

Last Updated: 05/10/2016

## Checklist Guide: Minnesota Dental Requirements

The following information has been compiled as a Checklist Guide for Commerce Department analysts to use in reviewing Dental product filings submitted to the Department for approval in Minnesota. The Checklist Guide is designed as an internal Commerce Department resource to outline certain state or federal laws that could apply to provisions typically found in Dental certificates or policy forms. It may be periodically updated to reflect statutory changes. Additional state or federal law requirements may exist to the extent they apply to provisions not typically found in policy forms or certificates. Compliance with these additional requirements, if applicable to the product filing, would still be required even though they are not listed in this Checklist Guide.

**NOTE:** While the Department is making this Checklist Guide publicly available, companies or health plans should refer to all relevant Minnesota Statutes and Rules and applicable federal law in developing the product filings that they submit to the Department for approval. To the extent the provisions in this Checklist Guide conflict with state or federal law, companies making filings should comply with the language of the state or federal law.

References to the Affordable Care Act (ACA) in this guidance document are intended to include the federal Patient Protection and Affordable Care Act, Public Law 111-148, as amended, including the federal Health Care and Education Reconciliation Act of 2010, Public Law 111-152, and any amendment to, or regulations or guidance issued under these acts.

## Helpful Information and definitions

**Stand-alone dental** policies offered separately from a medical policy will be reviewed according to this checklist.

**Embedded** - medical plans with embedded pediatric dental benefits are subject to review as a major medical policy. Please refer to the Major Medical checklist for guidance on state and federal laws that will be used in the review of form filings.

**Exchange-Certified dental plans** - must meet one of two required actuarial value levels (70% or 85%) for pediatric dental coverage. The 70% plan is referred to as the low option and the 85% the high option (CFR 45 § 156.150 (b))

**Limited scope pediatric dental plans** - means a dental plan meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as amended, that provides pediatric dental benefits meeting the requirements of the Affordable Care Act and is offered by a health carrier. A limited-scope pediatric dental plan includes a dental plan that is offered separately or in conjunction with an individual or small group health plan to individuals who have not attained the age of 19 years as of the beginning of the policy year or to a family. (*Minn. Stat. § 62K.03 Subd. 8*)

**Dental plan** - means a policy, contract, or certificate offered by a dental organization, any accident and sickness insurance company, nonprofit health service plan (62C) or HMO (62D) for the coverage of dental care services. Dental plan means individual or group coverage. (*Minn. Stat. §§ 62Q.76, Subd. 3, and 60A.06 Subd. 1 clause 5a*)

**Pediatric services** - are defined as services for individuals under the age of 19 [Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Final Rule, issued February 25, 2013 (45 C.F.R. Parts 147, 155 and 156), Part II].

*Special note: If you see the symbol “ $\diamond$ ”, this denotes a mandate for which a specific contractual reference is required.*

## Individual Market Requirements

### 62A.03 General Provisions of Policy

Subdivision 1. **Conditions.** No policy of individual accident and sickness insurance may be delivered or issued for delivery to a person in this state unless:

- (1) **Premium.** The entire money and other considerations therefor are expressed therein.
- (2) **Time effective.** The time at which the insurance takes effect and terminates is expressed therein.
- (3) **One person.** It purports to insure only one person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family deemed the policyholder, any two or more eligible members of that family, including:
  - (a) husband,

- (b) wife,
- (c) dependent children as described in sections 62A.302 and 62A.3021, or
- (d) any other person dependent upon the policyholder.

(4) **Appearance.** The style, arrangement, and overall appearance of the policy give no undue prominence to any portion of the text and every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in light-face type of a style in general use. The type size must be uniform and not less than ten point with a lowercase unspaced alphabet length not less than 120 point. The "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, the reference to renewal or cancellation by a separate statement, if any, and the captions and subcaptions.

(5) **Description of policy.** The policy, on the first page, indicates or refers to its provisions for renewal or cancellation either in the brief description, if any, or by a separate statement printed in type not smaller than the type used for captions or a separate provision bearing a caption which accurately describes the renewability or cancelability of the policy.

(6) **Exceptions in policy.** The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in section 62A.04, printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS." However, if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(7) **Form number.** Each form, including riders and endorsements, is identified by a form number in the lower left hand corner of the first page thereof.

(8) **No incorporation by reference.** It contains no provision purporting to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates, classification of risks, or short rate table filed with the commissioner.

## 72A.51 Right to Cancel

**Subd. 2. Return of policy or contract; notice.** Any individual person may cancel an individual policy of insurance against loss or damage by reason of the sickness of the assured or the assured's dependents, a nonprofit health service plan contract providing benefits for hospital, surgical and medical care, a health maintenance organization subscriber contract, or a policy of insurance authorized by section 60A.06, subdivision 1, clause (4), except Medicare-related coverage as defined in section 62A.3099, subdivision 17, and long-term care insurance as defined in section 62S.01, subdivision 18, by returning the policy or contract and by giving written notice of cancellation any time before midnight of the tenth day following the date of purchase. Notice of cancellation may be given personally or by mail. The policy or contract may be returned personally or by mail. If by mail, the notice or return of the policy or contract is effective upon being postmarked, properly addressed and

postage prepaid.

**Subd. 3. Refund of consideration.** With the exception of a variable annuity contract issued pursuant to sections 61A.13 to 61A.21, a person's cancellation of an insurance policy or contract under this section and section 72A.52 is without liability and the person is entitled to a refund of the entire consideration paid for the policy or contract within ten days after notice of cancellation and the returned policy or contract are received by the insurer or its agent. Cancellation under this section and section 72A.52 of a variable annuity contract issued pursuant to sections 61A.13 to 61A.21 shall entitle a person to an amount equal to the sum of (a) the difference between the premiums paid including any contract fees or other charges and the amounts allocated to any separate accounts under the contract and (b) the cash value of the contract, or, if the contract does not have a cash value, the reserve for the contract, on the date the returned contract is received by the insurer or its agent. Cancellation of an insurance policy or contract under this section or section 72A.52 makes the policy or contract void from its inception.

## 72A.52 Notice Requirements

**Subdivision 1. Contents.** In addition to all other legal requirements a policy or contract of insurance described in section 72A.51 shall show the name and address of the insurer and the seller of the policy or contract and shall include a notice, clearly and conspicuously in boldface type of a minimum size of ten points, which shall include the following elements:

- (1) a minimum of ten days to cancel the policy beginning on the date the policy is received by the owner;
- (2) if the policy is a replacement policy, a minimum of 30 days beginning on the date the policy is received by the owner. Pursuant to section 61A.57, this requirement may also be provided in a separate written notice that is delivered with the policy or contract;
- (3) a requirement for the return of the policy to the company or an agent of the company;
- (4) a statement that the policy is considered void from the beginning;
- (5) for policies or contracts other than a variable annuity or a variable life policy, a statement that the insurer will refund all premiums paid, including any fees or charges, if the policy is returned; and
- (6) a statement describing when the cancellation becomes effective.

