DELTA DENTAL

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December 26, 2012

Centers for Medicare & Medicaid Services
ATTN: CMS-9980-P
U.S. Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Comments on the Proposed Rule for Standards Related to Essential Health Benefits

To Whom It May Concern:

I am writing on behalf of the Delta Dental Plans Association ("DDPA") in response to the invitation for comments on the November 26, 2012, Proposed Rule for "Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation." We are pleased to offer comments on the proposed rule specifically relating to implementation of pediatric dental essential health benefits, the role of stand-alone dental benefits plans in providing the "pediatric" dental essential health benefit both inside and outside of an Exchange.

In addition, our comments include draft regulatory language for your consideration in defining and addressing certain critical issues relating to the pediatric dental essential health benefit. Our recommendations include: the "minimum" essential services that must be included in the pediatric dental essential health benefit; benchmark pediatric dental benefit plans; provision of an evidence-based "pediatric" dental benefit plan; and application of the qualified health plan waiver both inside and outside the Exchange.

DDPA is the nation's largest, most experienced dental benefits system. Since 1954, DDPA has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups. A nationwide system of dental health service plans, DDPA offers custom programs and reporting systems that provide employees with quality, cost-effective dental benefit programs and services. Our nationwide network of 39 companies and 142,000 dentists, serves more than 59.5 million Americans in over 97,900 group plans across the nation.

We very much appreciate the opportunity to submit comments on this important proposed rule. Please let me or my staff know if you have any questions.

Sincerely,

Kim E. Volk

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President and CEO
Enclosure

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December 26, 2012

DELTA DENTAL PLANS ASSOCIATION ("DDPA") COMMENTS ON THE NOTICE OF PROPOSED RULE MAKING FOR STANDARDS RELATED TO ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE, AND ACCREDITATION ISSUED NOVEMBER 26, 2012

I. In General

The Delta Dental Plans Association ("DDPA") welcomes the opportunity to comment on the November 26, 2012, proposed "Standards for Essential Health Benefits, Actuarial Value, and Accreditation" ("EHB NPRM") issued by the Department of Health and Human Services. Underlying our comments is the significant difference in both the nature and structure of dental benefits from medical benefits and the corresponding difference in the legal treatment of stand-alone dental benefits and dental benefit plans.

Dental benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and as a result are not regulated in the same manner as comprehensive, major medical coverage. This was established in the 1996 HIPAA amendments to the PHSA, ERISA, and the IRC, and the Accountable Care Act ("ACA") builds upon those provisions and continues the exception for "excepted benefits".

As an "excepted benefits" plan, a stand-alone "limited scope" dental benefit plan is not subject to the ACA's prohibition on lifetime and annual limits on the dollar value of benefits. In fact, such limits are a critical standard feature of typical employer-provided dental benefit coverage currently offered in the market. In addition, typical employer-provided dental benefit plans establish frequency limits for certain dental services, restrictions on the amount of the fee for which a benefit will be computed, and limitations on the nature of the dental conditions for which a benefit will be payable.

Because of the unique nature of excepted benefit plans, we appreciate the agency's recognition and initiative to establish separate provisions for the set of dental-specific benchmarks and standards in the EHB NPRM, and for defining the pediatric oral health essential health benefits. We also request the agency to address the critical need to clarify and provide for the separate pricing and offering of those benefits by qualified health plans and stand-alone dental benefit plans, and the role of stand-alone dental benefit plans in providing the pediatric oral health essential health benefit in the market outside the Exchange.

We offer suggested language for addition to the proposed rule, set forth below, following our specific comments on the EHB NPRM.

II. Existing Dental Plan Coverage

Millions of Americans currently have family dental plan coverage. Included in these plans are benefits for children. A major concern is that as the essential health benefits package only includes a requirement for a pediatric dental benefit, families may be encouraged to drop their coverage because of this segmentation. Alternatively, families may be forced to split up coverage between adults and children with different carriers, lose access to their child's dentist due to switching networks, or purchase duplicative coverage to preserve the coverage that they already have and enjoy. This appears to be an unintended consequence of a provision meant to extend and improve coverage.

To avoid these complications for families, HHS should provide that individuals may satisfy the essential health benefit package requirements when purchasing health insurance either inside or outside the Exchange by demonstrating that existing family dental coverage includes benefits that meet the required pediatric essential health benefit.

