MANAGED CARE *GROUP* STAND-ALONE VISION & DENTAL PRODUCTS

Pursuant to the Requirements of
M.G.L. c. 176I & c. 176O and regulations 211 CMR 51.00 & 211 CMR 52.00

NOTE TO CARRIERS COMPLETING THIS CHECKLIST:
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.***

NOTE: A FILING THAT DOES NOT INCLUDE ALL APPLICABLE MATERIALS AND SUPPORTING DOCUMENTATION WILL BE RETURNED AND NOT REVIEWED.

Date: ______________________________

Carrier Name & NAIC #: ______________________________

Contact Name & Title: ______________________________

Address: ______________________________

Telephone & Fax: ______________________________

Email Address: ______________________________

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

NEW APPLICATION SUBMISSIONS
(Pursuant to M.G.L. c. 176I & 211 CMR 51.00)
CARRIERS SEEKING APPROVAL OF AN INTIAL APPLICATION MUST COMPLETE ALL PAGES OF THIS DOCUMENT.

MATRIAL CHANGE SUBMISSIONS
(Pursuant to M.G.L. c. 176I & c. 176O and regulations 211 CMR 51.00 & 211 CMR 52.00)
CARRIERS SUBMITTING A MATERIAL CHANGE SHOULD REVIEW ALL PAGES AND COMPLETE OLNY THOSE PAGES THAT ARE APPLICABLE TO ANY ADDITION(S) OR CHANGE(S) TO MATERIAL(S) PREVIOUSLY SUBMITTED.

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.

PLEASE REVIEW THE FOLLOWING ADDITIONAL CHECKLIST, COMPLETE AND FORWARD WITH YOUR SUBMISSION:

- Checklist For The Initial Approval Of An Insured Preferred Provider Plan (Form# Application For Approval - Insured Preferred Provider Plan ver091217)

Initials______

CARRIER ACKNOWLEGMENTS:

According to 211 CMR 51.05, "[t]he Evidence of Coverage, including all amendments and material changes, must be submitted to the Commissioner for approval. 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*."

Initials______

According to 211 CMR 51.06(1), "[e]ach Organization with a Preferred Provider Health Plan…shall file with the Commissioner ***any material changes or additions*** to the material previously submitted on or before their effective date, including amendments to an Evidence of Coverage and significant changes to the lists of Preferred Providers."

Initials______

According to 211 CMR 52.02 the term "material change" is defined as "[a] modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of:

- an Insured;
- a Carrier, including a Dental or Vision Carrier; and/or
- a health, Dental, or Vision Care Provider."

Initials______

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______

When submitting a material change to a previously filed application for approval of an insured preferred provider plan –

- complete only those sections of the checklist(s) specific to the submission and
- include red-line version(s) of the previously filed document(s).

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______

BULLETIN 2013-07

The Commonwealth Health Insurance Connector Authority ("Health Connector"), is the designated state-based Exchange for health and dental coverage for individuals, families and small businesses. It is the Health Connector that certifies stand-alone dental plans [Qualified Dental Plans - "QDPs"] in Massachusetts and it is only those carriers that have been certified by the Health Connector that may offer "QDPs."

As stated in Bulletin 2013-07, "[w]hen a Carrier files a stand-alone dental plan [including riders to be attached to a stand-alone dental plan] with the Division intended to be offered outside of the Exchange, the Carrier must indicate in the filing whether the stand-alone dental plan incorporates, at a minimum, the same benefits as a QDP that the Carrier [emphasis added] is offering within the Exchange…"

NOTICES IN STAND-ALONE DENTAL CERTIFICATES:

Identify the section where the appropriate notification language has been included within the certificate

1. According to Bulletin 2013-07, "[a]ll Carriers that are offering or renewing health plans must disclose, at the time of solicitation, whether a plan covers dental benefits at the pediatric dental EHB level. The Division recommends that Carriers use the following example of notification language for plans sold outside the Exchange that include the pediatric dental EHB:

_______	This policy includes coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

2. The Division recommends that Carriers use the following example of notification language for plans sold outside the Exchange that do not include dental benefits at the pediatric dental EHB level:

_______	This policy DOES NOT include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. It will only be offered when the Carrier is reasonably assured that an applicant is covered by a stand-alone dental plan with the required level of coverage for pediatric dental services.