The insurer must return all payments made for this policy within ten days after it receives notice of cancellation and the returned policy. For variable annuity contracts issued pursuant to sections 61A.13 to 61A.21, this notice shall be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of the amount calculated in accordance with the provisions of section 72A.51, subdivision 3. For variable life insurance policies, this notice must be suitably modified so as to notify the purchaser that the purchaser is entitled to a refund of: (i) the premiums paid; or (ii) the variable account value plus any amount deducted from the portion of the premium applied to the account.

## 72C.10 Filing Requirements; Duties of Commissioner

**Subdivision 1. Readability compliance; filing and approval.** No insurer shall make, issue, amend, or renew any policy or contract after the dates specified in section 72C.11 for the applicable type of policy unless the contract is in compliance with the requirements of sections 72C.06 to 72C.09 and unless the contract is filed with the commissioner for approval. The contract shall be deemed approved 60 days after filing unless disapproved by the commissioner within the 60-day period. When an insurer, service plan corporation, or the Minnesota Comprehensive Health Association fails to respond to an objection or inquiry within 60 days, the filing is automatically disapproved. A resubmission is required if action by the Department of Commerce is subsequently requested. An additional filing fee is required for the resubmission. The commissioner shall not unreasonably withhold approval. Any disapproval shall be delivered to the insurer in writing, stating the grounds therefor. Any policy filed with the commissioner shall be accompanied by a Flesch scale readability analysis and test score and by the insurer's certification that the policy or contract is in its judgment readable based on the factors specified in sections 72C.06 to 72C.08.

**Subd. 2. Contract or policy disapproval.** The commissioner shall disapprove any contract or policy covered by subdivision 1 if the commissioner finds that:

- (a) it is not accompanied by a certified Flesch scale analysis readability score of more than 40;
- (b) it is not accompanied by the insurer's certification that the policy or contract is in its judgment readable under the standards of sections 72C.01 to 72C.13;
- (c) it does not comply with the readability standards established by section 72C.06;
- (d) it does not comply with the legibility standards established by section 72C.07; or
- (e) it does not comply with the format requirements established by section 72C.08.

## Group Market Requirements

### 60A.02 Definitions

**Subd. 1a. Association or associations.** (a) "Association" or "associations" means an organized body of people who have some interest in common and that has at the onset a minimum of 100 persons; is organized and maintained in good faith for purposes other than that of obtaining insurance; and has a constitution and bylaws which provide that: (1) the association or associations hold regular meetings not less frequently than annually to further purposes of the members; (2) except for credit unions, the association or associations collect dues or solicit contributions from members; (3) the members have voting privileges and representation on the governing board and committees, which provide the members with control of the association including the purchase and administration of insurance products offered to members; and (4) the members are not, within the first 30 days of membership, directly solicited, offered, or sold an insurance policy if the policy is available as an

association benefit.

#### 60A.082 Group Insurance; Benefits Continued if Insurer Changed

A person covered under group life, group accidental death and dismemberment, group disability income or group medical expense insurance, shall not be denied benefits to which the person is otherwise entitled solely because of a change in the insurance company writing the coverage or in the group contract applicable to the person. In the case of one or more carriers replacing or remaining in place after one or more plans have been discontinued, each carrier shall accept any person who was covered under the discontinued plan or plans without denial of benefits to which other persons in the group covered by that carrier are entitled. "Insurance company" shall include a service plan corporation under chapter 62C or 62D.

For purposes of satisfying any preexisting condition limitation, the insurance company shall credit the period of time the person was covered by the prior plan, if the person has maintained continuous coverage.

The commissioner shall promulgate rules to carry out this section. Nothing in this section shall preclude an employer, union or association from reducing the level of benefits under any group insurance policy or plan.

#### 60A.084 Notification on Group Policies

An employer providing life or health benefits may not change benefits, limit coverage, or otherwise restrict participation until the certificate holder or enrollee has been notified of any changes, limitations, or restrictions. Notice in a format which meets the requirements of the United States Department of Labor is satisfactory for compliance with this section.

#### 60A.085 Cancellation of Group Coverage; Notification to Covered Persons

- (a) No cancellation of any group life, group accidental death and dismemberment,
- (b) group disability income, or group medical expense policy, plan, or contract regulated under chapter 62A or 62C is effective unless the insurer has made a good faith effort to notify all covered persons of the cancellation at least 30 days before the effective cancellation date. For purposes of this section, an insurer has made a good faith effort to notify all covered persons if the insurer has notified all the persons included on the list required by paragraph (b) at the home address given and only if the list has been updated within the last 12 months.
- (c) At the time of the application for coverage subject to paragraph (a), the insurer shall obtain an accurate list of the names and home addresses of all persons to be covered.

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- (d) Paragraph (a) does not apply if the group policy, plan, or contract is replaced, or if the insurer has reasonable evidence to indicate that it will be replaced, by a substantially similar policy, plan, or contract.
- (e) In no event shall this section extend coverage under a group policy, plan, or contract more than 120 days beyond the date coverage would otherwise cancel based on the terms of the group policy, plan, or contract.
- (f) If coverage under the group policy, plan, or contract is extended by this section, then the time period during which affected members may exercise any conversion privilege provided for in the group policy, plan, or contract is extended for the same length of time, plus 30 days.

### 60A.086 Retroactive Termination of Coverage Under Group Policies Prohibited

**Subd. 2. Requirement.** No plan of coverage described in subdivision 1 shall permit the issuer to retroactively cancel, retroactively rescind, or otherwise retroactively terminate the coverage of an employee, dependent, or other covered person under the group coverage, without the written consent of that employee, dependent, or other covered person. For purposes of this subdivision, "covered person" includes a person on continuation coverage or eligible for continuation coverage.

**Subd. 3. Nonapplicability. (a)** This section does not apply where the group policy or contract is lawfully terminated retroactively and not replaced with substantially similar coverage.

- (b) This section does not apply where the employee, dependent, or other covered person committed fraud or misrepresentation with respect to eligibility under the terms of the group policy or contract or with respect to any other material fact, but retroactive termination without written consent must not be based upon the failure of the employee, dependent, or other covered person to meet the group sponsor's eligibility requirements, if the group sponsor requested the issuer of the coverage to include the person as a covered person.
- (c) This section does not apply where the issuer of coverage described in subdivision 1 retroactively terminates coverage of an employee, dependent, or other covered person solely because the group sponsor did not notify the issuer of the coverage in advance of the employee's voluntary or involuntary termination from employment, provided that the retroactive termination of coverage is effective no earlier than the end of the day of termination from employment. This paragraph does not affect continuation rights under federal or state law and does not limit the effect of section 62Q.16.

