Group and Individual Dental and Vision Checklist

Use this checklist

- When reviewing group or individual dental and vision insurance policies or products.
- To ensure the product or policy meets requirements as listed in the Texas Insurance Code (TIC), the Texas Administrative Code (TAC), department guidelines, and other laws.
- In addition to, not in place of, the "Individual Health Product Requirements" checklist or the "Group Health Product" checklist, as applicable.
- To enter the page number or reference location in the "Page" field.

Dental requirements

Disclosure of benefit terms. If applicable, policy must:

Page _____ : Disclose that benefit offered is limited to least costly treatment - TIC Section 1451.205.

Page _____ : Specify in dollars and cents the payment amount for services, or explain standard on which payment of benefits is based - TIC Section 1451.205.

Page _____ : Accessible website for dentist and patient - Include information on type of dental services covered, reimbursement percentage of allowed charges, and, for contracting dentist, an estimate of the amount of the payment or reimbursement methods - TIC Section 1451.205 (b) and (c) and Section 1451.206(a)(2).

Payments

Page_____ : No difference permitted in payments to contracting and non-contracting dentists - TIC Section 1451.206(a)(1)(A).

Page _____ : Insured may assign right to payment to dentist; if assigned, payment is made directly to dentist, and payor's obligation discharged - TIC Section 1451.206(a)(1)(B) and(c).

Page _____ : Plan must provide 100 percent of contracted amount reimbursement method with no fee to access the payment or reimbursement. Disclose on the website and on request, any fees associated with the methods of payment or reimbursement available under the plan or policy – TIC Section 1451.206(a)(1)(C) and Section 1451.206(a)(2).

Page _____ : Payment need not be greater than amount specified in plan or dentist's fee for services provided - TIC Section 1451.206(b).

Page _____ : Relationship between dentist, employee benefit plans and health insurers- Specifies the following:

- An issuer may not recover an overpayment unless the issuer gives notice (specifies a reason for the request) not later than 180 days after the date the dentist received the payment.
- The dentist is allowed up to 45 days from the notice to provide a written objection to the recovery request.
- Prohibits the inclusion of a provision that both (1) allows the insurer to disallow or deny payment to the dentist for a service that ordinarily would have been covered; and (2) prohibits the dentist from billing for and collecting the amount owed for the service from the patient.
- An issuer must allow a network dentist to elect not to participate in the third-party access to contract and elect not to enter into a contract directly with the third party. TIC Section 1451.206.

Page _____ : Teledentistry services as defined by Section 111.001 of the Occupation Code and TIC Sections 1455.001 - 1455.006:

- Must cover teledentistry services provided by a preferred or contracted provider on the same basis and to the same extend that the plan covers the service in an in-person setting - TIC Section 1455.004(a)(1).
- May not exclude benefits solely because the covered service or procedure is not provided through an in-person consultation - TIC Section 1455.004(a)(2)(A).
- May not limit, deny, or reduce coverage for a teledentistry service based on the platform used - TIC Section 1455.004(a)(2)(B).
- Deductible, copayment, or coinsurance must be the same as if services were provided through an in-person consultation; a separate deductible or annual or lifetime maximum may not apply to teledentistry coverage. TIC Section 1455.004(b), (b-1), and (d).

Prior authorization of dental care services

Page _____ : Prior authorization defined - TIC Section 1451.208(a).

Page _____ : Prior authorization does not include a predetermination - TIC Section 1451.208(a)(2).

Page _____ : If plan or policy requires prior authorization, the prior authorization must include a specific benefit payment or reimbursement amount - TIC Section 1451.208(b).

Page _____ : If plan or policy requires prior authorization, except for as provided in TIC 1451.208(c) the plan or policy may not reimburse the dentist an amount that is less than the amount stated in the prior authorization - TIC Section 1451.208(b).

Page _____ : Preauthorization Renewal - before the expiration of an existing preauthorization,if the health benefit plan receives a request to renew, it must review the request and issue a determination - TIC Section 1222.0003- 1222.0004 and Section 1301.001 (definition of preauthorization).

Prohibited practices

Page _____ : Health plan or policy cannot interfere or prevent an individual from choosing a dentist - TIC Section 1451.207(a)(1) and 28 TAC Section 21.3603.

Page _____ : Health plan or policy must not deny a dentist the right to participate as a contracting provider- TIC Section 1451.207(a)(2).

Page _____ : Health plan or policy cannot authorize a person to regulate, interfere with or intervene in provision of dental care services provided by licensed dentist - TIC Section 1451.207(a)(3).

Page _____ : Health plan or policy cannot require a dentist to make or obtain a dental x-ray or other diagnostic aid in providing dental care services - TIC Section 1451.207(a)(4) and TIC Section 1451.207(b).

Page _____ : Health plan or policy cannot deduct the amount of an overpayment of a claim from a payment or reimbursement for dental services provided by dentist who didnot receive the overpayment - TIC Section 1451.207(a)(5).

Page _____ : A health insurance policy may not provide a different level of payment of benefits or reimbursement, including deductibles, maximums, or other cost-sharing provisions, for covered dental care services based on whether the services are provided by a contracting or non-contracting dentist - TIC Section 1451.206 and 28 TAC Section 21.3604.

Page _____ : Preferred provider benefits are not permitted in a dental plan – TIC Section 1301.002 and 28 TAC Section 3.3701.

Vision requirements

Only applies to a managed care plan that provides or arranges for benefits for vision or medical eye care services or procedures.

Benefits provided

Page _____ : It must cover services by an optometrist and therapeutic optometrist- TIC Section 1451.151 - 1451.153.