

**CHECKLIST FOR GROUP STAND-ALONE VISION AND DENTAL PRODUCTS**

**Pursuant to the Requirements of M.G.L. c. 176O and 211 CMR 52.00**

**& Chapter 162 of the Acts of 2005**

**NOTE TO CARRIERS COMPLETING THIS CHECKLIST:**

*Pursuant to Bulletin No. 2001-05 and 2008-19, please include a completed checklist when submitting an application for an insured preferred provider plan **or a material change to a previously approved product.***

*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.*
- *Please review Chapter 162 of the Acts of 2005 and Bulletin 2006-03.*

**Date:**

**Carrier Name & NAIC #:**

**Contact Name & Title:**

**Address:**

**Telephone & Fax:**

**Email Address:**

**Product Name & Form #:**

**(Attach a separate sheet if necessary.)**

**Carrier Certification:**

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

## **MATERIAL CHANGES**

From time to time carriers modify the materials (i.e. evidences of coverage, (3) amendments, (4) riders, (5) directories, (6) disclosures, (7) application forms, etc.) associated with a previously filed application for approval of an insured preferred provider plan. Should your submission include such changes or additions, please review at least the following additional checklist:

- **CHECKLIST FOR THE INITIAL APPROVAL OF AN INSURED PREFERRED PROVIDER PLAN (Form# Application For Approval - Insured Preferred Provider Plan ver020911):**

Is this submission a material change to an application for approval of an insured preferred provider plan?

YES [  ]                      NO [  ]

**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).**

**A FILING THAT DOES NOT INCLUDE APPLICABLE COMPLETED CHECKLISTS AND SUPPORTING DOCUMENTATION WILL BE RETURNED AND NOT REVIEWED.**

## **APPLICABILITY [211 CMR 52.02]:**

Certain requirements of 211 CMR 52.00 et seq., as specified herein, shall also apply to dental and vision carriers. Such provisions are: 211 CMR 52.12(1) through (4); 211 CMR 52.12(11); 211 CMR 52.13(2); 211 CMR 52.13(3)(a), (c) through (e), (g) through (i), (m) through (p); 211 CMR 52.13(4) through (10); 211 CMR 52.14(1)(c) and (d); 211 CMR 52.14(2), (3) and (7); and 211 CMR 52.18.

## **DEFINITIONS (if used) [211 CMR 52.03]:**

Pg.#\_\_\_ **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 provides coverage solely for dental care services or vision care services.

Pg.#\_\_\_ **Dental carrier**, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; a nonprofit hospital service corporation organized under chapter 176A; a nonprofit medical service corporation organized under chapter 176B; a dental service corporation organized under chapter 176E, or an organization entering into a preferred provider arrangement under chapter 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 dental care services.

Pg.#\_\_\_ **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.

Pg.#\_\_\_ **Dental care professional**, a dentist or other dental care practitioner licensed, accredited or certified to perform specified dental services consistent with the law.

Pg.#\_\_\_ **Dental care provider**, a dental care professional or facility.

Pg.#\_\_\_ **Dental care services**, or dental services, services for the diagnosis, prevention, treatment, cure or relief of a dental condition, illness, injury or disease.

- Pg.# \_\_\_ **Health 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 of health care services. Unless otherwise noted, “health benefit plan” shall not include a dental benefit plan or a vision benefit plan.
- Pg.# \_\_\_ **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 an insured, carrier, including a dental or vision carrier, or health, dental or vision care provider.
- Pg.# \_\_\_ **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.
- Pg.# \_\_\_ **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.
- Pg.# \_\_\_ **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.
- Pg.# \_\_\_ **Vision carrier**, an insurer licensed or otherwise authorized to transact accident or health insurance under chapter 175; an optometric service corporation organized under chapter 176F, or an organization entering into a preferred provider arrangement under chapter 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.
- Pg.# \_\_\_ **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.
- Pg.# \_\_\_ **Vision care professional**, an ophthalmologist, optometrist or other vision care practitioner licensed, accredited or certified to perform specified vision services consistent with the law.
- Pg.# \_\_\_ **Vision care provider**, a vision care professional or facility.
- Pg.# \_\_\_ **Vision care services**, or vision services, services for the diagnosis, prevention, treatment, cure or relief of a vision condition, illness, injury or disease.