3. The Division recommends that Carriers use the following example of notification language for plans sold inside the Exchange that do not include dental benefits at the pediatric dental EHB level:

_______	This policy DOES NOT include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. Coverage of the appropriate level of pediatric dental services may be purchased as a stand-alone plan. You can purchase an Exchange-certified stand-alone dental plan that includes the appropriate level of coverage for pediatric dental services from products offered by the Commonwealth Health Insurance Connector Authority.

In order to be clear that the filed plan IS NOT an Exchange certified stand-alone dental plan, consider the following example of notification language:

_______	"This policy may include coverage of pediatric dental services as required under the federal Patient Protection and Affordable Care Act. However, this plan IS NOT an Exchange-certified stand-alone dental plan. You can purchase an Exchange-certified stand-alone dental plan that includes the appropriate level of coverage for pediatric dental services from products offered by the Commonwealth Health Insurance Connector Authority."

MATERIALS NECESSARY FOR COMPLIANCE
MANAGED CARE STAND-ALONE VISION OR DENTAL PLANS
(Pursuant to M.G.L. c. 176O and 211 CMR 52.00)

DEFINITIONS (if used) [211 CMR 52.02]:

INSERT PAGE#&SECTION

________	Actively Practices. A Health Care Professional who regularly treats patients in a clinical setting.
________	Administrative Disenrollment. A change in the status of an Insured whereby the Insured remains with the same Carrier but his or her membership may appear under a different identification number. Examples of an Administrative Disenrollment are a change in employers, a move from an individual plan to a spouse's plan, or any similar change that may be recorded by the Carrier as both a disenrollment and an enrollment.
________	Adverse Determination. A determination, based upon a review of information provided, by a Carrier or its designated Utilization Review Organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other Health Care Services, for failure to meet the requirements for coverage based on Medical Necessity, appropriateness of health care setting and level of care, or effectiveness, including a determination that a requested or recommended Health Care Service or treatment is experimental or investigational.
________	Alternative Payment Contract. Any contract between a Carrier and a Provider or Provider organization that utilizes alternative payment methodologies, which are methods of payment that are not solely based on fee-for-service reimbursements and that may include, but is not limited to, shared savings arrangements, bundled payments, global payments, and fee-for-service payments that are settled or reconciled with a bundled or global payment.
________	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.
________	Carrier. 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 health maintenance organization organized under M.G.L. c. 176G; and 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 of one or more subsidiaries or affiliated corporations of the employer. Unless otherwise noted, the term "Carrier" shall not include any entity to the extent it offers a policy, certificate, or contract that is not a health benefit plan as defined in M.G.L. c. 176J, § 1.
________	Clinical Review Criteria. The written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by a Carrier to determine the Medical Necessity and appropriateness of Health Care Services.
________	Commissioner. The Commissioner of Insurance, appointed pursuant to M.G.L. c. 26, § 6, or his or her designee.

INSERT PAGE#&SECTION

________	Complaint. (a) any Inquiry made by or on behalf of an Insured to a Carrier or Utilization Review Organization that is not explained or resolved to the Insured's satisfaction within three business Days of the Inquiry; (b) any matter concerning an Adverse Determination; or (c) in the case of a Carrier or Utilization Review Organization that does not have an internal Inquiry process, a Complaint means any Inquiry.
________	Concurrent Review. Utilization Review conducted during an Insured's inpatient hospital stay or course of treatment.
________	Cost Sharing or Cost-sharing. Includes 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. Health Care Services to which an Insured is entitled under the terms of the Health 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.
________	Emergency Medical Condition. A medical condition, whether physical, behavioral, related to substance use disorder, or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an Insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(l)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

