GROUP STAND-ALONE DENTAL PRODUCTS

Date: _____

Carrier Name & NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone & Fax: _____

Email Address: _____

Product Name & Form #: (Attach a separate sheet if necessary.) _____

Carrier Certification:

I _____, a duly authorized representative of _____, certify that it is my good faith belief based on the review of this checklist and submitted materials that the submitted materials comply with applicable Massachusetts law.

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:

Please note that there are 3 sections to this checklist that should be completed for each group plan:

All dental carriers should complete page 1

Dental Carriers offering insured plans through a network of providers should complete pages 2-6

Dental Carriers offering insured plans with differing benefits for services when provided by network ("preferred") compared to out-of-network providers should complete page 7

Please also note that if a carrier is filing a new insured preferred provider plan product that has not previously been approved under M.G.L. c. 176I, then it should separately complete checklist: https://www.mass.gov/doc/initial-approval-of-an-insured-preferred-provider-plan/download.

When completing these checklists, please indicate for each requirement the page number(s), and/or section(s), where the required information may be found in the submitted materials.

- ***For items requiring company confirmation, please place a checkmark (√) next to the requirement acknowledging confirmation. If a requirement is not applicable (N/A), please place "N/A" next to the requirement and explain, either within the checklist or on a separate sheet, the legal basis under which the requirement does not apply to the filed materials. Any section of the checklist that is not complete will be returned for completion.***

REQUIREMENTS ONLY FOR DENTAL PLANS OFFERING COVERAGE THROUGH NETWORKS OF DENTAL PROVIDERS

According to 211 CMR 52.13(6) "[a] Carrier, including a Dental and Vision Carrier, shall provide to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, notice of all Material Changes to the Evidence of Coverage."

***Initials*_____**

According to M.G.L. c. 176O §2(d), "[a] carrier that contracts with another entity to perform some or all of the functions governed by this chapter shall be responsible for ensuring compliance by said entity with the provisions of this chapter. Any failure by said entity to meet the requirements of this chapter shall be the responsibility of the carrier to remedy and shall subject the carrier to any and all enforcement actions, including financial penalties, authorized under this chapter."

***Initials*_____**

DEFINITIONS (if used) [211 CMR 52.02]:

INSERT PAGE# & SECTION	
_____	Actively Practices. A Health Care Professional who regularly treats patients in a clinical setting.
_____	Bureau of Managed Care or Bureau. The bureau in the Division of Insurance established by M.G.L. c. 176O, § 2.
_____	Capitation. A set payment per patient per unit of time made by a Carrier to a licensed Health Care Professional, Health Care Provider group, or organization that employs or utilizes services of Health Care Professionals to cover a specified set of services and administrative costs without regard to the actual number of services provided.
_____	Commissioner. The Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.
_____	Cost Sharing or Cost-sharing. Deductibles, coinsurance, copayments, or similar charges required of an Insured, but does not include premiums, balance-billing amounts for out-of-network Providers, or spending for non-covered Benefits.
_____	Covered Benefits or Benefits. Dental Care Services to which an Insured is entitled under the terms of the Dental Benefit Plan.
_____	Dental Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Dental Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Dental Care Services.
_____	Dental Care Professional. A dentist or other dental care practitioner licensed, accredited or certified to perform specified Dental Services consistent with the law.
_____	Dental Care Provider. A Dental Care Professional or Facility licensed to provide Dental Care Services.
_____	Dental Care Services or Dental Services. Services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury, or disease.
_____	Dental Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Dental Care Services and is: • an insurer licensed or otherwise authorized to transact accident or health insurance

	under M.G.L. c. 175; • a nonprofit hospital service corporation organized under M.G.L. c. 176A; • a nonprofit medical service corporation organized under M.G.L. c. 176B; • a dental service corporation organized under M.G.L. c. 176E, • or an organization entering into a preferred provider arrangement under M.G.L. c. 176I, • but not including an employer purchasing coverage or acting on behalf of its employees or the employees or one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Dental Care Services.
_____	Division. The Division of Insurance established pursuant to M.G.L. c. 26, § 1.
_____	Evidence of Coverage. Any certificate, contract or agreement of health insurance including riders, amendments, endorsements and any other supplementary inserts or a summary plan description pursuant to § 104(b)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1024(b), issued to an Insured specifying the Benefits to which the Insured is entitled.
_____	Insured. An enrollee, covered person, Insured, member, policy holder or subscriber of a Dental Carrier,
_____	Internet Website. Includes, but shall not be limited to, an internet website, an intranet website, a web portal, or electronic mail.
_____	Network or Provider Network. A group of Dental Care Providers who contract with a Dental Carrier or affiliate to provide Dental Care Services to Insureds covered by any or all of the Dental Carrier's plans, policies, contracts or other arrangements.
_____	Participating Provider. A Provider who, under a contract with the Dental Carrier or with its contractor or subcontractor, has agreed to provide Dental Care Services to Insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Dental Carrier
_____	Service Area. The geographical area as approved by the Commissioner within which the Dental Carrier has developed a Network of Providers to afford adequate access to members for covered Dental Services.