III. Comments Specific to the EHB NPRM

A. Proposed Section 156.110(b)(2).

Definition of "Pediatric Services". We support the agency's statement in the Preamble that the phrase "pediatric services" means services for individuals under the age of 19 years of age. See 77 Fed. Reg. 70643, at 70649. We strongly urge the agency to adopt an age definition for "pediatric services" in regulatory language, and suggest below a proposed amendment to that effect in the regulations. We do not support the agency's proposal to permit flexibility for each state to extend pediatric coverage beyond the proposed 19 year age limit.

For purposes of the Medicaid and CHIP programs the term "child" is defined as an individual under 19 years of age, and a State option permits a higher age but only up to age 21. The Preamble discussion does not include this upper limit. The American Academy of Pediatric Dentistry, for example, defines an "adolescent" as a person between the ages of 10 and 18. Each higher age bracket above age 19 will increase the required premium for the pediatric essential health benefit.

Pediatric Dental Benchmark Plan in General. We support the regulatory approach in the EHB NPRM that utilizes a "benchmark" reference plan to set the "covered services" required in the EHB. Prior to the issuance of the EHB Bulletin last December 16, 2011, DDPA proposed a draft regulation for the pediatric dental essential benefit that employed this general approach of listing several benchmark plans that would satisfy the requirement. We recommended that the benefit for essential pediatric oral services required under Section 1302(b)(1)(J) should be determined by reference to a set of benchmark *dental* plans, rather than to any of the benchmark medical plans used by a State to define the EHB generally.

The EHB NPRM recognizes that the initial four benchmarks set for determining the EHB did not contain dental benefits sufficient to set a pediatric dental essential benefit. The ASPE research

brief on essential health benefits noted that "routine" pediatric dental services are not frequently covered in the small group *health* market. *See* ASPE Research Brief (December 2011) at page 3. Moreover, 97 percent of dental coverage is provided through separate (stand-alone) dental plans or policies. The initial four benchmark options, while offering a range of benefit options for the EHB generally, did not accurately portray the average *pediatric dental* benefits being offered by employers.

The Recommended Benchmarks for Pediatric Dental Benefits. We support the provisions of proposed section 156.110(b)(2) of the EHB NPRM including "supplemental" benchmarks of CHIP, and the Federal Employees Dental and Vision Insurance Program ("FEDVIP") as "benchmark" plans. We request, that the agency further clarify in regulatory language that the FEDVIP benchmark relates only to the category of dental benefits of those programs that are typically provided to children rather than to adults. See below for a suggested amendment to accomplish that.

We also request that the agency include an explicit authorization for a pediatric oral health essential benefit plan that employs an "evidence-based" approach to covered benefits with an actuarial value equivalent to the CHIP benchmark. This approach is consistent with the EHB recommendations of the Institute of Medicine. We have included suggested regulatory language below.

Choice of Benchmark Must Be Guided by Affordability. We also request that the pediatric oral health essential benefits be further clarified to emphasize that their scope should be balanced by a consideration of affordability for individuals and small group employers.

While many benefits may be considered desirable by consumers, only a selection of them should be considered "essential" in order to attain the goal of affordability. It seems clear that Congress did not intend to include all of the same pediatric oral health care benefits that are included in the FEDVIP and CHIP programs because these programs can provide comprehensive benefits.

The phrase "essential" is not superfluous and has been interpreted by Congressional staff as meaning a "minimum" set of benefits. The plain meaning of the term essential is "basic", and as a result, the pediatric oral health care essential benefit must be benchmarked as a basic benefit and not as comprehensive dental benefits. See IOM, *Essential Health Benefits: Balancing Coverage and Costs* (2011) at 60.

We therefore recommend that States be directed by HHS to ensure that affordability guides their choice of benchmark for the pediatric dental benefit. A suggestion for that approach is shown in the regulatory language proposed below.

B. Proposed Section 156.115(d).

Provision of Routine Non-Pediatric (Adult) Dental Services. We support the proposed rule at section 156.115(d) that prohibits a qualified health plan from providing adult dental benefits or "cosmetic" orthodontia as part of its essential health benefits package. As we have noted, 97 percent of dental coverage is provided through separate (stand-alone) dental plans or policies.

