STATE OF NEW JERSEY
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
MANAGED CARE BUREAU
Telephone No.: (609) 292-7272
Facsimile No.: (609) 633-0527
Web Site: www.state.nj.us/dobi/managed.htm

DENTAL SERVICE CORPORATION (DSC) APPLICATION TO OBTAIN A CERTIFICATE OF AUTHORITY (COA)

PART II OF II –FORMAL APPLICATION

Instructions

1. The information requested in this Formal Application is based upon the Dental Service Corporation Act, **N.J.S.A. 17:48C-1 et seq.** Copies of this statute, and application can be obtained by visiting our website at www.state.nj.us/dobi/managed.htm.

2. **Two (2) copies** of the application must each be remitted in three-ring hard cover binders that identify the submission on the front and spine of the binder, with one check or money order for $5000.00 payable to the Treasurer, State of New Jersey, pursuant to **N.J.A.C. 11:1-32.1 et seq** to the:

   State of New Jersey
   Department of Banking and Insurance
   Managed Care Bureau Chief
   P. O. Box 325
   20 West State Street 11th Floor
   Trenton, NJ 08625-0325

   In addition, submit seven (7) separate copies of items numbered one (1) through seven (7) of Section IV (Financial) without three ring hard cover binders.

3. Complete the application cover sheet and provide responses to all items with supporting documentation as described in the ensuing sections. Number each response and document according to the item number to which it responds. Number each page within the section in the upper right hand section and corner in consecutive order. Tabs should be inserted indicating each of the sections of the application.

STATE OF NEW JERSEY

DENTAL SERVICE CORPORATION (DSC)
APPLICATION TO OBTAIN A
CERTIFICATE OF AUTHORITY (COA)

PART II 0F II-FORMAL APPLICATION
COVER SHEET

_____

Full Name of Applicant Dental Service Corporation (DSC) FEIN Number

_____

Address

_____

City County State Zip Code

_____

Telephone Number Facsimile Number Website Address

Full Name of Chief Executive Officer Telephone Number

_____

CEO Facsimile Number Email Address

_____

Application Administrative Contact Telephone Number

_____

Administrative Contact Facsimile Number Email Address

CERTIFICATION STATEMENT

I Certify that all information and statements made in this application are true, complete and current to the best of my knowledge and belief.

_____

I. General Description:

1. Provide any changes to the information submitted with the Feasibility Study that are not specifically outlined below.

II. Organizational/Legal:

1. Provide executed copies of the basic organizational documents or other applicable documents of the proposed DSC, to include a *certified copy* of the certificate of incorporation. Refer to **N.J.S.A. 17:48C-3** on required language for the certificate of incorporation, which must also bear the acknowledgement of the New Jersey State Treasurer.

2. Provide executed copies of the bylaws (certified by the lawful custodian of the original), rules and regulations or similar documents regulating the conduct of the internal affairs of the proposed DSC. (Refer to **N.J.S.A. 17:48C-3** on required language for the bylaws and **N.J.S.A. 17:48C-4**).

3. **If different than the information filed with the Feasibility Study, Section II, item three (3), provide a list of those names that have not already been provided**, including personal addresses, and official positions of the persons who are to be responsible for the conduct of the affairs of the DSC, including all members of the Board of Directors, Board of Trustees, Executive Committee or other governing board or committee, and the principal officers. For those individuals that are currently licensed to practice dentistry in this state, provide their New Jersey license number to practice dentistry. **(Refer to N.J.S.A. 17:48C-6 and 15)**

4. Provide a copy of any form of contract or agreement made, or to be made, between any person listed in item three (3) above and the applicant.

5. Provide an original fully completed and notarized Biographical Affidavit (**Exhibit A**) for each person listed in item 3 above **that has not already been provided**.

6. Provide an explanation of how the applicant proposes to notify an employer which employs 25 or more employees or members that he must provide an alternative dental coverage plan. **(Refer to N.J.S.A. 17:48C-18.1 and N.J.A.C. 11:10-2.1 et seq.)**

7. Provide a copy of the form that will be required to be completed by each employer or other organization demonstrating compliance with P.L. 1983, c. 142 through 145 **(N.J.S.A. 17:48C-18.1 and N.J.A.C. 11:10-2.1 et seq.)**

8. Provide a description and supporting documentation demonstrating compliance with **N.J.S.A. 17:48C-18.2** on how the employer or other organization shall be required to pay for or contribute towards the provision of alternative coverage.

9. Provide a copy of the Letter of Intent to be utilized by the proposed DSC and participating dentists with skills in appropriate fields and accessible to subscribers, to indicate ability to render the intended dental service. **(Refer to N.J.S.A. 17:48C-5(b))**

10. Provide a complete description of the plan of payments to participating dentists, which were adopted by the board of trustees, recorded in the minutes of a board of trustees meeting, supported by copies of the meeting minutes and resolution adopting these plans or any other party that the DSC will contract with. This description should also include complete information pertaining to any bonus, penalty or withhold mechanisms that are intended to be used. **(Refer to N.J.S.A. 17:48C-12 and 15)**

III. Dental Services

1. Provide a detailed description of the standards of care, criteria and procedures for assessing the quality, adequacy and appropriateness of health care resources utilized.