**STANDARDS FOR PROVIDER CONTRACTS [211 CMR 52.12]:**

**211 CMR 52.12(1) - M.G.L. c. 176O, § 4**

Contracts between carriers and providers **shall state** that a carrier shall not refuse to contract, or compensate for covered services, with an otherwise eligible health care provider solely because such provider has in good faith:

- Pg.# \_\_\_ (a) communicated with or advocated on behalf of one or more of his 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

Pg.#\_\_\_ (b) communicated with one or more of his 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.

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

**211 CMR 52.12(2) - M.G.L. c. 176O, § 5**

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.

Pg.#\_\_\_ **Please identify the section(s) and page number(s) of the provider contracts(s) that address this requirement.**

**211 CMR 52.12(3) - M.G.L. c. 176O, § 10(a)&(b)**

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.

Pg.#\_\_\_ (a) Health care professionals shall not profit from provision of covered services that are not medically necessary or medically appropriate.

Pg.#\_\_\_ (b) Carriers shall not profit from denial or withholding of covered services that are medically necessary or medically appropriate.

Pg.#\_\_\_ (c) Nothing in 211 CMR 52.12(3) shall be construed to prohibit contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to providers or which are made with respect to groups of insureds if 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 52.12(4).

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

**211 CMR 52.12(4)**

No carrier may enter into a new contract, revise the risk arrangements in an existing contract, or after July 1, 2001, 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:

Pg.#\_\_\_ (a) stop loss protection,

Pg.#\_\_\_ (b) minimum patient population size for the provider group, and

Pg.#\_\_\_ (c) identification of the health care services for which the provider is at risk.

**Please 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 211 CMR 52.12(4)(a)-(c).**

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**211 CMR 52.12(11)**

Nothing in 211 CMR 52.12 shall be construed to preclude a carrier from requiring a health care provider to hold confidential specific compensation terms.

Pg.#\_\_\_ **Please 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)**

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.”

Pg.#\_\_\_ **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(7) - 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.

**Please confirm that the carrier complies with this requirement.**

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**DATES REQUIRED [211 CMR 52.13(10)]:**

Every evidence of coverage described in 211 CMR 52.13 must contain the effective date, date of issue and, if applicable, expiration date.

Pg.#\_\_\_ **Please identify the page where such information may be located.**

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

Dental and vision carriers shall issue and deliver to at least one adult insured in each household residing in Massachusetts, upon enrollment (i) an evidence of coverage, (ii) a summary of the information contained in the evidence of coverage, or (iii) 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. Dental and vision carriers shall be exempt from the provisions of 211 CMR 52.13(3)(b), 211 CMR 52.13(3)(f), 211 CMR 52.13(3)(j) through (l) and 211 CMR 52.13(3)(q) through (y). The evidence of coverage shall contain a clear, concise and complete statement of:

Pg.#\_\_\_ (a) The health, dental or vision care services and any other benefits to which the insured is entitled on a nondiscriminatory basis, including benefits mandated by state or federal law.

(c) the limitations on the scope of health care services and any other benefits to be provided, including:

Pg.#\_\_\_ i. all restrictions relating to preexisting condition exclusions;

Pg.#\_\_\_ ii. an explanation of any facility fee, allowed amount, co-insurance, copayment, deductible or other amount that the insured may be responsible to pay to obtain covered benefits from network or out-of-network providers; and

Pg.#\_\_\_ iii. the toll-free telephone number and website established by the carrier under section 22 and an explanation of the information that an insured may obtain through such toll-free telephone number and website [Amends M.G.L. c. 176O 6(a)(3) - Section 192 of Chapter 224 of the Acts of 2012 effective November 4, 2012].

Pg.#\_\_\_ (d) 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.

(e) the locations where, and the manner in which, health care services and other benefits may be obtained, including:

Pg.#\_\_\_ (i) an explanation that whenever a proposed admission, procedure or service that is a medically necessary covered benefit is not available to an insured within the carrier's network, the carrier shall cover the out-of-network admission, procedure or service and the insured will not be responsible to pay more than the amount which would be required for similar admissions, procedures or services offered within the carrier's network; and

Pg.#\_\_\_ (ii) an explanation that whenever a location is part of the carrier's network, that the carrier shall cover medically necessary covered benefits delivered at that location and the insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by out-of-network providers unless the insured has a reasonable opportunity to choose to have the service performed by a network provider [Amends M.G.L. c. 176O 6(a)(4) - Section 192 of Chapter 224 of the Acts of 2012 effective November 4, 2012].