We note that separately in the Preamble for the proposed rule entitled "HHS Notice of Benefit and Payment Parameters for 2014" (December 7, 2012) in describing the proposed rule for premium tax credits and the allocation of premiums the agency observes that stand-alone dental benefit plans must provide to an Exchange a dollar allocation of the expected premium for: (1) the pediatric dental essential health benefit; and (2) any benefits offered by the stand-alone dental plan that are not the pediatric dental essential benefit. See 77 Fed. Reg. 73117, at 73168.

We read this explanation as the agency's position that stand-alone dental plans might separately offer "adult" or "family" dental coverage in an Exchange, so long as the premium and benefits are separately offered and disclosed. We understand that any dental benefits offered other than the pediatric dental essential benefits are not eligible for the premium tax credit assistance. Accordingly, for purposes of the EHB NPRM, we request that the agency clarify at least in the Preamble for the final rule that routine non-pediatric dental services may be offered as a separate stand-alone plan in an Exchange.

Pediatric Orthodontics Coverage Is Not Essential. We support the EHB NPRM notation that non-medically necessary orthodontia is not being considered for inclusion as pediatric essential health benefit dental coverage. Non-medically necessary orthodontia is most often performed for cosmetic reasons and as a result would not be considered basic care for purposes of the pediatric oral health care essential benefit.

Medically necessary orthodontia is normally provided as a covered benefit in medical plans, Medicaid, and some CHIP programs. In those cases "medical necessity" is typically defined narrowly. The pediatric oral health care essential benefit is not a "medical" benefit and therefore must not include orthodontia that is cosmetic in nature nor incidental to or an integral part of treatment that is primarily "medical" care (most often the result of a genetic condition, an accident, injury, or other trauma).

We propose language below to establish a default definition (to be used when a state has no definition of its own) of the phrase "medically necessary orthodontia" for purposes of the pediatric dental essential benefit to be mean services for a severe, dysfunctional, handicapping malocclusion that meets a score on the Handicapping Labio-Lingual Deviations (HLD), or on the Salzmann Malocclusion Severity Assessment that would qualify cleft palate deformity, craniofacial anomaly, deep impinging overbite with tissue destruction, cross bite of individual anterior teeth causing tissue destruction, overjet greater than 9 mm, or reverse overjet greater than 3.5 mm, or a severe traumatic deviation due to burn or accident.

C. Proposed Section 156.150.

Annual Limitation on Cost-Sharing. We support the provisions of proposed section 156.150(a) that establishes a special rule for stand-alone dental plans that requires the demonstration of a "reasonable" annual limitation on cost-sharing with respect to in-network services. We very much appreciate the agency's recognition that applying the same annual limitation to a stand-alone dental plan that is applied to qualified health plans would put individuals in a stand-alone plan at much greater financial risk compared to individuals in a

qualified health plan, that no limitation would be inappropriate, and that combining the cost-sharing limitation with a qualified health plan would require a high level of coordination that would be difficult to administer.

We propose that a regulatory "safe harbor" should be included in the final rule that would establish an amount of $1,000 as an annual cost-sharing limitation that is deemed to be "reasonable" (See draft of safe harbor in section 156.150(a) below). This recommendation is based on the following analysis and balances keeping a largely preventive benefit affordable with protecting consumers from overly burdensome out-of-pocket costs.

- If the intent of the out-of-pocket limit is to protect consumers from catastrophic costs, the "attachment point" should be somewhere near where the cost curve begins to accelerate quickly. This does not happen until approximately the 98thpercentile (the difference between the 95th percentile and the 96.5th percentile is only $40 while the difference between the 98th percentile and the 99th percentile is $1,950).
- $1000 is the best option when considering the tradeoffs. A lower out-of-pocket maximum protects more members, but it raises the premiums for all consumers. A higher out-of-pocket maximum keeps rates reasonable, but it leaves some folks unprotected. $1,000 strikes a reasonable balance while being easy to communicate to subscribers.
- An out-of-pocket limit results in a substantial increase in orthodontic benefit compared to what is currently available in the typical commercial market. Typically, orthodontia is covered with a lifetime limit ranging from $1,000 - $1,500. If the average cost is assumed to be $6,350, and it is further assumed that the case lasts 24 months (6 months of one year, 12 months of the next year, and 6 months of a third year to 24 months total), and if it is further assumed $250 per year of other dental costs (essentially two visits per year), then the plan would pay over $3,700 toward the orthodontia case. This is a substantial increase from $1,000 - $1,500 dental plans currently see (in fact, double or triple). This increase would be covered by increased premium, and would be offset by a reasonable out-of-pocket limit of $1000.