2. Provide a detailed description of how, when and where emergency/urgent dental services will be made available to subscribers.

3. Provide an Officer Certification that the proposed DSC will not impose any restrictions as to methods of diagnosis or treatment on dentists who administer to the DSC's subscribers. **(Refer to N.J.S.A. 17:48C-3)**

4. As the network is begun to be developed through executed Letters of Intent, provide a list of dentists names and license numbers by county and specialty, which are to provide dental services to the applicants subscribers. Submit a Draft Provider Directory and [final copy when completed]. **(Refer to N.J.S.A. 17:48C-5(b))**

5. Provide a description of the DSC's provider credentialling policies and procedures.

6. Provide a detailed description of the systems and processes utilized to coordinate the Continuous Quality Improvement (CQI) program, including the Utilization Management (UM) and risk management programs.

7. Provide a detailed description of the systems utilized to evaluate the effectiveness of the CQI, UM and risk programs.

8. Provide a detailed description of the complaint system to be utilized by both providers and subscribers for any type of complaint.

9. Provide a description of the system used to monitor subscriber and provider satisfaction and feedback.

IV. Financial

1. Provide updated information to that submitted with the Feasibility Study PART I, if applicable, to include the most recently audited financial statements of the DSC applicant, completed on either a Statutory Accounting Basis (SAP), or Generally Accepted Accounting Principles (GAAP) basis, or both SAP and GAAP if available, with accompanying notes and management letters.

2. Provide copies of management agreements **with non-affiliates** that are intended to be used to effectuate the DSC, not already included in Section II above.

3. Provide copies of management agreements **with affiliates** that are intended to be used to effectuate the DSC, not already included in Section II above**. (Refer to N.J.S.A.17:27A-1 et. seq. and N.J.A.C. 11:1-35.1 et. seq.)**

4. Describe in a one-page summary the DSC's Financial Management Information System.

5. Explain any other financial controls systems, check signing procedures, petty cash, controls, lending policies, time tracking, purchasing policies, bank reconciliation etc. will be utilized.

6. Describe any changes to the detail provided in the Feasibility Study regarding what provisions the DSC will have in place at the beginning of operations for contingency funding and Stop Loss and Insolvency protection. Complete **Exhibit B** (Table of Insurance Coverage).

7. Provide a description of the DSC's Open and Unreported (O&U) claim tracking system, and Coordination of Benefits (COB) system.

8. Provide an explanation of the system used to monitor the quality, accuracy, and timeliness of claim payments in conformance with HINT. **(Refer to N.J.S.A. 17B:30-23, N.J.S.A. 17:48C-8.1 and N.J.A.C. 11:22-1.1 et seq.)**

9. Provide a description of the standards the DSC will use to receive and transmit health care transactions electronically, pursuant to the requirements of **N.J.S.A. 17:48C-8.1**.

10. Provide a copy of the proposed DSC's claim form. **(Refer to P.L. 1999, c. 154 and N.J.A.C. 11:22-3.1 et. seq.)**

11. Provide a description of the DSC's fraud prevention plan, pursuant to the requirements of **N.J.S.A. 17:48C-8.1 et seq**.

<u>Note</u>: If the Feasibility Study (Part I of the Application) is found to be acceptable to the Commissioner, a pre-operational limited scope examination may be required; the cost of which will be borne by the DSC, per N.J.S.A. 17:48C-28.

V. Marketing

1. Provide Draft copies of literature and advertising materials that are proposed to be disseminated to subscribers, employers, brokers, agents or others.

2. Provide the proposed DSC'S member enrollment form. **(Refer to P.L. 1999, c. 154 and N.J.A.C. 11:22-3.1 et. seq.)**

VI. Other

In addition to the above information, the Commissioner may require any other relevant information which is reasonably necessary to determine whether to approve or disapprove this application.

When all items are found to be acceptable to the Commissioner to operate as a DSC, pursuant to N.J.S.A. 17:48C-1 et. seq., and a COA is issued to the applicant, the following items are required to be submitted for regulatory approval before the DSC actually begins to market its services and enroll subscribers:

1. Draft copy/copies of the form of any contract and member handbook to be used by the applicant and an individual or group subscriber, including the applications, riders and endorsements for use in connection with the issuance or renewal of any subscription certificate, to the Department's Health Insurance Bureau (HIB) for regulatory approval. Contact information for the HIB may be found at www.state.nj.us/dobi/llhealth.htm.