### 62A.10 Group Insurance

**Subdivision 1. Requirements.** Group accident and health insurance may be issued to cover groups of not less than two employees nor less than ten members, and which may include the employee's or member's dependents, consisting of husband, wife, children, and actual

dependents residing in the household. The master policy may be issued to any governmental corporation, unit, agency, or department thereof, or to any corporation, copartnership, individual, employer, to a purchasing pool as described in section 62Q.17, to any association as defined by section 60A.02, subdivision 1a, or to a multiple employer trust, or to the trustee of a fund, established or adopted by two or more employers or maintained for the benefit of members of an association, where officers, members, employees, or classes or divisions thereof, may be insured for their individual benefit.

**Subd. 4. Policy forms.** No policy or certificate of group accident and health insurance may be issued or delivered in this state unless the same has been approved by the commissioner in accordance with section 62A.02, subdivisions 1 to 6. These forms shall contain the standard provisions relating and applicable to health and accident insurance and shall conform with the other requirements of law relating to the contents and terms of policies of accident and sickness insurance insofar as they may be applicable to group accident and health insurance, and also the following provisions:

- (1) **Entire contract.** A provision that the policy and the application of the creditor, employer, trustee, or executive officer or trustee of any association, and the individual applications, if any, of the debtors, employees, or members, insured, shall constitute the entire contract between the parties, and that all statements made by the creditor, employer, trustee, or any executive officer or trustee on behalf of the group to be insured, shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in the written application;
- (2) **Master policy certificates.** A provision that the insurer will issue a master policy to the creditor, employer, trustee, or to the executive officer or trustee of the association; and the insurer shall also issue to the creditor, the employer, trustee, or to the executive officer or trustee of the association, for delivery to the debtor, employee, or member, who is insured under the policy, an individual certificate setting forth a statement as to the insurance protection to which the debtor, employee, or member is entitled and to whom payable, together with a statement as to when and where the master policy, or a copy thereof, may be seen for inspection by the individual insured. The individual certificate may contain the names of, and insure the dependents of, the employee, or member, as provided for herein;
- (3) **New insureds.** A provision that to the group or class thereof originally insured may be added, from time to time, all new employees of the employer, members of the association, or debtors of the creditor eligible to and applying for insurance in that group or class and covered or to be covered by the master policy.

## 62A.14 Disabled Children

**Subd. 2. Group policies.** A group hospital or medical expense insurance policy delivered or issued for delivery in this state more than 120 days after May 16, 1969, or a group health maintenance contract delivered or issued for delivery in this state after August 1, 1984, which provides that coverage of a dependent child of an employee or other member of the

covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability and (b) chiefly dependent upon the employee or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the insurer or organization by the employee or member within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer or organization but not more frequently than annually after the two-year period following the child's attainment of the limiting age. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this provision.

#### 62A.141 Coverage for Disabled Dependents

No group policy or group plan of health and accident insurance regulated under this chapter, chapter 62C, or 62D, which provides for dependent coverage may be issued or renewed in this state after August 1, 1983, unless it covers the disabled dependents of the insured, subscriber, or enrollee of the policy or plan. For purposes of this section, a disabled dependent is a person that is and continues to be both: (1) incapable of self-sustaining employment by reason of developmental disability, mental illness or disorder, or physical disability; and (2) chiefly dependent upon the policyholder for support and maintenance. Consequently, the policy or plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning disabled dependents.

If ordered by the commissioner of commerce, the insurer of a Minnesota-domiciled nonprofit association which is composed solely of agricultural members may restrict coverage under this section to apply only to Minnesota residents.

#### 62A.148 Group Insurance; Provision of Benefits for Disabled Employees

No employer or insurer of that employer shall terminate, suspend or otherwise restrict the participation in or the receipt of benefits otherwise payable under any program or policy of group insurance to any covered employee who becomes totally disabled while employed by the employer solely on account of absence caused by such total disability. This includes coverage of dependents of the employee. If the employee is required to pay all or any part of the premium for the extension of coverage, payment shall be made to the employer, by the employee.

#### 62A.17 Termination of or Layoff from Employment; Continuation and Conversion Rights

**Subdivision 1. Continuation of coverage.** Every group insurance policy, group subscriber contract, and health care plan included within the provisions of section 62A.16, except policies, contracts, or health care plans covering employees of an agency of the federal government, shall contain a provision which permits every covered employee who is

voluntarily or involuntarily terminated or laid off from employment, if the policy, contract, or health care plan remains in force for active employees of the employer, to elect to continue the coverage for the employee and dependents.

An employee shall be considered to be laid off from employment if there is a reduction in hours to the point where the employee is no longer eligible under the policy, contract, or health care plan. Termination shall not include discharge for gross misconduct.

Upon request by the terminated or laid off employee, a health carrier must provide the instructions necessary to enable the employee to elect continuation of coverage.

## Individual and Group Market Requirements

### 60A.08 Contracts of Insurance

**Subd. 5. Signatures required.** All insurance policies shall be signed by the secretary or an assistant secretary, and by the president or vice-president, or in their absence, by two directors of the insurer. The signatures may be facsimile signatures. *(Also see Minn. Rule 2605.0400 PROVISIONS APPLICABLE TO ALL POLICY FORM AND RATE FILINGS.)*

### 62A.02 Policy Forms (Also refer to Bulletin 2002-5)

**Subd. 3. Standards for disapproval.** (a) The commissioner shall, within 60 days after the filing of any form or rate, disapprove the form or rate:

- (1) if the benefits provided are not reasonable in relation to the premium charged;
- (2) if it contains a provision or provisions which are unjust, unfair, inequitable, misleading, deceptive or encourage misrepresentation of the health plan form, or otherwise does not comply with this chapter, chapter 62L, or chapter 72A;
- (3) if the proposed premium rate is excessive or not adequate; or
- (4) the actuarial reasons and data submitted do not justify the rate.

### 62A.011 Definitions

**Subd. 2. Health carrier.** "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a fraternal benefit society operating under chapter 64B; or a joint self-insurance employee health plan operating under chapter 62H.