INSERT PAGE#&SECTION

________	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. For workers' compensation preferred provider arrangements, the Evidence of Coverage will be considered to be the information annually distributed pursuant to 211 CMR 51.04(3)(i)1. through 3.
________	Finding of Neglect. A written determination by the Commissioner that a Carrier has failed to make and file the materials required by M.G.L. c. 176O or 211 CMR 52.00 in the form and within the time required.
________	Health Care Professional. A physician or other health care practitioner licensed, accredited or certified to perform specified Health Services consistent with the law.
________	Health Care Provider or Provider. A Health Care Professional or Facility.
________	Health Care Services or Health Services. Services for the diagnosis, prevention, treatment, cure or relief of a physical, behavioral, substance use disorder or mental health condition, illness, injury or disease.
________	Incentive Plan. Any compensation arrangement between a Carrier and Health Care Professional or Licensed Health Care Provider Group or organization that employs or utilizes services of one or more licensed Health Care Professionals that may directly or indirectly have the effect of reducing or limiting specific services furnished to Insureds of the organization. Incentive Plan shall not mean contracts that involve general payments such as Capitation payments or shared risk agreements that are made with respect to Health Care Professionals or Providers, or Health Care Professional groups or Provider groups which are made with respect to groups of Insureds if such contracts, which impose risk on such Health Care Professionals or Providers or Health Care Professional groups or Provider groups for the cost of medical care, services and equipment provided or authorized by another Health Care Professional or Provider or by another Health Care Professional group or Provider group, comply with 211 CMR 52.00.
________	Inquiry. Any communication by or on behalf of an Insured to the Carrier or Utilization Review Organization that has not been the subject of an Adverse Determination and that requests redress of an action, omission or policy of the Carrier.
________	Insured. An enrollee, covered person, Insured, member, policy holder or subscriber of a Carrier, including a Dental or Vision Carrier, including an individual whose eligibility as an Insured of a Carrier is in dispute or under review, or any other individual whose care may be subject to review by a Utilization Review program or entity as described under the provisions of M.G.L. c. 176O, 211 CMR 52.00 and 958 CMR 3.000: *Health Insurance Consumer Protection*.
________	Internet Website. Includes, but shall not be limited to, an internet website, an intranet website, a web portal, or electronic mail.

INSERT PAGE#&SECTION

________	Licensed Health Care Provider Group. A partnership, association, corporation, individual practice association, or other group that distributes income from the practice among members. An individual practice association is a Licensed Health Care Provider Group only if it is composed of individual Health Care Professionals and has no subcontracts with Licensed Health Care Provider Groups.
________	Limited Health Services. Pharmaceutical services, and such other services as may be determined by the Commissioner to be Limited Health Services. Limited Health Services shall not include hospital, medical, surgical or emergency services except as such services are provided in conjunction with the Limited Health Services set forth in the preceding sentence.
________	Material Change. A modification to any of a Carrier's, including a Dental or Vision Carrier's, procedures or documents required by 211 CMR 52.00 that substantially affects the rights or responsibilities of: (a) an Insured; (b) a Carrier, including a Dental or Vision Carrier; and/or (c) a health, Dental, or Vision Care Provider.
________	Medical Necessity or Medically Necessary. Health Care Services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the Insured in question considering potential benefits and harms to the individual; (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, is based on scientific evidence.
________	Network or Provider Network. A group of health, Dental or Vision Care Providers who contract with a Carrier, including a Dental or Vision Carrier, or affiliate to provide health, Dental or Vision Care Services to Insureds covered by any or all of the Carrier's, including a Dental or Vision Carrier's or affiliate's, plans, policies, contracts or other arrangements. Network shall not mean those Participating Providers who provide services to subscribers of a nonprofit hospital service corporation organized under M.G.L. c. 176A, or a nonprofit medical service corporation organized under M.G.L. c. 176B.
________	Nongatekeeper Preferred Provider Plan. An insured preferred provider plan approved for offer under M.G.L. c. 176I which offers preferred Benefits when a covered person receives care from preferred Network Providers but does not require the Insured to designate a Primary Care Provider to coordinate the delivery of care or receive referrals from the Carrier or any Network Provider as a condition of receiving Benefits at the preferred benefit level.
________	Participating Provider. A Provider who, under a contract with the Carrier, including a Dental or Vision Carrier, or with its contractor or subcontractor, has agreed to provide health, Dental or Vision Care Services to Insureds with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the Carrier, including a Dental or Vision Carrier.
________	Prospective Review. Utilization Review conducted prior to an admission or a course of treatment. Prospective Review shall include any pre-authorization and pre-certification requirements of a Carrier or Utilization Review Organization.
________	Retrospective Review. Utilization Review of Medical Necessity that is conducted after services have been provided to a patient. Retrospective Review shall not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

