

## Pediatric Dental and Vision Checklist – FORM REVIEW REQUIREMENTS

1

Medical Plan with pediatric dental benefits – Sections A (Vision) and B (Dental)

Medical Plan with pediatric dental benefits carved out – Section A (Vision) only

Form #  Form

Company Name:		NAIC #:	
SERFF Tracking Number:		SERFF TOI and Sub-TOI Codes:	
Market Type:	<input type="checkbox"/> Individual <input type="checkbox"/> Small Group <input type="checkbox"/> Non-employer Group	Plan Intended for Issuance:	<input type="checkbox"/> Inside the Exchange Only <input type="checkbox"/> Outside the Exchange Only <input type="checkbox"/> Both Inside and Outside the Exchange
Product Name:			
Each Plan Name included in this submission:			
<input type="checkbox"/> Medical Plan with pediatric dental benefits – complete Sections A (Vision) and B (Dental)			
<input type="checkbox"/> Medical Plan with pediatric dental benefits carved out – complete Section A (Vision) only			
Indicate method of providing pediatric dental benefits:			
<input type="checkbox"/> Bundled <input type="checkbox"/> Reasonable Assurance			

### **Instructions:**

1. This check list does not apply to Pediatric Stand Alone Dental Plans (see separate checklist). A Stand Alone Dental Plan must be submitted as a separate policy, certificate, or contract of insurance from the medical plans.
2. If the plan does not include pediatric dental benefits, please do not complete Section B (Dental).
3. Provide the page number with corresponding form name where requirement is located.
4. Any exceptions to compliance with the Checklist requirements must include an explanation.
5. This completed document must also be filed under the Supporting Documentation tab along with any applicable supplemental documentation

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### SECTION A - Pediatric Vision

REVIEW REQUIREMENT	AUTHORITY	INCLUDED YES – NO N/A	PAGE # AND DOCUMENT	COMMENTS
<b>FEDVIP High Option Vision Benefits</b>	45 CFR 146 Appendix	<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>One routine eye examination, including dilation if professional indicated, each year</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>One pair of prescription eyeglass lenses each year</b> <input type="checkbox"/> One frame each year <input type="checkbox"/> In lieu of eyeglasses, one pair of contact lenses each year		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices, such as high-power spectacles, magnifiers and telescopes</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		

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### SECTION B - Pediatric Dental

REVIEW REQUIREMENT	AUTHORITY	INCLUDED YES – NO N/A	PAGE # AND DOCUMENT	COMMENTS
<b>FEDVIP High Option Pediatric Dental Benefits</b>	45 CFR 146 Appendix, PHSA §2707	<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>General Services</b>				
<b>Class A (Basic) Services – preventive and diagnostic</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>Class B (Intermediate) Services – include minor restorative services</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>Class C (Major) Services – includes major restorative, endodontic, periodontal, prosthodontic services</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		
<b>Class D Services - orthodontic</b>		<input type="checkbox"/> YES <input type="checkbox"/> NO – explain		