**Subd. 3. Health plan.** "Health plan" means a policy or certificate of accident and sickness insurance as defined in section 62A.01 offered by an insurance company licensed under chapter 60A; a subscriber contract or certificate offered by a nonprofit health service plan corporation operating under chapter 62C; a health maintenance contract or certificate offered by a health maintenance organization operating under chapter 62D; a health benefit certificate offered by a fraternal benefit society operating under chapter 64B; or health coverage offered by a joint self-insurance employee health plan operating under chapter 62H. Health plan means individual and group coverage, unless otherwise specified. Health plan does not include coverage that is:

- (6) designed solely to provide hearing, dental, or vision care;

#### 62A.04 Standard Provisions

**Subd. 2. Required provisions.** Except as provided in subdivision 4 each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subdivision in the words in which the same appear in this section. The insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

**(1) A provision as follows: Entire Contract; Changes:**

This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

**(2) A provision as follows: Time Limit on Certain Defenses:**

**(a)** After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two year period. The foregoing policy provision shall not be so construed as to affect any legal requirement for avoidance of a policy or denial of a claim during such initial two year period, nor to limit the application of clauses (1), (2), (3), (4) and (5), in the event of misstatement with respect to age or occupation or other insurance. A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age 50 or, (2) in the case of a policy issued after age 44, for at least five years from its date of issue, may contain in lieu of the foregoing the following provisions (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE": 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

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statements contained in the application.

- (b) No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

**(3)(a)** Except as required for qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a provision as follows:

**Grace Period: A grace period of .....** (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

A policy which contains a cancellation provision may add, at the end of the above provision, subject to the right of the insurer to cancel in accordance with the cancellation provision hereof.

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision,

Unless not less than five days prior to the premium due date the insurer has delivered to the insured or has mailed to the insured's last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.

(b) For qualified health plans sold through MNsure to individuals receiving advance payments of the premium tax credit, a grace period provision must be included that complies with the Affordable Care Act and is no less restrictive than the grace period required by the Affordable Care Act. (H. R. 3590—115, An issuer of a qualified health plan receiving an advance payment with respect to an individual enrolled in the plan shall (II) allow a 3-month grace period for nonpayment of premiums before discontinuing coverage.)

**(4) A provision as follows: Reinstatement:** If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. If the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application.

**(5) A provision as follows: Notice of Claim:**

Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably

possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

**(6) A provision as follows: Claim Forms:**

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

**(7) A provision as follows: Proof of Loss:**

Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the insurer is liable and in case of claim for any other loss within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required.

**(8) A provision as follows: Time of Payment of Claims:**

Indemnities payable under this policy for any loss other than loss for which this policy provides periodic payment will be paid immediately upon receipt of due written proof of such loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides periodic payment will be paid ..... (insert period for payment which must not be less frequently than monthly) and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof.

**(9) A provision as follows: Payment of Claims**

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured.

**(10) A provision as follows: Physical Examinations and Autopsy:**

The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

**(11) A provision as follows: Legal Actions:**

No action at law or in equity shall be 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

requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**(12) A provision as follows: Change of Beneficiary:**

Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy. The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.

**Subd. 3. Optional provisions.** Except as provided in subdivision 4, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. The insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subdivision or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

- (1) Change of Occupation
- (2) Misstatement of Age
- (3) Other Insurance in this Insurer
- (4) Insurance with Other Insurers
- (5) Insurance with Other Insurers
- (6) Relation of Earnings to Insurance
- (7) Unpaid Premium
- (8) Cancellation
- (9) Conformity with State Statutes
- (10) Illegal Occupation
- (11) Narcotics

**62A.042 Family Coverage; Coverage of Newborn Infants**

**Subdivision 1. Individual family policies.**

(a) No policy of individual accident and sickness insurance which provides for insurance for more than one person under section 62A.03, subdivision 1, clause (3), and no individual health maintenance contract which provides for coverage for more than one person under chapter 62D, shall be renewed to insure or cover any person in this state or be delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered members of the family any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an

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additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

**(b)** The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

**Subd. 2. Group policies. (a)** No group accident and sickness insurance policy and no group health maintenance contract which provide for coverage of family members or other dependents of an employee or other member of the covered group shall be renewed to cover members of a group located in this state or delivered or issued for delivery to any person in this state unless the policy or contract includes as insured or covered family members or dependents any newborn infants immediately from the moment of birth and thereafter which insurance or contract shall provide coverage for illness, injury, congenital malformation, or premature birth. For purposes of this paragraph, "newborn infants" includes grandchildren who are financially dependent upon a covered grandparent and who reside with that covered grandparent continuously from birth. No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier shall be entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may reduce the health benefits owed to the insured, certificate holder, member, or subscriber by the amount of past due premiums applicable to the additional dependent.

**(b)**The coverage under paragraph (a) includes benefits for inpatient or outpatient expenses arising from medical and dental treatment up to the limiting age for coverage of the dependent, including orthodontic and oral surgery treatment, involved in the management of birth defects known as cleft lip and cleft palate. Benefits for individuals age 19 up to the limiting age for coverage of the dependent are limited to inpatient or outpatient expenses arising from medical and dental treatment that was scheduled or initiated prior to the dependent turning age 19. If orthodontic services are eligible for coverage under a dental insurance plan and another policy or contract, the dental plan shall be primary and the other policy or contract shall be secondary in regard to the coverage required under paragraph (a). Payment for dental or orthodontic treatment not related to the management of the congenital condition of cleft lip and cleft palate shall not be covered under this provision.

### 62A.043 Dental and Podiatric Coverage

**Subdivision 1. Policies and contracts covered.** The provisions of this section shall apply to all individual or group policies or subscriber contracts providing payment for care in this state, which policies or contracts are issued or renewed after August 1, 1976 by an accident and health insurance company regulated under this chapter, or a nonprofit health service plan corporation regulated under chapter 62C.

**Subd. 2. Services covered.** Any policy or contract referred to in subdivision 1 which provides coverage for services which can be lawfully performed within the scope of the license of a duly licensed dentist or podiatrist, shall provide benefits for such services whether performed by a duly licensed physician, dentist or podiatrist.

**Subd. 3. Disorders covered.** Except for policies which only provide coverage for specified diseases, no policy or certificate of health, medical, hospitalization, or accident and sickness insurance regulated under this chapter, or subscriber contract provided by a nonprofit health service plan corporation regulated under chapter 62C, or health maintenance organization regulated under chapter 62D, shall be issued, renewed, continued, delivered, issued for delivery, or executed in this state after August 1, 1987, unless the policy, plan, or contract specifically provides coverage for surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage shall be the same as that for treatment to any other joint in the body, and shall apply if the treatment is administered or prescribed by a physician or dentist.

### 62A.048 Dependent Coverage

- (a) A health plan that covers a Minnesota resident must, if it provides dependent coverage, allow dependent children who do not reside with the participant to be covered on the same basis as if they reside with the participant. Every health plan must provide coverage in accordance with section 518A.41 to dependents covered by a qualified court or administrative order meeting the requirements of section 518A.41, and enrollment of a child cannot be denied on the basis that the child was born out of wedlock, the child is not claimed as a dependent on a parent's federal income tax return, or the child does not reside with the parent or in the health carrier's service area.
- (b) For the purpose of this section, health plan includes coverage offered by community integrated service networks, coverage designed solely to provide dental or vision care, and any plan governed under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.