STANDARDS FOR PROVIDER CONTRACTS *[211 CMR 52.11]*:

INSERT PAGE# & SECTION

_____	Contracts between Carriers and Providers **shall state** that a Carrier shall not refuse to contract with or compensate for covered services delivered by an otherwise eligible Health Care Provider solely because such Provider has in good faith: (a) communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Carrier's Health Benefit Plans as they relate to the needs of such Provider's patients; or (b) communicated with one or more of his or her prospective, current or former patients with respect to the method by which such Provider is compensated by the Carrier for services provided to the patient. *[211 CMR 52.11(1)]*
_____	Contracts between Carriers and Providers **shall state** that the Provider is not required to indemnify the Carrier for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Carrier based on the Carrier's management decisions, Utilization Review provisions or other policies, guidelines or actions. *[211 CMR 52.11(2)]*
	No contract between a Carrier and a Licensed Health Care Provider Group may contain any Incentive Plan that includes a specific payment made to a Health Care Professional as an inducement to reduce, delay or limit specific, Medically Necessary services covered by the health care contract.
_____	(a) Providers shall not profit from provision of covered services that are not dentally necessary or appropriate.
_____	(b) Carriers shall not profit from denial or withholding of covered services that are dentally necessary or appropriate.
_____	(c) Nothing in 211 CMR 52.11(3) shall be construed to prohibit contracts that contain Incentive Plans that involve general payments such as Capitation payments or shared risk agreements between Carriers and Providers, so long as such contracts, which impose risk on such Providers for the costs of care, services and equipment provided or authorized by another Health Care Provider, comply with 211 CMR 52.11(4) and 155.00: *Risk-bearing Provider Organizations*.
_____	(d) In the event that a Provider with which a Carrier has a contract makes any decisions about coverage of requested care, then the Carrier remains responsible to ensure compliance with all applicable utilization review processes, including but not limited to adverse determination notices that describe rights to appeal medical necessity denials. *[211 CMR 52.11(3)]*

No Carrier may enter into a new contract, revise the risk arrangements in an existing contract, or revise the fee schedule in an existing contract with a Health Care Provider which imposes financial risk on such Provider for the costs of care, services or equipment provided or authorized by another Provider unless such contract includes specific provisions with respect to the following:

(a) stop loss protection; (b) minimum patient population size for the Provider group; and

(c) identification of the Health Care Services for which the Provider is at risk.

Carrier's requirements for Utilization Review, quality management and improvement, credentialing and the delivery of Preventive Health Services. *[211 CMR 52.11(11)]*

Identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.

EVIDENCE OF COVERAGE [211 CMR 52.13(3) - M.G.L. c. 176O §6(b)]:
INSERT PAGE# & SECTION

The Carrier has taken reasonable measures to ensure that it furnishes, upon request of the Insured, a paper copy of the Evidence of Coverage and any amendments thereto. *[211 CMR 52.13(4)(c)]*

A Carrier, including a Dental and Vision Carrier, shall always deliver at least one Evidence of Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 52.14 or 52.15. *[Group Plans. 211 CMR 52.13(5)]*

_____ (a) The health, Dental or Vision Care Services and any other Benefits to which the Insured is entitled on a nondiscriminatory basis, including Benefits mandated by state or federal law;

_____ (c) The toll-free telephone number and website established by the Carrier to identify the Network status of an identified Provider;(d) The limitations on the scope of:

2. Dental or Vision Care Services and any other Benefits to be provided, including an explanation of any deductible or copayment feature.

_____ (e) All restrictions relating to preexisting condition limitations or exclusions, or a statement that there are no preexisting condition limitations or exclusions if there are none under the Health, Dental or Vision Benefit Plan;

_____ (f) A description of the locations where, and the manner in which Dental Services and other Benefits may be obtained.

_____ (g) A description of eligibility of coverage for dependents, including a summary description of the procedure by which dependents may be added to the plan;

_____ (h) The criteria by which an Insured may be disenrolled or denied enrollment. 211 CMR 52.13(3)(h) shall apply to Carriers, including Dental and Vision Carriers.

