RESET FORM

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

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

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_____	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)]*

_____

_____

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.

_____

_____

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.

_____

_____

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.

_____

_____

_____

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.

_____

_____

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.

_____

_____

EVIDENCE OF COVERAGE - ADDITONALCARRIER 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.

_____

_____

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.

_____

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.

INDIVIDUAL REQUIREMENTS
FOR PRODUCTS MARKETED AND SOLD IN MASSACHUSETTS

INDIVIDUAL REQUIREMENTS – POLICY:

General Requirements for all individual dental insurance filings:

_____ • Policy or Evidence of Coverage
_____ • Provider Contracts
_____ • Disclosure Statement (Outline of Coverage)
_____ • Application
_____ • Notice of Information Practices
_____ • Replacement form
_____ • Flesch Score Document

INDIVIDUAL REQUIREMENTS – COVER PAGE:

_____ Company name, address and telephone number are listed.

_____ All pre-existing conditions must appear as a separate paragraph on the cover page. 211 CMR 42.05(1)(b)

_____ All policies must 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)

INDIVIDUAL REQUIREMENTS – DEFINITIONS:

Definitions should be in alphabetical order for ease of disclosure of policy provisions and comparison with other policies. If used, must conform with the following:

_____ **Accident, Accidental Injury, Accidental Means** - "must be defined to employ "result" language and may not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition may not be modified or an exception or limitation may be included to provide that injuries shall not include injuries for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law." 211 CMR 42.04

_____ **Class** "underwriting/rating classifications used when policy originally issued." 211 CMR 42.04

_____ **Medicare** - "program established under Title XVIII of federal Social Security Act, "Health Insurance for the Aged Act", 42 UCSC § 1396 et seq., as amended." 211 CMR 42.04

_____ **Policy** - "any 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** - "medical condition for which an insured persons received medical 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 medical advice or treatment for that medical condition, or a pregnancy existing on the effective date of coverage." 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. This definition may be modified to exclude sickness or disease for which benefits are provided under any workmen's compensation, occupational disease, employer's liability or similar law." 211 CMR 42.04

INDIVIDUAL REQUIREMENTS – DISCLOSURE:

_____ 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)

_____ 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 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. 211 CMR 42.09(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)

_____ 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)

_____ 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)

INDIVIDUAL REQUIREMENTS – LIMITATIONS & EXCLUSIONS:

_____ Limitations on benefits should where possible be so labeled in a separate section of the policy or placed with the benefit provisions to which they apply, rather than or in addition to included in other sections of the policy.

_____ Termination of the policy should be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period while the policy was in force may be predicated upon the continuous total disability of the insured or limited to the extent of the benefit period.

_____ 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)

The following exclusions are common and permitted:

_____ 1. Pre-existing

_____ 2. War or act of war, declared or undeclared.

_____ 3. Participation in a felony, riot or insurrection.

_____ 4. Service in armed forces or auxiliary units.
_____ 5. Intentionally self-inflicted injury or attempted suicide.
_____ 6. Aviation (non-fare paying passengers).
_____ 7. Alcohol or drug detoxification or rehabilitation
_____ 8. Government facility, non-Medicaid government program including Medicare, any state or workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services provided by a member of the insured's immediate family and services for which no charge is made in the absence of insurance.

INDIVIDUAL REQUIREMENTS – UNIFORM PROVISIONS:

M.G.L. c. 175, §108 3.(b)

_____ (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 for 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 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 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.

_____ No claim for loss incurred or disability (as defined in the policy) commencing after two years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

_____ (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.

_____ In a policy providing a loss-of-time benefit which may be payable for at least two years, an insurer may at its option insert after the first sentence of provision (5) the following three sentences:—

_____ Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two years, he shall, at least once in every six months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability in whole or in part by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six months preceding the date on which such notice is actually given.

_____ (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.

_____ The following two paragraphs, or either of them, may be added to provision (9) at the option of the insurer:—

_____ If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding [insert an amount which shall not exceed $1,000], to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

_____ Subject to any written direction of the insured in the application or otherwise all or a portion of any indemnities provided by this policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the hospital or person rendering such services; but it is not required that the service be rendered by a particular hospital or person.