### 62A.136 Hearing, Dental and Vision Plan Coverage

The following provisions do not apply to health plans as defined in section 62A.011, subdivision 3, clause (6), providing hearing, dental, or vision coverage only: sections

62A.041; 62A.0411; 62A.047; 62A.149; 62A.151; 62A.152; 62A.154; 62A.155; 62A.17, subdivision 6; 62A.21, subdivision 2b; 62A.26; 62A.28; 62A.285; 62A.30; 62A.304; and 62A.3093.

#### **62A.146 Continuation of Benefits to Survivors (See also Subd. 2 of 62A.21)**

No policy, contract, or plan of accident and health protection issued by an insurer, nonprofit health service plan corporation, or health maintenance organization, providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis which in addition to coverage of the insured, subscriber, or enrollee, also provides coverage to dependents, shall, except upon the written consent of the survivor or survivors of the deceased insured, subscriber, or enrollee, terminate, suspend, or otherwise restrict the participation in or the receipt of benefits otherwise payable under the policy, contract, or plan to the survivor or survivors until the earlier of the following dates:

- (a) the date the surviving spouse becomes covered under another group health plan; or
- (b) the date coverage would have terminated under the policy, contract, or plan had the insured, subscriber, or enrollee lived.

The survivor or survivors, in order to have the coverage and benefits extended, may be required to pay the entire cost of the protection on a monthly basis. The policy, contract, or plan must require the group policyholder or contract holder to, upon request, provide the insured, subscriber, or enrollee with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium or fee contributions charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children who are not the survivors of a deceased insured, without regard to whether such cost is paid by the employer or employee. Failure of the survivor to make premium or fee payments within 90 days after notice of the requirement to pay the premiums or fees shall be a basis for the termination of the coverage without written consent. In event of termination by reason of the survivor's failure to make required premium or fee contributions, written notice of cancellation must be mailed to the survivor's last known address at least 30 days before the cancellation. If the coverage is provided under a group policy, contract, or plan, any required premium or fee contributions for the coverage shall be paid by the survivor to the group policyholder or contract holder for remittance to the insurer, nonprofit health service plan corporation, or health maintenance organization.

#### **62A.19 Prohibition Against Nondiagnostic X-Rays**

No individual or group policy of dental insurance offered for sale to a Minnesota resident by an insurer regulated under this chapter, individual or group service plan or subscriber contract regulated under chapter 62C, health maintenance contract regulated under

chapter 62D, or fraternal contract benefit regulated under chapter 64B, shall subject any policyholder, subscriber, or enrollee to undue exposure to radiation by requiring a health care provider to take or obtain x-rays that are not directly related to patient care.

Any health care provider receiving such a request may refuse to provide x-rays not necessary to the diagnosis and treatment of the patient. An insurer, nonprofit health service plan corporation, health maintenance organization, fraternal benefit society, or dental plan may not deny or withhold benefits based solely upon the refusal to provide x-rays. Nothing in this section prohibits requests for x-rays or other diagnostic aids routinely taken in conjunction with the diagnosis and treatment of injury or disease, or routinely required by the insurer for preapproval or predetermination of treatment. An insurer may not retroactively request new x-rays not taken in conjunction with the diagnosis or treatment of injury or disease.

## 62A.20 Continuation Coverage of Current Spouse and Children

**Subdivision 1. Requirement.** Every policy of accident and health insurance providing coverage of hospital or medical expense on either an expense- incurred basis or other than an expense-incurred basis, which in addition to covering the insured also provides coverage to the spouse and dependent children of the insured shall contain:

- (1) a provision which allows the spouse and dependent children to elect to continue coverage when the insured becomes enrolled for benefits under Title XVIII of the Social Security Act (Medicare); and
- (2) a provision which allows the dependent children to continue coverage when they cease to be dependent children under the generally applicable requirement of the plan.

Upon request by the insured or the insured's spouse or dependent child, a health carrier must provide the instructions necessary to enable the spouse or child to elect continuation of coverage.

**Subd. 2. Continuation privilege.** The coverage described in subdivision 1 may be continued until the earlier of the following dates:

- (a) the date coverage would otherwise terminate under the policy;
- (b) 36 months after continuation by the spouse or dependent was elected; or
- (c) the spouse or dependent children become covered under another group health plan.

If coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated

spouse and dependent children to whom subdivision 1 is not applicable, without regard to whether such cost is paid by the employer or employee.

#### 62A.21 Continuation and Conversion Privileges for Insured Former Spouses and Children

**Subdivision 1. Break in marital relationship, termination of coverage prohibited.** No policy of accident and health insurance providing coverage of hospital or medical expense on either an expense incurred basis or other than an expense incurred basis, which in addition to covering the insured also provides coverage to the spouse of the insured shall contain a provision for termination of coverage for a spouse covered under the policy solely as a result of a break in the marital relationship.

**Subd. 2a. Continuation privilege.** Every policy described in subdivision 1 shall contain a provision which permits continuation of coverage under the policy for the insured's former spouse and dependent children upon entry of a valid decree of dissolution of marriage. The coverage shall be continued until the earlier of the following dates:

- (a) the date the insured's former spouse becomes covered under any other group health plan; or
- (b) the date coverage would otherwise terminate under the policy.

If the coverage is provided under a group policy, any required premium contributions for the coverage shall be paid by the insured on a monthly basis to the group policyholder for remittance to the insurer. The policy must require the group policyholder to, upon request, provide the insured with written verification from the insurer of the cost of this coverage promptly at the time of eligibility for this coverage and at any time during the continuation period. In no event shall the amount of premium charged exceed 102 percent of the cost to the plan for such period of coverage for other similarly situated spouses and dependent children with respect to whom the marital relationship has not dissolved, without regard to whether such cost is paid by the employer or employee.

Upon request by the insured's former spouse or dependent child, a health carrier must provide the instructions necessary to enable the child or former spouse to elect continuation of coverage.

*(The requirement for a continuation privilege applies to Dental coverage as it is not exempted by Minn. Stat. § 62A.136.)*

#### 62A.22 Refusal to Provide Coverage Because of Option Under Workers' Compensation

No insurer offering an individual or group policy of accident or health coverage in this state shall refuse to provide or renew accident or health coverage because the insured has an option to elect workers' compensation coverage pursuant to section 176.041, subdivision 1a.

#### 62A.25 Reconstructive Surgery

**Subd. 2. Required coverage.** (a) Every policy, plan, certificate or contract to which this section applies shall provide benefits for reconstructive surgery when such service is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.