Premiums that are in-force today for families will be increased by the elimination of annual maximums on pediatric coverage and coverage for medically necessary orthodontia in the small group and individual markets. The consideration of high additional premiums for catastrophic out-of-pocket limits should be balanced by the impact on adults dropping their own coverage to afford higher cost premiums for their children. When "out-of-pocket" maximums drop under $1000, the premium costs escalate quickly for families. The safe harbor of $1000 will provide an easy to understand limit that protects consumers and keeps dental coverage a viable option both for the children and adults.

Calculation of Actuarial Value. We support the provision of the proposed section 156.150(b)(2), a special rule for stand-alone dental plans that establishes a "high" and a "low" level of coverage for the pediatric dental essential benefit. We very much appreciate the agency's recognition that the actuarial value standards for qualified health plans are not

appropriate for stand-alone dental plans because the standard population that underlies the AV-calculator cannot be adapted to reflect a pediatric-only population that utilizes the essential health benefit dental services, and because pediatric dental coverage is comprised largely of preventive services with 100 percent cost-sharing covered by the plan.

However, because the pediatric dental benefit consists largely of preventive services, the proposed "high" and "low" actuarial values would only allow very subtle differences that would hardly merit a consumer's choice between a meaningful "high" and "low" option. We therefore propose that either: (1) only one actuarial value level be established for the pediatric dental essential health benefit; or (2) the "low" level of coverage be 70 percent instead of 75 percent (see proposed alternative amendments below). This range would permit a more meaningful choice between "high" and "low" coverage. This would apply to the pediatric dental essential health benefit whether it is offered separately or in conjunction with a qualified health plan.

D. Other Specific Comments

Proposed Section 147.150. The proposed rule must also include the other provision of section 2707 of the Public Health Service Act with respect to stand-alone dental plans. We recommend the addition of a new subsection (d) (see below) that restates the statutory provision of section 2707(d) of the Public Health Service Act that the requirement to provide the essential health benefits package does not apply to stand-alone dental benefit plans.

IV. Outside the Exchange

DDPA member plans continue to have a significant concern with the ability of stand-alone dental plans to effectively provide coverage of the pediatric oral health services as part of the EHB in the individual and small group markets outside the Exchange.

Section 155.1065 (d) of the final Exchanges and Qualified Health Plans rule provides that a qualified health plan offered through an Exchange will not fail to be certified by an Exchange as a qualified health plan if a stand-alone dental plan in the Exchange offers the required pediatric dental benefit. (*See also* footnote 27 of the EHB Bulletin at page 10). This implements the "required element" at Section 1302 (b)(4)(F) and constitutes a limited "waiver" of the requirement that qualified health plans must provide all the health benefits listed in Section 1302(b)(1).

However, the ACA is silent with respect to whether this waiver is available to a health plan offering the EHB outside an Exchange because an Exchange does not certify plans in that market. The ACA does not include any explicit prohibition against stand-alone dental plans to offer the pediatric essential dental benefit in the market outside the Exchange.

The existing market already relies upon freely available stand-alone dental plans in all States, and those stand-alone plans are now the usual suppliers of what will become the required pediatric dental benefit for purposes of meeting the EHB package in the individual and small group insurance market outside an Exchange, and will continue to have the capacity and desire to

do so. Accordingly, State regulators should not have to require a health plan to offer the essential pediatric dental benefit in those markets or be faulted for failing to enforce such a requirement.

Also, individuals and families utilizing stand-alone dental plans to satisfy their dental treatment needs should not have to switch plans or purchase duplicative coverage from a health insurance plan due to a drafting error in the ACA.

Legislative History. The legislative history of the Senate-passed provision clearly evidences an intent to authorize stand-alone dental benefit plans to offer the pediatric essential dental benefit outside the Exchange. The narrative explanation of the Senate Finance Committee's amendment states as its purpose: "to allow stand-alone dental plans to offer the required pediatric dental services and to be offered in the individual and small group markets including within the insurance exchanges." [Emphasis added].