_____ (10) ***Physical Examinations.*** — The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

_____ (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.

_____ (12) ***Change of Beneficiary.*** — Unless the insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy

INDIVIDUAL REQUIREMENTS – OPTIONAL PROVISIONS:

M.G.L. c. 175, §108 3.(b)

_____ (1) ***Change of Occupation.*** — If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro-rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is

the more recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable or prior to date of proof of change in occupation with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

_____ (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 C 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.

_____ (5) ***Insurance with Other Insurers.*** — If there be other valid coverage, not with this insurer, providing benefits for the same loss on other than 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 for such benefits under this policy shall be for such proportion of the indemnities otherwise provided hereunder for such loss as the like indemnities of which the insurer had notice (including the indemnities under this policy) bear to the total amount of all like indemnities for such loss, and for the return of such portion of the premium paid as shall exceed the pro-rata portion for the indemnities thus determined.

_____ If policy provision (5) is included in a policy which also contains policy provision (4) there shall be added to the caption of said provision (5) the phrase C OTHER 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 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, or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying said policy provisions (5) 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 the said policy provision (5) no third party liability coverage shall be included as other valid coverage.

_____ (6) ***Overinsurance.*** — see statutory citation

_____ (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.

_____ (10) ***Illegal Occupation.*** — The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

INDIVIDUAL REQUIREMENTS – 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)

_____ 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."

INDIVIDUAL REQUIREMENTS – APPLICATION FORM:

_____ Applications to be attached to policy forms upon issue should be attached to such forms upon submission. If such an application was previously filed and approved or deemed approved, the approximate date of such approval must be noted, if possible.

_____ 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)

_____ **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.

_____ 7. 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.]

_____ 8. 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.

_____ 9. The application must disclose for all health policies whether or not and to what extent benefits are or are not contingent upon hospital confinement.

_____ 10. The application must disclose the premium rate for the policy being solicited.

_____ 11. The application must disclose clearly and unambiguously the terms of renewability and premium guarantee, if any.

_____ 12. At the completion of the above required statements of disclosure space shall be made for the applicant's signature acknowledging understanding of such disclosures.

INDIVIDUAL REQUIREMENTS – CONFIDENTIALITY OF INFORMATION:

Application form must conform to requirements of 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:

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 s/he is entitled to receive a copy of the authorization form.

INDIVIDUAL REQUIREMENTS – REPLACEMENT FORM (211 CMR 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

INDIVIDUAL REQUIREMENTS – RATE FILING:

A rate filing must be enclosed with each policy, rider, or endorsement that affects the premium rate to be charged. 211 CMR 42.06(2)

All rate filings shall at least explain formulas used to derive rates, expected claim costs, assumptions regarding mortality, morbidity and lapse rates, and the detailed commission schedule and anticipated administrative expenses associated with the policy. In order to substantiate rate revision filings, filings must maintain experience for that policy form, may combine experience for different policy forms whether the coverage is substantially the same, and must demonstrate that the carrier is using fund accounting for guaranteed renewable policies to reflect premiums, investment income, losses, expenses, and provisions for reserves specific to that policy form. 211 CMR 42.06(2)
Any rates filed, whether initial or revised, will be disapproved unless the aggregate anticipated loss ratio for the entire period for which rates are computed to provide coverage meets the minimum loss ratio standard for the policy. 211 CMR 42.06(2).

For hospital and medical expense policies (including indemnity policies) and for similar policies: [Check *(√)* type of policy filed]

[ ] No less than 60% for policies sold as optionally renewable policies 211 CMR 42.06(2)(b)1
[ ] No less than 55% for policies sold as conditionally renewable policies 211 CMR 42.06(2)(b)2
[ ] No less than 55% for policies sold as guaranteed renewable policies 211 CMR 42.06(2)(b)2
[ ] No less than 50% for policies sold as guaranteed rate policies 211 CMR 42.06(2)(b)3

Every carrier must maintain on file with the Division an up-to-date rate manual for all individual accident and health policies, riders, and endorsements currently available for sale in Massachusetts, that must include:

(a) name of carrier on each page,
(b) table of contents or index, and
(c) identification by form number of each policy or endorsement to which the rates apply. 211 CMR 42.06(4)

Provide statement to confirm:

A rate filing and/or rate manual & actuarial memorandum needs to be forwarded to actuary for review. 211 CMR 42.06(3)(a)

Provide statement to confirm:

All rate filings are subject to review by an actuary specified by the Commissioner whose costs will be paid by the company submitting the filing. Filing is to include certification from company's Chief Financial Officer that all actuarial costs associated with reviewing the filing will be borne by the company as part of the filing. 211 CMR 42.06(3)(a)

Provide statement to confirm appropriate documents are attached to submission.