#### ◇ 62A.27 Coverage of Adopted Children

- (a) A health plan that provides coverage to a Minnesota resident must cover adopted children of the insured, subscriber, participant, or enrollee on the same basis as other dependents. Consequently, the plan shall not contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning children placed for adoption with the participant.
- (b) The coverage required by this section is effective from the date of placement for adoption. For purposes of this section, placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with a person terminates upon the termination of the legal obligation for total or partial support.
- (c) For the purpose of this section, health plan includes:
  - (1) coverage offered by community integrated service networks;
  - (2) coverage that is designed solely to provide dental or vision care; and
  - (3) any plan under the federal Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, sections 1001 to 1461.
- (d) No policy or contract covered by this section may require notification to a health carrier as a condition for this dependent coverage. However, if the policy or contract mandates an additional premium for each dependent, the health carrier is entitled to all premiums that would have been collected had the health carrier been aware of the additional dependent. The health carrier may withhold payment of any health benefits for the new dependent until it has been compensated with the applicable premium which would have been owed if the health carrier had been informed of the additional dependent immediately.

#### ◇ 62A.3021 Coverage of Dependents by Plans Other than Health Plans

**Subd. 2. Dependent.** "Dependent" means an eligible employee's spouse, unmarried child who is under the age of 25, dependent child of any age who is disabled and who meets the eligibility criteria in section 62A.14, subdivision 2, or any other person whom state or federal law requires to be treated as a dependent for purposes of health plans. For the purpose of this definition, a child includes a child for whom the employee or the employee's spouse has been appointed legal guardian and an adoptive child as provided in section 62A.27. A

child also includes grandchildren as provided in section 62A.042 with continued eligibility of grandchildren as provided in section 62A.302, subdivision 4.

### 62A.3091 Nondiscriminate Coverage of Tests

#### Subdivision 1. Scope of requirement.

This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

- (1) a health plan, as defined in section 62A.011;
- (2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and
- (3) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

#### Subd. 2. Requirement.

Coverage described in subdivision 1 that covers laboratory tests, diagnostic tests, and x-rays must provide the same coverage, without requiring additional signatures, for all such tests ordered by an advanced practice nurse operating pursuant to chapter 148. Nothing in this section shall be construed to interfere with any written agreement between a physician and an advanced practice nurse.

### 62A.3092 Equal Treatment of Surgical First Assisting Services

#### Subdivision 1. Scope of requirement.

This section applies to any of the following if issued or renewed to a Minnesota resident or to cover a Minnesota resident:

- (1) a health plan, as defined in section 62A.011;
- (2) coverage described in section 62A.011, subdivision 3, clauses (2), (3), or (6) to (12); and
- (3) a policy, contract, or certificate issued by a community integrated service network licensed under chapter 62N.

#### Subd. 2. Requirement.

Coverage described in subdivision 1 that provides for payment for surgical first assisting benefits or services shall be construed as providing for payment for a registered nurse who performs first assistant functions and services that are within the scope of practice of a registered nurse.

### 62A.095 Subrogation Clauses Regulated

**Subdivision 1. Applicability.**

- (a) A health plan may not be offered, sold, or issued to a resident of this state, or to cover a resident of this state, unless the health plan complies with subdivision 2.
- (b) Health plans providing benefits under health care programs administered by the commissioner of human services are not subject to the limits described in subdivision 2 but are subject to the right of subrogation provisions under section 256B.37 and the lien provisions under section 256.015; 256B.042; 256D.03, subdivision 8; or 256L.03, subdivision 6.

For purposes of this section, "health plan" includes coverage that is excluded under section 62A.011, subdivision 3, clauses (4), (6), (7), (8), (9), and (10).

**Subd. 2. Subrogation clause; limits.**

No health plan described in subdivision 1 shall contain a subrogation, reimbursement, or similar clause that provides subrogation, reimbursement, or similar rights to the health carrier issuing the health plan, unless:

- (1) the clause provides that it applies only after the covered person has received a full recovery from another source; and
- (2) the clause provides that the health carrier's subrogation right is subject to subtraction for actual monies paid to account for the pro rata share of the covered person's costs, disbursements, and reasonable attorney fees, and other expenses incurred in obtaining the recovery from another source unless the health carrier is separately represented by an attorney.

If the health carrier is separately represented by an attorney, the health carrier and the covered person, by their attorneys, may enter into an agreement regarding allocation of the covered person's costs, disbursements, and reasonable attorney fees and other expenses. If the health carrier and covered person cannot reach agreement on allocation, the health carrier and covered person shall submit the matter to binding arbitration.

Nothing in this section shall limit a health carrier's right to recovery from another source which may otherwise exist at law.

For the purposes of this section, full recovery does not include payments made by a health plan to or for the benefit of a covered person.

**Subd. 3. Retroactive amendments regulated.**

No addition of, or amendment of, a subrogation, reimbursement, or similar clause in a health plan shall be applied to the disadvantage of a covered person with respect to benefits provided by the health carrier in connection with an injury, illness, condition, or other covered situation that originated prior to the addition of or amendment to the clause.

**61B.28 Miscellaneous Provisions**

**Subd. 7.** Notice concerning limitations and exclusions.

- (a) No person, including an insurer, agent, or affiliate of an insurer or agent, shall offer for sale in this state a covered life insurance, annuity, or health insurance policy or contract without delivering, either at the time of application for that policy or contract or at the time of delivery of the policy or contract, a notice in the form specified in subdivision 8, or in a form approved by the commissioner under paragraph (b), relating to coverage provided by the Minnesota Life and Health Insurance Guaranty Association. The notice may be part of the application. A copy of the notice must be given to the applicant or the policyholder. The person offering the policy or contract shall document the fact that the notice was given at the time of application or the fact that the notice was delivered at the time the policy or contract was delivered. This does not require that the receipt of the notice be acknowledged by the applicant. *(The language for the form can be found in 61B.28 MISCELLANEOUS PROVISIONS. Subd. 8.)*
- (b) The association may prepare, and file with the commissioner for approval, a form of notice as an alternative to the form of notice specified in subdivision 8 describing the general purposes and limitations of this chapter. The form of notice shall:
- (1) state the name, address, and telephone number of the Minnesota Life and Health Insurance Guaranty Association;
  - (2) prominently warn the policy or contract holder that the Minnesota Life and Health Insurance Guaranty Association may not cover the policy or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in the state;
  - (3) state that the insurer and its agents are prohibited by law from using the existence of the Minnesota Life and Health Insurance Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance;
  - (4) emphasize that the policy or contract holder should not rely on coverage under the Minnesota Life and Health Insurance Guaranty Association when selecting an insurer;
  - (5) provide other information as directed by the commissioner. The commissioner may approve any form of notice proposed by the association and, as to the approved form of notice, the association may notify all member insurers by mail that the form of notice is available as an alternative to the notice specified in subdivision 8.
- (c) A policy or contract not covered by the Minnesota Life and Health Insurance

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Guaranty Association or the Minnesota Insurance Guaranty Association must contain the following notice in ten-point type, stamped in red ink or contrasting type on the policy or contract and the application:

"THIS POLICY OR CONTRACT IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM."