Pg.#\_\_\_ (g) The criteria by which an insured may be disenrolled or denied enrollment. This provision shall apply to carriers, including dental and vision carriers.

(h) The involuntary disenrollment rate among insureds of the carrier. This provision shall apply to carriers, including dental and vision carriers.

Pg.#\_\_\_ 1. For the purposes of 211 CMR 52.13(3)(h), 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.

Pg.#\_\_\_ 2. For the purposes of 211 CMR 52.13(3)(h), 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)(i)2. and 3.

(i) The requirement that an insured's coverage may be canceled, or its renewal refused, may arise only in the circumstances below. This provision shall apply to carriers, including dental and vision carriers.

Pg.#\_\_\_ 1. 1.failure by the insured or other responsible party to make payments required under the contract;

Pg.#\_\_\_ 2. misrepresentation or fraud on the part of the insured;

Pg.#\_\_\_ 3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of 211 CMR 52.13(3)(i)3;

Pg.#\_\_\_ 4. relocation of the insured outside the service area of the carrier; or

Pg.#\_\_\_ 5. non-renewal or cancellation of the group contract through which the insured receives coverage.

Pg.#\_\_\_ (m)A description of the carrier’s, including a dental or vision carrier’s, method for resolving insured inquiries and complaints;

Pg.#\_\_\_ (n) A summary description of the procedure, if any, for out-of-network referrals and any additional charge for utilizing out-of-network providers. This provision shall apply to carriers, including dental and vision carriers.

Pg.#\_\_\_ (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.

Pg.#\_\_\_ (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 Arabic, Cambodian, Chinese, English, French, Greek, Haitian-Creole, Italian, Lao, Portuguese, Russian and Spanish. This provision shall apply to carriers, including dental and vision carriers. (See also M.G.L. c. 176O, §15 (k))

### **DEPENDENT ELIGIBILITY – Applicable to Vision Stand-Alone Only**

According to M.G.L. c. 175, § 110(P), “[a] blanket or general policy of insurance described in subdivision (A), (C) or (D), except policies or certificates which provide stand-alone dental services or coverage to Medicare or other governmental programs which shall be delivered, issued or renewed in the commonwealth, shall provide, as benefits to all group members having a place of employment in the commonwealth, coverage to dependent persons under 26 years of age.”

Pg.#\_\_\_ **Please identify the section(s) and page number(s) of the evidence of coverage(s) that clearly identify the above-noted statute (See Section 39 of Chapter 35 of the Acts of 2013 - For individual see Section 38 of Chapter 35 of the Acts of 2013)**

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.”

Pg.#\_\_\_ **Please identify the section(s) and page number(s) of the evidence of coverage(s) that clearly identify the above-noted statute (See Section 40 and 41 of Chapter 35 of the Acts of 2013)**

**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:

Pg.#\_\_\_ **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.

**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...

- Pg.#\_\_\_ • 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,
- Pg.#\_\_\_ • whether or not said judgment was entered prior to the effective date of said plan,
- Pg.#\_\_\_ • 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.
- Pg.#\_\_\_ • Such eligibility shall continue through the member’s participation in the plan until the remarriage of either the member or such spouse
- Pg.#\_\_\_ • or until such time as provided by said judgment, whichever is earlier.
- Pg.#\_\_\_ • 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)...

- Pg.#\_\_\_ • 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.

**Divorce or of Separate Support [(M.G.L. c. 176A, §8F and c. 176B, §6B)]**

Pg.#\_\_\_ (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.

Pg.#\_\_\_ (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.

## **GROUP HEALTH CARE INSURERS, TERMINATION OF COVERAGE**

Pg.#\_\_\_ **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.**"

## **REQUIRED DISCLOSURES [211 CMR 52.14]:**

(1) A carrier shall provide to at least one adult insured in each household upon enrollment, and to a prospective insured upon request, the following information:

Pg.#\_\_\_ (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 for 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)(i)2. and 3.

