INDIVIDUAL 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 individual plan:

All dental carriers should complete pages 1-8

Dental Carriers offering insured plans through a network of providers should complete pages 9-14

Dental Carriers offering insured plans with differing benefits for services when provided by network ("preferred") compared to out-of-network providers should complete page 15

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, it should separately complete checklist: https://www.mass.gov/doc/initial-approval-of-an-insured-preferred-provider-plan/download.

When completing this checklist, 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 this checklist that is not complete will be returned for completion.***

REQUIREMENTS FOR ALL INDIVIDUAL PLANS

_____ Submit a certification by a company official that each form meets the standards of M.G.L. c. 175, § 2B. If insurer feels that any form is exempt from M.G.L. c. 175, § 2B, the certification should state reason(s) for exemption. The term "text" includes all printed matter except the name and address of the insurer, name or title of the policy, captions and subcaptions, and schedule pages and tables used in the policy.

Cover Page

_____ Company name, address and telephone number are listed.

_____ Pre-existing conditions are to appear as a separate paragraph on the cover page. *[211 CMR 42.05(1)(b)]*

_____ Policies are to include at least a 10-day right of examination from date of delivery, and such right must be explained in the policy. [*211 CMR 42.05(1)(e)]*

Disclosure

If any of the following definitions are used, they are to conform with the following:

_____ **Class** "underwriting/rating classifications used when policy originally issued." [*211 CMR*

_____ *42.04]*

Policy - "any [insured] policy, plan, certificate, contract, agreement, statement of coverage, rider or endorsement which provides insurance benefits whether as a service or on an

_____ indemnity reimbursement or prepaid basis." [*211 CMR 42.04]*

Pre-existing condition - "condition for which an insured persons received dental advice or treatment during a period to be determined by the carrier prior to the effective date of coverage or because of which an individual had symptoms which would have led an

_____ ordinarily prudent person to seek dental advice or treatment for that dental condition." *211 CMR 42.04*

Sickness - "must be defined to be no more restrictive that a sickness or disease of an insured that first manifests itself after the effective date of insurance and while the insurance is in force. *[211 CMR 42.04]*

_____ A carrier's policy name may not misrepresent the extent of benefits actually provided nor may a name be used which conflicts with the prescribed category name or which is similar to the prescribed name of a different category. No misleading policy names may be used and no policy may be marketed or advertised as a group policy unless it qualifies as such *[211 CMR 42.09(1)(a)]*

_____ A policy paying benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import must define and explain the terms

_ in its outline of coverage. *[211 CMR 42.05(1)(a)]*

_____ If age is to be used as a determining factor for reducing benefits made available in the policy as originally issued, such fact must be prominently set forth in the policy. *[211 CMR 42.09(1)(b)]*

_____ All insurance policies must contain a renewability provision on the first page of the policy in a highlighted section. *[211 CMR 42.09(1)(c)]*

Policies providing conversion privileges must specify the benefits to be provided or shall state that the converted coverage shall be on the policy form then being issued by the company for this purpose. *[211 CMR 42.09(1)(f)]*

_____ Pre-existing limitations must appear as a separate paragraph of the policy and be labeled as "Pre-existing Condition Limitations." *[211 CMR 42.05(1)(b)]*

_____ The policy must clearly explain all limitations and elimination periods, including elimination periods affecting different levels of benefits. *211 CMR 42.05(2)(g)*

Uniform Provisions M.G.L. c. 175, §108 3.(a) – To be consistent with the law

_____ (1) ***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) ***Time Limit on Certain Defenses***. — 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 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 until avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of provisions (1) to (5), inclusive, of paragraph (b) of this subdivision, in the event of misstatement at least age fifty, or, in the case of a policy issued after age forty-four, for at least five years from its date of issue, may contain in lieu of the foregoing provision the following provision 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 statements contained in the application.

_____ (3) ***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 in which the insurer reserves the right to refuse renewal shall have, at the beginning of the above provision:— Unless not less than thirty days prior to the premium due date the insurer has delivered to the insured or has mailed to his 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.

_____ (4) ***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; provided, however, that 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. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement.

_____ The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums until at least age fifty, or, in the case of a policy issued after age forty-four, for at least five years

from its date of issue.

_____ (5) ***Notice of Claim***. — Written notice of claim must be given to the insurer within twenty 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) ***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 fifteen 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) ***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 ninety days after the termination of the period for which the insurer is liable and in case of claim for any other loss within ninety 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) ***Time of Payment of Claims***. — Indemnities payable under this policy for any loss other than loss for which this policy provides any 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) ***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.