1. (i) The requirement that an Insured's coverage may be canceled, or its renewal refused may arise only in the following circumstances: Failure by the Insured or other responsible party to make payments required under the contract;
2. Misrepresentation or fraud on the part of the Insured;
3. Commission of acts of physical or verbal abuse by the Insured which pose a threat to Providers or other Insureds of the Carrier and which are unrelated to the physical or medical condition of the Insured;
4. Relocation of the Insured outside the Service Ares of the Carrier; or
5. Non-renewal or cancellation of a group contract through which the insured has coverage.

_____ (j) A description of the Carrier's method of resolving Insured inquiries and complaints.(n) A summary description of the procedure, if any, for out-of-Network referrals and any additional charge for utilizing out-of-network Providers. 211 CMR 52.13(3)(n) shall apply to Dental Carriers;

_____ (o) A summary description of the Utilization Review procedures and quality assurance programs used by the Dental Carrier including the toll-free telephone number to be established by the Carrier that enables consumers to determine the status or outcome of Utilization Review decisions;

_____ (p) A statement detailing what translator and interpretation services are available to assist Insureds, including that the Carrier will provide, upon request, interpreter and translation services related to administrative procedures. The statement must appear in at least the languages identified by the Centers for Medicare & Medicaid Services as the top non-English languages in Massachusetts, 211 CMR 52.13(3)(p) shall apply to Carriers, including Dental and Vision Carriers.

INTERNET WEBSITE [211 CMR 52.13(4)

Does the carrier refer Insureds to an Internet Website where information described within the Evidence of Coverage can be accessed? *[Internet Websites. 211 CMR 52.13(4)]*
YES ___ NO ___

IF YES ADDRESS THE FOLLOWING:

If the Dental Carrier, refers the Insured to resources where the information described in the Evidence of Coverage can be accessed, including, but not limited to, an Internet Website, such Carrier must be able to demonstrate compliance with applicable law, and with the following with respect to the Internet Website:

The Carrier **has issued and delivered written notice** to the Insured that includes:

1. All necessary information and a clear explanation of the manner by which Insureds can access their specific Evidence of Coverage and any amendments thereto through such Internet Website;
2. A list of the specific information to be furnished by the Carrier through an Internet Website;
3. The significance of such information to the Insured;
4. The Insured's right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;
5. The manner by which the Insured can exercise the right to receive a paper copy at no cost to the Insured; and
6. A toll-free number for the Insured to call with any questions or requests. *[211 CMR 52.13(4)(a)]*

ATTACH A COPY OF THE WRITTEN NOTICE ADRESSING ITEMS 1-6

The Carrier has taken reasonable measures to ensure that the information and documents furnished in an Internet Website is substantially the same as that contained in its paper documents. All notice and time requirements applicable to Evidences of Coverage shall apply to information and documents furnished by an Internet Website. . *[211 CMR 52.13(4)(b)]*

Certify that the carrier complies with this requirement.

_____

_____

The Carrier has taken reasonable measures to ensure that it furnishes, upon request of the Insured, a paper copy of the Evidence of Coverage and any amendments thereto. . *[211 CMR 52.13(4)(c)]*

Certify that the carrier complies with this requirement.

_____

_____

A Carrier, including a Dental and Vision Carrier, shall always deliver at least one Evidence of Coverage to the group representative of a group plan, notwithstanding the provisions of 211 CMR 52.13, 52.14 or 52.15. *[Group Plans. 211 CMR 52.13(5)]*

Certify that the carrier complies with this requirement.

REQUIREMENTS ONLY FOR DENTAL PLANS OFFERING PREFERRED PROVIDER DENTAL BENEFITS

EVIDENCE OF COVERAGE [211 CMR 51.05]:
The Evidence of Coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O, 211 CMR 51.00 and 52.00: Managed Care Consumer Protections and Accreditation of Carriers. As noted in 211 CMR 51.05(2), "[t]he Evidence of Coverage must also include the following in clear and understandable language:

_____	(a) a complete description of the benefit differential between services offered by Preferred Providers and non-preferred providers;
_____	(b) Provisions that if a Covered Person receives Emergency Care and cannot reasonably reach a Preferred Provider, payment for such care will be made at the same level and in the same manner as if the Covered Person had been treated by a Preferred Provider;
_____	(c) Benefit levels for covered Health Care Services rendered by non-preferred providers must be at least 80% of the Benefit Levels for the same covered Health Care Services rendered by Preferred Providers. 1. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a Usual and Customary Charge, and not a percentage of the amount paid to Preferred Providers. 2. The 80% requirement shall be met if the coinsurance percentage for Health Care Services rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same Health Care Services rendered by a Preferred Provider, excluding reasonable deductibles and copayments.
_____	(d) A description of all benefits required to be provided by law in accordance with all of the provisions of the Organization's enabling or licensing statutes.