HHS should therefore clarify that it is not necessary for State regulators to require health plans to cover the essential pediatric dental benefit portion of the EHB unless the benefit is not available from a stand-alone dental benefit plan. This would apply the qualified health plan "waiver" consistently for the pediatric dental benefit portion of the EHB in the market outside the Exchange in the same manner that the qualified health plan "waiver" operates inside the Exchange, as intended by the Stabenow Amendment.

Federal courts rely extensively on legislative history where statutory language is unclear or ambiguous. See *United States v. Great Northern Ry.*, 287 U.S. 144 (1932) ("In aid of the process of construction we are at liberty, if the meaning be uncertain, to have recourse to the legislative history of the measure and the statements by those in charge of it during its consideration by the Congress.").

V. Separate Offer and Pricing of Pediatric Dental Benefits

In the March 27, 2012, final rule establishing standards and guidance for Exchanges and Qualified Health Plans, the agency stated that the pediatric essential dental benefit is required to be offered and priced separately from the medical coverage where an Exchange determines that it "is in the interest of the consumer". See 77 Fed. Reg. 18411 (right hand column response).

This is consistent with the legislative history of the ACA which even more emphatically states that the required pediatric dental benefits in the non-group and small group markets (in and outside an Exchange) may be *separately offered and priced* from other required health benefits." See Stabenow-Lincoln modified amendment C-7 to the Chairman's Mark.

Most recently, the American Dental Association and the American Academy of Pediatric Dentistry wrote in support of separate offer and price as "necessary to provide consumers with the tools and information they need to make informed dental coverage decisions". See comment letter to Mr. Michael Hash on Federally-Facilitated Exchanges, dated August 3, 2012.

Separate offer and pricing ensures meaningful choice. Absent separate offer and pricing where one or two medical plans control a majority of the market, this will discourage the participation of competing stand-alone dental plans. This contravenes section 1302(b)(4) of the ACA which

declares QHP "waiver" permitting the role of stand-alone dental plans to be a "required element" of the essential health benefits.

VI. Proposed Pediatric Essential Health Benefits Regulation

We are also submitting as part of these comments on the EHB NPRM draft proposed amendments to the regulations for the agency's consideration in defining the scope of the pediatric essential health benefit and other clarifying rules that should be provided in order to establish some uniformity and consistency across the states with respect to certain aspects of the pediatric dental EHB requirement.

The proposed clarifications include: (1) amending the definition of the benchmark for essential pediatric oral services to include consideration of affordability, to limit the FEDVIP benchmark to dental services typically provided to children, and to explicitly include an evidence-based benchmark; (2) definition of pediatric; (3) definition of "medically necessary orthodontia;"(4) establishing a safe harbor for the cost-sharing limit on pediatric oral services; (5) revision of the high/low AV levels for pediatric oral services; (6) codification of the exclusion of stand-alone dental plans from the requirements of section 2707 of the Affordable Care Act; ; (7) application of the qualified health plan waiver inside and outside an Exchange; (5) allowance for existing family coverage to meet the pediatric dental EHB requirement; (9) clarification that families with children must purchase both the QHP medical plan and stand-alone dental plan to meet the EHB requirement; (10) a requirement for the separate offer and pricing of the pediatric dental benefit to facilitate the comparison and choice of the essential pediatric dental plans for consumers; and (11) the explicit use of uniform limits on benefits and services by excepted benefit plans to ensure affordability.

Draft Regulatory Language

Section 147.150. Coverage of essential health benefits

* * * *

(d) Dental-only. This section shall not apply to a stand-alone dental plan described in section 155.1065(a).

Section 156.110(b)

*** * * ***

(2) Supplementing pediatric oral services. A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of benefits from one of the following, provided that the specific benefits shall be guided by consideration of their affordability to individuals and small group employers:

(i) The benefits typically provided to children under the FEDVIP dental plan with the largest national enrollment that is described in and offered to federal employees under 5 USC 8952; or

(ii) The benefits available under that state's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment; or

(iii) A plan that provides coverage of benefits based upon (A) appropriate individual risk and age factors (including limits on scope and frequency) determined on the best scientific-evidence, and (B) an aggregate actuarial value that is equivalent to pediatric dental benefits provided under a CHIP plan described in (ii).