INSERT PAGE#&SECTION

________	Service Area. The geographical area as approved by the Commissioner within which the Carrier, including a Dental or Vision Carrier, has developed a Network of Providers to afford adequate access to members for covered Health, Dental or Vision Services.
________	Utilization Review. Set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, Health Care Services, procedures or settings. Such techniques may include, but are not limited to, Ambulatory Review, Prospective Review, Second Opinion, certification, Concurrent Review, Case Management, Discharge Planning or Retrospective Review.
________	Utilization Review Organization. An entity that conducts Utilization Review under contract with or on behalf of a Carrier, but does not include a Carrier performing Utilization Review for its own Health Benefit Plans. A Behavioral Health Manager is considered a Utilization Review Organization.
________	Vision Benefit Plan. A policy, contract, certificate or agreement of insurance entered into, offered or issued by a Carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs solely for Vision Care Services.
________	Vision Care Professional. An ophthalmologist, optometrist or other practitioner licensed, accredited or certified to perform specified Vision Services consistent with the law.
________	Vision Care Provider. A Vision Care Professional; or a Facility licensed to perform and provide Vision Care Services.
________	Vision Care Services or Vision Services. Services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.
________	Vision Carrier. An entity that offers a policy, certificate or contract that provides coverage solely for Vision Care Services and is: an insurer licensed or otherwise authorized to transact accident or health insurance under M.G.L. c. 175; an optometric service corporation organized under M.G.L. c. 176F, 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 of one or more subsidiaries or affiliated corporations of the employer, that offers a policy, certificate or contract that provides coverage solely for Vision Care 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 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) Health Care Professionals shall not profit from provision of covered services that are not Medically Necessary or medically appropriate. (b) Carriers shall not profit from denial or withholding of covered services that are Medically Necessary or medically 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)]* **Identify the section(s) and page number(s) of the provider contracts(s) that address the above-noted requirement by line item.**

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.

Provide a statement that advises whether the carrier has issued new contracts as described above, and if so, reference the section(s) of the provider contract that address the above. *[211 CMR 52.11(4)]*

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Contracts between Carriers and Health Care Providers shall require Providers to comply with the 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.

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PROMPT PAYMENT

(see also M.G.L. c. 176A, § 8(e); M.G.L. c. 176B, § 7; M.G.L. c. 176G, § 6; M.G.L. c. 176I, § 2)

INSERT PAGE#&SECTION

___________	According to M.G.L. c. 175, § 110(G), "[w]ithin forty-five days from . . . receipt of notice [of a claim by a claimant] if payment is not made the insurer shall notify the claimant in writing specifying the reasons for the nonpayment or whatever further documentation is necessary for payment of said claim within the terms of the policy. If the insurer fails to comply with the provisions of this paragraph, said insurer shall pay, in addition to any benefits which inure to such claimant or provider, interest on such benefits, which shall accrue beginning forty-five days after the insurer's receipt of notice of claim at the rate of one and one-half percent per month, not to exceed eighteen percent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim which an insurer is investigating because of suspected fraud." **Please identify the section(s) and page number(s) of the provider contracts(s) that clearly identify the above-noted statute** (See also Bulletin 00-13)

STANDARDS FOR CREDENTIALING [211 CMR 52.14(9) - M.G.L. C. 176O §15(I)]:

A Carrier, including a Dental or Vision Carrier, shall provide to a health, Dental or Vision Care Provider, a written reason or reasons for denying the application of any health, Dental, or Vision Care Provider who has applied to be a Participating Provider.

