received services), the patient's date of birth, and the provider name (the dentist who performed the services). The detailed information from left to right (as shown in the image below) may include:
 - a tooth number (if applicable);
 - a date of service which is the date on which the service was performed;
 - a procedure number or code which identifies the service performed;
 - a description of the service performed;
 - the amount submitted by the provider for that particular service;
 - the amount approved (which is the fee the provider has agreed to accept for this service);
 - the amount allowed (which is the amount Northeast Delta Dental will consider for the service based on the plan design and provider status);
 - the Applied to Deductible (which is the amount allowed that will be applied toward the deductible);
 - the Plan Co-Pay % (which is the benefit class under which the service is listed – such as Diagnostic and Preventive 100%);
 - the OV Co-Pay, if applicable (the Office Visit Copayment amount is based on the structure of the plan);

Northeast Delta Dental QHP Compliance Plan

- the Patient Payment is the amount the patient is responsible for, including any applicable deductibles and office visit co-payments;
- the Plan Payment is the amount Northeast Delta Dental has paid on your behalf, the total of which should match the Total Plan Payment amount above;
- the Processing Policy is the code assigned to describe the reason for denial (which is described in more detail under Processing Policies).

TOOTH NO.	DATE OF SERVICE	PROC. NO.	DESCRIPTION OF SERVICE	AMOUNT SUBMITTED	AMOUNT APPROVED	AMOUNT ALLOWED	APPLIED TO DEDUCT.	PLAN CO-PAY %	OV CO-PAY	PATIENT PAYMENT	PLAN PAYMENT	PROCESSING POLICY
21	05-02-2016	D1351	Sealant	\$45.00	\$45.00	\$45.00	\$0.00	100	0	\$0.00	\$45.00	
29	05-02-2016	D1351	Sealant	\$45.00	\$45.00	\$45.00	\$0.00	100	0	\$0.00	\$45.00	
28	05-02-2016	D1351	Sealant	\$45.00	\$45.00	\$45.00	\$0.00	100	0	\$0.00	\$45.00	
	05-02-2016	D1206	Fluoride Varnish	\$50.00	\$34.00	\$34.00	\$0.00	100	0	\$0.00	\$34.00	
	05-02-2016	D1110	Prophylaxis-adult	\$110.00	\$81.00	\$81.00	\$0.00	100	0	\$0.00	\$81.00	
	05-02-2016	D0431	Prediagnostic test	\$65.00	\$47.00	\$0.00	\$0.00	0	0	\$47.00	\$0.00	338
	05-02-2016	D0274	Bitewings-four images	\$74.00	\$57.00	\$57.00	\$0.00	100	0	\$0.00	\$57.00	

- Processing Policies is a detailed description of any code listed above in the Processing Policy column.
- The notes at the bottom of the EOB gives further information regarding the dispute process and how to acquire further information on benefits and remaining maximum dollar amounts.

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COORDINATION OF BENEFITS (COB)

SUBJECT: Coordination of Benefits (COB)

DESCRIPTION: Coordination of Benefits (COB) exists when an enrollee is also covered by another plan. Coordination of the benefits is the act of determining which of the plans will pay on the claim first.

POLICY: It is Northeast Delta Dental's policy to coordinate benefits in accordance with the guidelines set forth by NAIC and Northeast Delta Dental, in order to maximize the best use of the plan benefits on behalf of the enrollee.

PROCESS: When an Enrollee is covered under another health care program, the following rules shall be followed to establish the order of determining liability.

1. When only one plan has a Coordination of Benefits provision, the plan without such provision shall determine its benefits first.
2. The plan covering an Enrollee solely as an employee shall determine its benefits before the plan which covers the Enrollee solely as a Dependent.
3. The plan covering the Enrollee solely as a Dependent of the parent whose birthdate occurs earlier in a calendar year shall determine its benefits before the plan covering the Enrollee solely as a Dependent of the parent whose birthdate occurs later in a calendar year ("Birthday Rule"). A parent's year of birth is not relevant. If both parents have the same birthdate (month and day) the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time. If the other health care program does not use the Birthday Rule, then that plan's provisions will determine the order of liability.
4. If paragraphs 1 through 4 above do not establish an order of benefit determination, the benefits of the plan which has covered the Enrollee for the longer period of time shall be determined first.
5. Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows.
 - a. For a dependent child whose parents are married or are living together.
 1. The plan of the parent whose birthday is earlier in the calendar year is the primary plan.
 2. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 - b. For a dependent child whose parents are divorced, separated or do not live together, whether or not they have ever been married.
 1. If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If

Northeast Delta Dental QHP Compliance Plan

the parent with responsibility has no health care coverage for the child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

2. If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the provisions of paragraph 5. a. shall determine the order of benefits.
 3. If a court decree states that the parents have joint custody without specifying that one parent is responsible for the health care expenses or health care coverage of the child, the provisions paragraph 5. a. shall determine the order of benefits.
 4. If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (i) The plan covering the custodial parent;
 - (ii) The plan covering the custodial parent's spouse;
 - (iii) The plan covering the non-custodial parent; and then
 - (iv) The plan covering the non-custodial parent's spouse.
- c. For a child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined under subparagraph a. or b. of this paragraph as if those individuals were parents of the child.

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EXAMPLE OF REGULATORY STANDARDS

SUBJECT: Example of Regulatory Standards

PURPOSE: To comply with the regulatory standards as set forth in 45 CFR § 156.200.

POLICY: It is Northeast Delta Dental’s policy to comply with the following regulatory standards as set forth in 45 CFR § 156.200:

- The QHP issuer must comply with benefit design standards, including provision of Essential Health Benefits and following cost-sharing limits, with respect to each of its QHPs.
- The QHP issuer must pay applicable user fees to HHS.
- The QHP issuer must adhere to any requirements imposed by a state in connection with its Exchange.

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References: [§ 156.200\(b\)\(3\)](#); [§ 156.200\(b\)\(6\)](#); [§ 156.200 \(d\)](#)