* * * *

Section 156.115. Provision of EHB.

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(d) An issuer of a plan offering EHB may not include as EHB –

(1) routine non-pediatric dental services, routine non-pediatric eye exam services, or long-term/ custodial nursing home care benefits, or non-medically necessary orthodontia.

(2) "Medically necessary orthodontia" for purposes of the pediatric dental essential benefit shall be determined in accordance with the standard used for determining medically necessary orthodontia for the state's separate CHIP program, and if there either is no separate CHIP program or such a standard, then "medically necessary orthodontia" shall mean services for a severe, dysfunctional, handicapping malocclusion that meets a score on the Handicapping Labio-Lingual Deviations (HLD) or on the Salzmann Malocclusion Severity Assessment, that would qualify cleft palate deformity, craniofacial anomaly, deep impinging overbite with tissue destruction, cross bite of individual anterior teeth causing tissue destruction, overjet greater than 9 mm, or reverse overjet greater than 3.5 mm, or a severe traumatic deviation due to burn or accident..

Section 156.150. Application to stand-alone dental plans [inside the Exchange].

(a) Annual limitation on cost-sharing. A stand-alone dental plan covering the pediatric dental EHB under section 155.1065 of this subchapter must demonstrate to the Exchange that it has a reasonable annual limitation on cost-sharing, provided that an Exchange shall deem an annual limitation of $1,000 or more as "reasonable." Such annual limit is calculated without regard to EHBs provided by the QHP and without regard to out-of-network services.

(b) Calculation of AV. A stand-alone dental plan:

(1) May not use the AV calculator in section 156.135 of this chapter.

(2) Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit at either:

(i) A low level of coverage with an AV of 70 percent; or

(ii) A high level of coverage with an AV of 85 percent; and

(iii) Within a de minimis variation of +/- 2 percentage points of the level of coverage in paragraphs (b)(2)(1) or (ii) of this section.

[ALTERNATE (2) Must demonstrate that the stand-alone dental plan offers the pediatric dental essential health benefit at a level of coverage within a de minimis variation of +/- 2 percentage points of an AV level of 80 percent.]

(3) The level of coverage as defined in paragraph (b)(2) of this section must be certified by a member of the American Academy of Actuaries using generally accepted actuarial principles.

(c) *Definition of Pediatric*. For purposes of this regulation, the term "pediatric" means an individual who is an infant, child, or adolescent that is under 19 years of age.

(d) *Pediatric Dental Plans*. A qualified health plan or a stand-alone dental benefit plan may offer coverage of the essential pediatric oral health services that is substantially equivalent to one of the benchmark dental benefit packages selected by the State under section 156.110(b)(2).

(e) *Relation to Existing Dental Coverage*. An eligible individual who purchases qualified health plan coverage without pediatric oral health care services for a dependent child may satisfy the requirement in IRC section 5000A(a) by certifying that the individual has an existing family dental policy that includes coverage equal to or exceeding one of the benchmark dental packages selected by the State under section 156.110(b)(2).

(f) *Combined Purchase Required*. An eligible individual with one or more dependent children who purchases a qualified health plan offered under section 155.1065(d) without pediatric oral care services described in section 1302(b)(1)(J) of the Affordable Care Act must also purchase a separate stand-alone dental benefits plan that includes such pediatric oral care services to meet the essential health benefits requirements.

(g) *Separate Offer and Pricing Required*. Pediatric oral care services under section 1302(b)(1)(J) of the Affordable Care Act must be offered and priced separately from the other categories of essential health benefits required under sections 1302(b)(1)(A) through (I), of the ACA and from any other dental benefits that may be offered.

(h) *Scope and Affordability*. Nothing shall be construed to prevent a stand-alone dental benefits plan, with respect to similarly situated individuals enrolled in the plan, from establishing: limitations or restrictions on the frequency of benefits for certain covered services; restrictions on the amount of the fee for which benefits are computed; and limitations on the level, extent, or nature of conditions for any covered benefits; and, provided further with respect to excepted benefit limited scope dental benefit plans, lifetime and annual limits on the dollar value of benefits.