_____ (11) ***Legal Actions***. — No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty 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.

Optional Provisions M.G.L. c. 175, §108 3.(b) – To be consistent with law if in policy

_____ (2) ***Misstatement of Age.*** — If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

_____ (3) ***Other Insurance in This Insurer.*** — If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for [insert type of coverage or coverages] in excess of [insert maximum limit of indemnity or indemnities] the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

or, in lieu thereof:—

_____ Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

_____ (4) ***Insurance with Other Insurers.*** — If there be other valid coverage, not with this insurer,

providing benefits for the same loss on a provision of service basis or on an expense incurred basis and of which this insurer has not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense incurred coverage of this policy shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverages for the same loss of which this insurer had notice bears to the total like amounts under all valid coverages for such loss, and for the return of such portion of the premiums paid as shall exceed the pro-rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the like amount of such other coverage shall be taken as the amount which the services rendered would have cost in the absence of such coverage.

_____ If the above policy provision (4) is included in a policy which also contains the next following policy provision there shall be added to the caption of said provision (4) the phrase EXPENSE INCURRED BENEFITS. The insurer may, at its option, include in this provision a definition of other valid coverage, approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the commissioner. In the absence of such definition such term shall not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations or by union welfare plans or employer or employee benefit organizations. For the purpose of applying policy provision (4) with respect to any insured, any amount of benefit provided for such insured pursuant to any compulsory benefit statute including any workers' compensation or employer's liability statute whether provided by a governmental agency or otherwise shall in all cases be deemed to be other valid coverage of which the insurer has had notice. In applying said policy provision (4) no third party liability coverage shall be included as other valid coverage.

_____ (7) ***Unpaid Premium***. — Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

_____ (9) ***Conformity with State Statutes***. — Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

Application Forms

_____ The application forms must contain a question to elicit information as to whether the insurance to be issued is to replace any other accident and sickness insurance currently in force. A supplementary application or other form to be signed by the applicant containing

_____ such a question may be used. *[211 CMR 42.08(1)]*

Any rider, amendment or endorsement used to reduce or eliminate coverages at date of policy issue shall be ineffective without the signed acceptance by the insured policyholder. *[211 CMR 42.09(2)]*

_____ Riders or endorsements that provide a benefit for which a specific premium is charged shall show the premium on the application, rider or elsewhere in the policy. [*211 CMR 42.09(2)]*

_____ When the Medical Information Bureau is used by the insurer, the policy application or another appropriate notice shall indicate the possible use of this service as it relates to medical information concerning the insured. [*211 CMR 42.09(2)]*

Replacement Forms *42.08(2))*

_____ An agent or carrier soliciting the sale, upon determining that the sale would involve replacement must furnish to the applicant, at the time of taking the application, or before the policy is issued, the below noted notice. A copy of the notice must be left with or retained by the applicant and a signed copy must be retained by the carrier. [*211 CMR 42.08(2)]*

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

_____ According to (your application)/(the information furnished by you), you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by _____Insurance Company. For your own information and protection, certain facts should be pointed out to you which could affect your rights to coverage under the new policy.

_____ 1. Health conditions which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which may been payable under your present policy.

2. Even though some of your present health conditions may be covered under the new

_____ policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

3. Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits

_____ thereunder may be voided.

4. It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right, under the policy you have chosen.

_____ The above "Notice to Applicant" was delivered to me on _____

_____Applicant

_____

Confidentiality of Information (M.G.L. c. 175I)

A notice of information practices must be provided to all applicants no later than at the time the application for insurance is made. The notice must be in writing and must contain

EITHER:

_____ whether personal information may be collected from persons other than the individual proposed for coverage; [*M.G.L. c. 175I § 4(b)(1)]*

_____ the type of personal information that may be collected and the type of source and investigative technique that may be used to collect such information; *[M.G.L. c. 175I § 4(b)(2)]*

_____ the type of disclosure permitted by chapter 175I and the circumstances under which such disclosure may be made without prior authorization: provided, however, that only such circumstances need be described which occur with such frequency as to indicate a general business practice; *[M.G.L. c. 175I § 4(b)(3)]*

_____ a description of the rights established under sections eight, nine and ten and the manner in which such rights may be exercised: *[M.G.L. c. 175I § 4(b)(4)]*

_____ *§ 8* describes the right of an individual to obtain any personal information collected or maintained by the insurer upon written request, including any persons to whom the insurer has disclosed the information, and procedures by which such information may be corrected, amended, or deleted.