### 62K.03 Definitions

**Subd. 3. Dental plan.** "Dental plan" means a dental plan as defined in section 62Q.76, subdivision 3.

**Subd. 5. Health carrier.** "Health carrier" means a health carrier as defined in section 62A.011, subdivision 2.

**Subd. 8. Limited-scope pediatric dental plan.** "Limited-scope pediatric dental plan" means a dental plan meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986, as amended, that provides only pediatric dental benefits meeting the requirements of the Affordable Care Act and is offered by a health carrier. A limited-scope pediatric dental plan includes a dental plan that is offered separately or in conjunction with an individual or small group health plan to individuals who have not attained the age of 19 years as of the beginning of the policy year or to a family.

### 62K.07 Information Disclosures

*(Note: This section, as added by Laws 2013, chapter 84, article 2, section 8, is effective for health plans offered, sold, issued, or renewed on or after January 1, 2015. Laws 2013, chapter 84, article 2, section 17)*

- (a) A health carrier offering individual or small group health plans must submit the following information in a format determined by the commissioner of commerce:
- (1) claims payment policies and practices;
  - (2) periodic financial disclosures;
  - (3) data on enrollment;
  - (4) data on disenrollment;
  - (5) data on the number of claims that are denied;
  - (6) data on rating practices;
  - (7) information on cost-sharing and payments with respect to out-of-network coverage; and
  - (8) other information required by the secretary of the United States Department of Health and Human Services under the Affordable Care Act.
- (b) A health carrier offering an individual or small group health plan must comply with all

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information disclosure requirements of all applicable state and federal law, including the Affordable Care Act.

- (c) Except for qualified health plans sold on MNsure, information reported under paragraph (a), clauses (3) and (4), is nonpublic data as defined under section 13.02, subdivision 9. Information reported under paragraph (a), clauses (1) through (8), must be reported by MNsure for qualified health plans sold through MNsure.
- (d) The commissioner of Commerce shall enforce this section.

### 62K.08 Marketing Standards

#### Subdivision. 1. Marketing.

- (a) A health carrier offering individual or small group health plans must comply with all applicable provisions of the Affordable Care Act, including, but not limited to, the following:
  - (1) compliance with all state laws pertaining to the marketing of individual or small group health plans; and
  - (2) establishing marketing practices and benefit designs that will not have the effect of discouraging the enrollment of individuals with significant health needs in the health plan.
- (b) No marketing materials may lead consumers to believe that all health care needs will be covered.

### 62K.13 Service Area Requirements

*(NOTE: This section, as added by Laws 2013, chapter 84, article 2, section 14, is effective for health plans offered, sold, issued, or renewed on or after January 1, 2015. Laws 2013, chapter 84, article 2, section 17.)*

- (a) Any health carrier that offers an individual or small group health plan, must offer the health plan in a service area that is at least the entire geographic area of a county unless serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of enrollees. The service area for any individual or small group health plan must be established without regard to racial, ethnic, language, concentrated poverty, or health status-related factors, or other factors that exclude specific high-utilizing, high-cost, or medically underserved populations.
- (b) If a health carrier that offers an individual or small group health plan requests to serve less than the entire county, the request must be made to the commissioner of health on a form and manner determined by the commissioner and must provide specific data demonstrating that the service area is not discriminatory, is necessary, and is in the best interest of enrollees.

- (c) The commissioner of health shall enforce this section.

#### 62K.14 Limited-Scope Pediatric Dental Plans

*NOTE: Paragraphs (a) and (b) are effective for health plans and dental plans that are offered, sold, issued, or renewed on or after January 1, 2015. Laws 2013, chapter 84, article 2, section 15, the effective date.)*

- (a) Limited-scope pediatric dental plans must be offered to the extent permitted under the Affordable Care Act: **(1)** on a guaranteed issue and guaranteed renewable basis; **(2)** with premiums rated on allowable rating factors used for health plans; and **(3)** without any exclusions or limitations based on preexisting conditions.
- (b) Notwithstanding paragraph (a), a health carrier may discontinue a limited scope pediatric dental plan at the end of a plan year if the health carrier provides written notice to enrollees before coverage is to be discontinued that the particular plan is being discontinued and the health carrier offers enrollees other dental plan options that are the same or substantially similar to the dental plan being discontinued in terms of premiums, benefits, cost-sharing requirements, and network adequacy. The written notice to enrollees must be provided at least 105 days before the end of the plan year.
- (c) Limited-scope pediatric dental plans must ensure primary care dental services are available within 60 miles or 60 minutes' travel time.
- (d) If a stand-alone dental plan as defined under the Affordable Care Act or a limited-scope pediatric dental plan is offered, either separately or in conjunction with a health plan offered to individuals or small employers, the health plan shall not be considered in noncompliance with the requirements of the essential benefit package in the Affordable Care Act because the health plan does not offer coverage of pediatric dental benefits if these benefits are covered through the stand-alone or limited-scope pediatric dental plan, to the extent permitted under the Affordable Care Act.
- (e) Health carriers offering limited-scope pediatric dental plans must comply with this section and sections **62K.07, 62K.08, 62K.13, and 62K.15.**
- (f) The commissioner of commerce shall enforce paragraphs (a) and (b). Any limited-scope pediatric dental plan that is to be offered to replace a discontinued dental plan under paragraph (b) must be approved by the commissioner of commerce in terms of cost and benefit similarity, and the commissioner of health in terms of network adequacy similarity. The commissioner of health shall enforce paragraph (c).

## 62K.15 Annual Open Enrollments Periods

*(NOTE: This section, as added by Laws 2013, chapter 84, article 2, section 16, is effective for health plans offered, sold, issued, or renewed on or after January 1, 2015. Laws 2013, chapter 84, article 2, section 17.)*

- (a) Health carriers offering individual health plans must limit annual enrollment in the individual market to the annual open enrollment periods for MNSure. Nothing in this section limits the application of special or limited open enrollment periods as defined under the Affordable Care Act.
- (b) Health carriers offering individual health plans must inform all applicants at the time of application and enrollees at least annually of the open and special enrollment periods as defined under the Affordable Care Act.
- (c) The commissioner of Commerce shall enforce this section.

## 62Q.73 External Review of Adverse Determinations

### Subd. 3. Right to external review.

- (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may submit a written request for an external review of the adverse determination, if applicable under section 62Q.68, subdivision 1, or 62M.06, to the commissioner of health if the request involves a health plan company regulated by that commissioner or to the commissioner of commerce if the request involves a health plan company regulated by that commissioner. Notification of the enrollee's right to external review must accompany the denial issued by the insurer. The written request must be accompanied by a filing fee of \$25. The fee may be waived by the commissioner of health or commerce in cases of financial hardship and must be refunded if the adverse determination is completely reversed. No enrollee may be subject to filing fees totaling more than \$75 during a plan year for group coverage or policy year for individual coverage.
- (b) Nothing in this section requires the commissioner of health or commerce to independently investigate an adverse determination referred for independent external review.
- (c) If an enrollee requests an external review, the health plan company must participate in the external review. The cost of the external review in excess of the filing fee described in paragraph (a) shall be borne by the health plan company.
- (d) The enrollee must request external review within six months from the date of the adverse determination.