Confirm that the carrier complies with this requirement.

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EVIDENCES OF COVERAGE 211 CMR 52.13(2)

Dental and Vision Carriers shall issue and deliver to at least one adult Insured in each household residing in Massachusetts, upon enrollment:

a) an Evidence of Coverage;
b) a summary of the information contained in the Evidence of Coverage; or
c) refer the Insured to resources where the information described in such Evidence of Coverage can be accessed, including, but not limited to, an Internet Website.

Provide a detailed narrative explaining how the carrier complies with items a-c., as applicable. Indicating NA is not acceptable.

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FLESCH SCORE DOCUMENTATION (M.G.L. c. 175 §2B)

FORWARD 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, 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.

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

INSERT PAGE#&SECTION

_______ (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;

_______ (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;

_______ (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.

_______ (i) The involuntary disenrollment rate among Insureds of the Carrier. 211 CMR 52.13(3)(i) shall apply to Carriers, including Dental and Vision Carriers.

_______ 1. For the purposes of 211 CMR 52.13(3)(i), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, become disabled, retired or died.

_______ 2. For the purposes of 211 CMR 52.13(3)(i), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.

[211 CMR 52.14(1)(c)]

_______ (c) the voluntary and involuntary disenrollment rate among Insureds of the Carrier;

_______ 1. For the purposes of 211 CMR 52.14(1)(c), Carriers shall exclude all Administrative Disenrollments, Insureds who are disenrolled because they have moved out of a health plan's Service Area, Insureds whose continuation of coverage periods have expired, former dependents who no longer qualify as dependents, or Insureds who lose coverage under an employer-sponsored plan because they have ceased employment or because their employer group has cancelled coverage under the plan, reduced the numbers of hours worked, retired or died.

_______ 2. For the purposes of 211 CMR 52.14(1)(c), the term "voluntary disenrollment" means that an Insured has terminated coverage with the Carrier by nonpayment of premium.

_______ 3. For the purposes of 211 CMR 52.14(1)(c), the term "involuntary disenrollment" means that a Carrier has terminated the coverage of the Insured due to any of the reasons contained in 211 CMR 52.13(3)(j)2. and 3.]

_______ (k) A description of the Carrier's, including a Dental or Vision Carrier's, method for resolving Insured Inquiries and Complaints. For a Health Benefit Plan, this description shall include a description of the internal Grievance process and the external review process consistent with 958 CMR 3.000: *Health Insurance Consumer Protection*, including a description of the process for seeking expedited internal review and concurrent expedited internal and external

reviews pursuant to 958 CMR 3.000

_______ (m) A description of the Office of Patient Protection, including its toll-free telephone number, facsimile number, and Internet Website;

_______ (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 Carriers, including Dental and Vision Carriers;

_______ (o) A summary description of the Utilization Review procedures and quality assurance programs used by the Carrier, including a Dental or Vision 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 Carrier, including any Dental or Vision 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.

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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.

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EVIDENCE OF COVERAGE – ADDITONAL CARRIER RESPONSIBILITIES

Identify the page and section of the form that address the following:
A notice to Insureds regarding Emergency Medical Conditions that states all of the following:

________	1. that Insureds have the opportunity to obtain Health Care Services for an Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the Insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;
________	2. that no Insured shall in any way be discouraged from using the local pre hospital emergency medical service system, the 911 telephone number, or the local equivalent;
________	3. that no Insured will be denied coverage for medical and transportation expenses incurred as a result of such Emergency Medical Condition; and
________	4. if the Carrier requires an Insured to contact either the Carrier or its designee or the Primary Care Provider of the Insured within 48 hours of receiving emergency services, that notification already given to the Carrier, designee or Primary Care Provider by the attending emergency Provider shall satisfy that requirement. *[211 CMR 52.14(1)(d)]*

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.