_____ *§ 9* describes the right of an individual to have factual errors corrected and any misrepresentation or misleading information amended or deleted upon written request.

_____ *§ 10* describes the right of an individual to receive the specific reason for an adverse underwriting decision in writing.

_____ that information obtained from a report prepared by an insurance-support organization may be retained by the insurance-support organization and disclosed to other persons. *[M.G.L. c. 175I § 4(b)(5)]*

OR:

_____ an abbreviated notice may be used that informs the applicant that:

_____ personal information may be collected from a person other than the individual proposed for coverage; *[M.G.L. c. 175I § 4(c)(1)]*

_____ such information as well as other personal or privileged information subsequently collected by the insurance institution or insurance representative may in certain circumstances be disclosed to a third party without authorization; *[M.G.L. c. 175I § 4(c)(2)]*

_____ a right of access and correction exists with respect to all personal information collected; *[M.G.L. c. 175I § 4(c)(3)]*

_____ the more detailed notices described above will be furnished to the applicant upon request. *[M.G.L. c. 175I § (4)(c)(4)]*

_____ **AND:**

Any disclosure authorization form must meet requirements of *M.G.L. c. 175I § 6*:

1. is written in plain language
2. is dated
3. specifies the types of persons authorized to disclose information about the individual
4. specifies the nature of the information to be disclosed
5. names the insurance company and identifies by generic reference the person to whom the applicant is authorizing information to be disclosed.
6. specifies the purposes for which the information is collected.
7. specifies that the authorization shall be valid for no longer than thirty months from the time it is signed
8. advises the applicant that they/their authorized representative are entitled to receive a copy of the authorization form.

Outline of Coverage/Policy Summary/Disclosure Form

_____ No individual accident and sickness insurance policy or contract may be delivered or issued for delivery in Massachusetts unless the disclosure form is delivered with the policy, or is delivered to the applicant at the time application is made. [*211 CMR 42.09(3)(a)]*

_____ The summary must be a part of the policy and must be plainly printed in light-faced type of a style in general use, size of which shall be uniform and not less than 10-point with lower-case unspaced alphabet length not less than 12-point. *[211 CMR 42.09(3)(a)]*

_____ If the policy is issued on a changed basis from what was originally requested, a revised summary must be affixed to the policy. *[211 CMR 42.09(3)(b)]*

In the event that the policy is issued on a basis other than that applied for, the outline of coverage must contain the following statement, in no less than 12-point type, immediately above the company name:

_____ "NOTICE: Read this outline carefully. The coverage you originally applied for has not been issued. This policy is therefore not identical to the coverage you requested - it differs in the following respects: [list]" *211 CMR 42.09(1)(d)*

_____ Except as otherwise provided, disclosure forms must provide the following information when it is applicable to the form: *[211 CMR 42.09(3)(c)]*

1. Name of the carrier, description of the policy type, the policy number.
2. Description of benefits in a manner that does not misrepresent the actual coverage provided in the policy.
3. Any deductibles, coinsurance, and benefit maximums.
4. Whether the policy is renewable to eligibility to Medicare.
5. Whether there are any age limitations.
6. Whether the policy is subject to premium increases.
7. Any pre-existing condition limitations
8. Any waiting periods.
9. Whether mental illness is covered and the extent of benefits.
10. Whether pregnancy is covered.
11. Free look provisions and the procedure for returning the policy for a refund.
12. The following statement or similar language as approved by the Commissioner: "Read your policy carefully. This disclosure statement is a very brief summary of your policy. The policy itself sets forth the rights and obligations of both you and the insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY."
13. Exclusions, limitations and reductions listed in a manner that does not misrepresent the actual coverage provided.
14. The following statement or similar language as approved by the Commissioner "COMPLAINTS: If you have a complaint, call us at [ ] or your agent. If you are not satisfied, you may call the Massachusetts Division of Insurance."

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]*:

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)]*

Certify that the carrier complies with this requirement.

_____

_____

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)]*

Certify that the carrier complies with this requirement.

_____

_____

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)]*

Certify that the carrier complies with this requirement.

_____

_____

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)]*

Certify that the carrier complies with 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, and if there are preexisting condition limitations or exclusions, they must be labeled as "Preexisting Condition Provision" and appear as a separate paragraph on the first page of the policy;

_____ (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.