### Subd. 7. Standards of review.

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- (a) For an external review of any issue in an adverse determination that does not require a medical necessity determination, the external review must be based on whether the adverse determination was in compliance with the enrollee's health benefit plan.
- (b) For an external review of any issue in an adverse determination by a health plan company licensed under chapter 62D that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in Minnesota Rules, part 4685.0100, subpart 9b.
- (c) For an external review of any issue in an adverse determination by a health plan company, other than a health plan company licensed under chapter 62D, that requires a medical necessity determination, the external review must determine whether the adverse determination was consistent with the definition of medically necessary care in section 62Q.53, subdivision 2.
- (d) For an external review of an adverse determination involving experimental or investigational treatment, the external review entity must base its decision on all documents submitted by the health plan company and enrollee, including medical records, the attending physician or health care professional's recommendation, consulting reports from health care professionals, the terms of coverage, federal Food and Drug Administration approval, and medical or scientific evidence or evidence-based standards.

### 62Q.76 Definitions

**Subd. 3. Dental plan.** "Dental plan" means a policy, contract, or certificate offered by a dental organization for the coverage of dental care services. Dental plan means individual or group coverage.

### 62Q.77 Terms of Coverage Disclosure

A dental organization shall make available to an enrollee, upon request, a clear and concise description of the following terms of coverage:

- (1) the dental care services and other benefits to which the enrollee is entitled under the dental plan;
- (2) any exclusions or limitation on the services, kind of services, benefits, or kind of benefits to be provided, including any deductible or co-payment features and any requirements for referrals to specialists;
- (3) a description as to how services, including emergency dental care and out-of-area service, may be obtained;

- (4) a general description of payment and co-payment amounts, if any, for dental care services, which the enrollee is obligated to pay; and
- (5) a telephone number by which the enrollee may obtain additional information regarding coverage.

## 62Q.78 Dental Benefit Plan Requirements

### Subdivision 1. Utilization profiling.

- (a) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's provider network shall, upon request, make available to participating dentists the following information:
  - (1) a description of the methodology used in profiling so that dentists can clearly understand why and how they are affected; and
  - (2)(i) a list of the codes measured; (ii) a dentist's personal frequency data within each code so that the accuracy of the data can be verified; and (iii) an individual dentist's representation of scoring compared to classification points and how the dentist compares with peers in each category including the cutoff point of the score impacting qualification in order to inform the dentist about how the dentist may qualify or retain qualification for differentiated provider reimbursement or continued participation in the dental organization's provider network.
- (b) A dental organization that uses utilization profiling as a method of differentiating provider reimbursement or as a requirement for continued participation in the organization's provider network shall, upon request, provide a clear and concise description of the methodology of the utilization profiling on dental benefits to group purchasers and enrollees.
- (c) A dental organization shall not be considered to be engaging in the practice of dentistry pursuant to chapter 150A, to the extent it releases utilization profiling information as required by sections 62Q.76 to 62Q.79.

### Subd. 2. Reimbursement codes.

- (a) Unless the federal government requires the use of other procedural codes, for all dental care services in which a procedural code is used by the dental organization to determine coverage or reimbursement, the organization must use the most recent American Dental Association current dental terminology code that is available, within a year of its release. Current dental terminology codes must be used as specifically defined, must be listed separately, and must not be altered or changed by either the dentist or the dental organization.
- (a) Enrollee benefits must be determined on the basis of individual codes subject to provider and group contracts.

- (b) This subdivision does not prohibit or restrict dental organizations from setting reimbursement and pricing with groups, purchasers, and participating providers or addressing issues of fraud or errors in claims submissions.

**Subd. 3. Treatment options.** No contractual provision between a dental organization and a dentist shall in any way prohibit or limit a dentist from discussing all clinical options for treatment with the patient.

**Subd. 4. Contract amendment.** An amendment or change in terms of an existing contract between a dental organization and a dentist must be disclosed to the dentist at least 90 days before the effective date of the proposed change.

**Subd. 6. Payment for covered services.**

- (a) No contract of any dental plan or dental organization that covers any dental services or dental provider agreement with a dentist may require, directly or indirectly, that a dentist provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the dental plan or dental organization unless the dental services are covered services.
- (b) A dental plan or dental organization or other person providing third-party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

"Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, co-payments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

## 62Q.79 Limitations

- (a) The provisions contained in section 62Q.77 shall not require a dental organization to disclose information which the dental organization is already obligated to disclose under applicable Minnesota law governing the operation of the dental organization.
- (b) Any information a dental organization is required to disclose or communicate under section 62Q.77 to its subscribers, enrollees, participating providers, contracting groups, or dentists may be accomplished by electronic communication including, but not limited to, e-mail, the Internet, Web sites, and employer electronic bulletin boards.

## 72C.06 Readability

**Subdivision 1. Requirement.**

## Checklist Guide: Minnesota Dental Requirements

All insurance policies filed with the commissioner pursuant to section 72C.11 shall be written in language easily readable and understandable by a person of average intelligence and education.

### **Subd. 2. Compliance factors.**

In determining whether a policy or contract is readable within the meaning of this section the commissioner shall consider, at least, the following factors:

- (a) the simplicity of the sentence structure and the shortness of the sentences used;
- (b) the extent to which commonly used and understood words are employed;
- (c) the extent to which legal terms are avoided;
- (d) the extent to which references to other sections or provisions of the contract are minimized;
- (e) the extent to which definitional provisions are incorporated in the text of the policy or contract; and
- (f) any additional factors relevant to the readability or understandability of an insurance policy or contract which the commissioner may prescribe by rule.

## Helpful Resources and Links

Federal Employees Dental and Vision Insurance Program (FEDVIP):

<https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf>

HealthCare.gov (Affordable Care Act, Section by Section)

<http://www.healthcare.gov/law/full/>

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017

<https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

CMS.gov (Regulations, timelines and guidance on health market reforms):

<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html>

Minnesota's Benchmark Plan (2017 EHB Benchmark Plan Information)

<https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>

The Federal Guide for reviewing EHB benchmark materials:

<https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html>

Minnesota Health Insurance Exchange Plan Certification Guidance for Qualified Dental Plans

<https://mn.gov/mnsure-stat/assets/MNsure-2015-QDP-plan-certification-guidance.pdf>