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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. *[General Notice of Material Changes. 211 CMR 52.13(6)]*

Certify that the carrier complies with this requirement.

A Carrier, including a Dental or Vision Carrier, shall issue and deliver to at least one adult Insured in each household residing in Massachusetts, or in the case of a group policy, to the group representative, prior notice of material modifications in covered services under the health, Dental or Vision Plan, at least 60 Days before the effective date of the modifications. Such notices shall include the following:

a) any changes in Clinical Review Criteria; and
b) a statement of the effect of such changes on the personal liability of the Insured for the cost of any such changes. *[Advance Notice of Material Modifications. 211 CMR 52.13(7)]*

Certify that (1) the carrier complies with this requirement and (2) identify the page & section of the evidence of coverage where this statement may be found.

A Carrier, including a Dental or Vision Carrier, shall submit all Evidences of Coverage to the Bureau at least 30 Days prior to their effective dates. *[Advance Filing of Evidence of Coverage. 211 CMR 52.13(8)]*

Certify that (1) the carrier complies with this requirement and (2) identify the page & section of the evidence of coverage where this statement may be found.

Every Evidence of Coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date. *[Dates Required. 211 CMR 52.13(9)]*

Confirm where this information is located within the face page or secondary page location of the evidence of coverage.

DEPENDENT ELIGIBILITY – Applicable to Vision Stand-Alone Only

According to M.G.L. c. 176A §8BB and M.G.L. c. 176B §4BB, "[a]ny subscription certificate under an individual or group nonprofit hospital service agreement, except certificates which provide stand-alone dental services, supplemental coverage to Medicare or other governmental programs, that is delivered, issued or renewed in the commonwealth, shall provide, as benefits to all individuals or to all group members having a principal place of employment within the commonwealth, coverage to eligible dependents under 26 years of age."

Please identify the section(s) and page number(s) of the evidence of coverage(s) that clearly identify the above-noted statute.

CONTINUATION OF COVERAGE PROVISIONS

According to 211 CMR 52.13(3)(s), evidences of coverage shall contain a clear, concise and complete statement of the requirements for continuation of coverage mandated by state and federal law as follows:

Insured Leaves Group. [This provision applies to dental and vision insurance - *§110D states "Every policy of insurance" under chapter 110.]

According to M.G.L. c. 175 §110D, "[e]very policy of insurance issued after January first, nineteen hundred and sixty-eight under the provisions of section one hundred and ten shall contain a provision that, in the event that the insured person leaves the group covered by such insurance, said person shall remain insured under such policy for a period of thirty-one days thereafter unless, during such period, he shall otherwise be entitled to similar benefits. The provisions of this paragraph shall apply to any policy issued or renewed within or without the commonwealth and which covers residents of the commonwealth.

Please identify the section and page number of the evidence of coverage that completely describes the above-noted statute.

Divorce or of Separate Support. [*M.G.L. c. 175 §110I states "group hospital, surgical, medical, or dental insurance"]

According to M.G.L. c. 175 §110I(a), "[i]n the event of the granting of a judgment absolute of divorce or of separate support to which a member of a group hospital, surgical, medical, or dental insurance plan provided for in section one hundred and ten is a party…

- the person who was the spouse of said member prior to the issuance of such judgment shall be and remain eligible for benefits under said plan,
- whether or not said judgment was entered prior to the effective date of said plan,
- without additional premium or examination therefor, as if said judgment had not been entered; provided, however, that such eligibility shall not be required if said judgment so provides.
- Such eligibility shall continue through the member's participation in the plan until the remarriage of either the member or such spouse
- or until such time as provided by said judgment, whichever is earlier.
- The provision of this section shall apply to any policy issued or renewed within or without the commonwealth and which covers residents of the commonwealth.

According to M.G.L. c. 175 §110I(b), "[i]n the event of the remarriage of the group plan member referred to in subsection (a)…

- the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the member, by means of the addition of a rider to the family plan or the issuance of an individual plan, either of which may be at additional premium rates determined by the commissioner of insurance to be just and reasonable in accordance with the additional insuring risks involved.