(d) A notice to insureds regarding emergency medical conditions that states all of the following:

Pg.#\_\_\_ 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;

Pg.#\_\_\_ 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;

- Pg.#\_\_\_ 3. that no insured will be denied coverage for medical and transportation expenses incurred as a result of such emergency medical condition; and
- Pg.#\_\_\_ 4. if the carrier requires an insured to contact either the carrier or its designee or the primary care physician of the insured within 48 hours of receiving emergency services, that notification already given to the carrier, designee or primary care physician by the attending emergency physician shall satisfy that requirement.
- Pg.#\_\_\_ (2) The information required by 211 CMR 52.14 may be contained in the evidence of coverage and need not be provided in a separate document.
- Pg.#\_\_\_ (3) Every disclosure described in 211 CMR 52.14 must contain the effective date, date of issue and, if applicable, expiration date.
- Pg.#\_\_\_ (7) 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. **(See also M.G.L. c. 176O, § 15(i))**

**ADVANCE NOTICE OF MATERIAL MODIFICATIONS [211 CMR 52.13(7)]:**

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:

- Pg.#\_\_\_ (a) any changes in clinical review criteria; and
- Pg.#\_\_\_ (b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

**Please confirm that the carrier complies with this requirement and highlight the section of the evidence of coverage that addresses the above-noted provision in detail.**

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**GROUP PLANS [211 CMR 52.13(5)]:**

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, 211 CMR 52.14, or 211 CMR 52.15.

**Please confirm that the carrier complies with this requirement.**

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**GENERAL NOTICE OF MATERIAL CHANGES [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.

**Please confirm that the carrier complies with this requirement.**

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**ADVANCE FILING OF EVIDENCE OF COVERAGE [211 CMR 52.13(8)]:**

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.

**Please confirm that the carrier will comply with this requirement.**

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**INTERNET WEBSITES [211 CMR 52.13(4)]:**

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 the following with respect to the internet website, where the term “internet website” shall include “intranet website,” “electronic mail,” or “e-mail”:

(a) The carrier has issued and delivered written notice to the insured that includes:

- Pg.#\_\_\_ 1. All necessary information and a clear explanation of the manner by which insureds can access their specific evidences of coverage and any amendments thereto through such internet website;
- Pg.#\_\_\_ 2. A list of the specific information to be furnished by the carrier through an internet website;
- Pg.#\_\_\_ 3. The significance of such information to the insured;
- Pg.#\_\_\_ 4. The insured’s right to receive, free of charge, a paper copy of evidences of coverage and any amendments thereto at any time;
- Pg.#\_\_\_ 5. The manner by which the insured can exercise the right to receive a paper copy at no cost to the insured; and
- Pg.#\_\_\_ 6. A toll-free number for the insured to call with any questions or requests.

(b) 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.

**Please confirm that the carrier complies with this requirement.**

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(c) The carrier has taken reasonable measures to ensure that it furnishes, upon request of the insured, a paper copy of evidences of coverage and any amendments thereto.

**Please confirm that the carrier will complies with this requirement.**

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**Carrier DOES [ ] DOES NOT [ ] refer the insured to resources where the information described in the evidence of coverage can be accessed via the web. If carrier does refer to the web, please respond to the above issues.**

## **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.

- Pg.#\_\_\_ 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.]

- Pg.#\_\_\_ 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.
- Pg.#\_\_\_ 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.
- Pg.#\_\_\_ 4. The application must disclose the premium rate for the policy being solicited.
- Pg.#\_\_\_ 5. The application must disclose clearly and unambiguously the terms of renewability and premium guarantee, if any.
- Pg.#\_\_\_ 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.

## **MINIMUM CREDITABLE COVERAGE NOTICES – (BULLETIN 2010-07)**

Bulletin 2010-07 issued on June 29, 2010 replaces Bulletin 2008-02 issued originally on January 15, 2008. According to Bulletin 2010-07, **no minimum creditable coverage statement is required for limited scope vision or dental benefits if offered separately.**

**For purposes of this submission, please confirm that the filed product is not considered a "health plan", as defined in M.G.L. c. 176N and is intended only as a limited scope vision or dental benefit product.**