Please identify the section and page number of the evidence of coverage that completely describes the above-noted statute.____

Divorce or of Separate Support. [(M.G.L. c. 176A §8F and c. 176B §6B)]
(a) In the event of the granting of a judgment absolute of divorce or of separate support to which a subscriber of a group nonprofit hospital service contract [medical service plan] is a party, the person who was the spouse of said subscriber prior to the issuance of such judgment shall be and remain eligible for benefits under said contract, whether or not said judgment was entered prior to the effective date of said contract, without additional premium or examination therefor, as if said judgment had not been entered; provided, however, that such eligibility shall not be required if said judgment so provides. Such eligibility shall continue through the subscriber's participation in the plan until the remarriage of either the subscriber or such spouse, or until such time as provided by said judgment, whichever is earlier.

(b) In the event of the remarriage of the group contract subscriber referred to in paragraph (a), the former spouse thereafter shall have the right, if so provided in said judgment, to continue to receive benefits as are available to the subscriber, by means of the addition of a rider to the family contract or the issuance of an individual contract, either of which may be at additional premium rates determined by the commissioner of insurance to be just and reasonable in accordance with the additional insuring risks involved.

Please identify the section and page number of the evidence of coverage that completely describes the above-noted statute. ____

GROUP HEALTH CARE INSURERS, TERMINATION OF COVERAGE

Group Health Care Insurers. According to 940 CMR 9.04, it shall be considered an unfair and deceptive act or practice in violation of M.G.L. c. 93A, § 2, for a carrier to deny a member's claim for covered health care services on the grounds that, prior to the date covered health care services were received, the employer's plan has been terminated for nonpayment of premiums, unless the carrier has sent written notice of the termination to the member prior to the date the covered health care services were received in the manner set forth in 940 CMR 9.05.

As defined in 940 CMR 9.04, the term "**Group Health Insurance Plan"** means "[a] contract, arrangement or policy between a Group Health Care Insurer and a Sponsor under which the Group Health Care Insurer agrees to pay for or provide **medical, chiropractic, optometric, dental or other health care services**."

Please identify the section(s) and page number of the evidence of coverage that clearly identify the above-noted regulatory provision.

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APPLICATION FORMS [211 CMR 40.00]:

Form and Content of Policy Applications – [211 CMR 40.13]:

When a person uses an application form to be completed by the applicant as an offer to contract for an insured health plan, such application form shall contain statements disclosing to the applicant the nature of the policy offered for sale. In complying with 211 CMR 40.13 the following guidelines as to the contents and applicability of disclosure requirements shall be used.

_______ 1. If the advertised or marketed policy contains a provision which allows the carrier to deny claims for any loss, where the cause of such loss is in some manner traceable to a condition existing prior to the effective date of the policy, the application shall state clearly and unambiguously in negative terms the nature and extent of that exclusion in accordance with guidelines spelled out in 211 CMR 40.07(3)(a).

[Pre-Existing Conditions - 211 CMR 40.07(3)(a).

A marketing method shall, in negative terms, disclose the extent to which any loss is not covered if the cause of such loss is traceable to a condition existing prior to the effective date of the policy or it shall be considered misleading and therefore prohibited. The use of the term "pre-existing condition" without an appropriate definition or description shall not be used or it shall be considered misleading, and therefore prohibited.]

_______ 2. If the application is for a policy whose benefits are subject to a waiting period either of the deductible kind, *e.g*. "fifth day for sickness" or of the one-time exclusionary kind, "30 day" or "six months for certain conditions," the application must disclose in negative terms the nature of such exclusion.

_______ 3. The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

_______ 4. The application must disclose the premium rate for the policy being solicited.

_______ 5. The application must disclose clearly and unambiguously the terms of renewability and premium guarantee, if any.

_______ 6. At the completion of the above required statements of disclosure space shall be made for the applicant's signature acknowledging understanding of such disclosures.