   List of References which are not intended to be exhaustive:

   N.J.S.A. 17:48C-7 through 11
   N.J.S.A. 17:48C-13
   N.J.S.A. 17:48C-16 through 18
   N.J.A.C. 11:2-13.1 (Group Coverage Discontinuance and Replacement)
   N.J.A.C. 11:4-28 (Coordination of Benefits)
   N.J.A.C. 11:10-2.1 (Employee's Dental Benefit Plans; Alternative Coverage)

2. Concurrently with item one (1) above, the rates should be sent to the Managed Care Bureau.

Actuarial Requirements for Rate Submission

Note: DSC's are required to include with each submission of new or revised rates an actuarial memorandum which includes anticipated loss ratio, methodology for calculating gross premium, an explanation and documentation supporting the premium assumptions and the objective basis for any rate differentials. The following information shall be included in the actuarial memorandum:

a. The number of years for which the policy is expected to be delivered or issued for delivery in this State, and the number of policies expected to be delivered or issued for delivery in this State for each form in each such year;

b. The anticipated loss ratio calculated over the life of the policy form, with separate disclosures of the present value of future paid benefits and the present value of future paid or written premiums utilized in the calculation of the anticipated loss ratio, when any statutorily required additional actuarial active live reserves are neither reflected in the future benefits nor the future premiums in the calculation;

c. The future benefits on both a paid and incurred basis and the future premiums on both a written and earned basis for each of the years recognized in the calculation of the anticipated loss ratio, when neither the future benefits nor the future premiums include, or are adjusted for, any statutorily required additional actuarial active life reserves;

d. The expected incurred/earned loss ratio for each of the years recognized in the calculation of the anticipated loss ratio, wherein;

    i. The expected incurred claims shall equal expected paid claims adjusted for changes in the expected claim liabilities and claim reserves and in any expected statutorily required additional actuarial active life reserves for each such year; and

    ii. The expected earned premiums shall equal premiums expected to be received adjusted for any changes in expected advance premiums and in expected unearned premium reserves for each such year, but changes in any expected statutorily required additional actuarial active life reserves shall not be included in the adjustment of premiums expected to be received;

e. The assumptions used in the calculation of the loss ratios for each benefit provision wherein the premiums are determined separately including the following:

    i. The annual claim costs (ultimate) by attained age and sex;

    ii. The select and/or anti-select morbidity factors by policy duration (year) by issue, age and sex;

    iii. The lapse and mortality rates, or total termination rates, by policy duration by issue age and sex, and any skewing of those rates occurring within a policy year resulting from modal premium payments;

iv. The secular trend factors by policy duration by issue age and sex, which secular trend factors, when used in the calculation of the anticipated loss ratio, shall not be applied for a period greater than the number of years for which trending is reflected in the calculation of premiums;

v. The interest rates by policy duration, which rates shall equal an insurer's recent current and future expected new investment return rates (after investment expenses, but before Federal income taxes). Alternatively, the Department will permit the use of a six percent level interest rate.

vi. Expenses by policy duration, including commission, override and bonus rates; other marketing expense rates; other maintenance expense rates; any new-market expense rates; other acquisition expense rates; and the explicit profit margin or risk charge; on a per policy issue, per policy in force, per dollar of claim, per dollar of premium, an any other applicable bases;

vii. The distribution of expected policy issues by policy and rider benefits by issue age and sex.

f. The cell and cell weights, when a model office is used in the calculation of the anticipated loss ratio;

g. A demonstration evidencing that unfair pricing discrimination is not utilized by or incorporated within the policy form's premium table or structure.

i. The demonstration shall show that the rates charged any group will not differ by more than 25 percent from the average rate of all groups.

h. The specific formulas and methodology used in calculating gross premiums; and

i. A certification signed by an actuary who is a member in good standing of the American Academy of Actuaries and who is familiar with rating and other actuarial aspects of health and/or dental plans, stating that the assumptions are appropriate to the policy form, reasonably represent the expected experience for the policy form and fully disclose the basis of the calculation of the anticipated loss ratio. **(Refer to N.J.S.A. 17:48C-14, 19, 21, and 22)**

3. Draft copy/copies of any form of contract or agreement to be made between any dentist and the proposed DSC, to the HIB for regulatory approval. **(Refer to N.J.S.A. 17:48C-12 and 15 and N.J.A.C. 11:22-1.1 et seq.)**

4. In accordance with **N.J.S.A. 17:27A**, every insurer which is Authorized to do business in New Jersey and which is a member of an insurance company holding system shall register with the Commissioner of Banking and Insurance. Registration filing requirements as well as all other holding company filing requirements, can be found at **N.J.A.C. 11:1-35**. Upon approval of the Certificate of Authority, an initial Form B-Insurance Holding Company System Annual Registration Statement filing must be submitted.

5. Pursuant to **N.J.S.A. 17:48C-26**, the DSC shall file annually on or before March 1 of each year, financial statements prepared on a SAP basis.

EXHIBIT A

DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF LIFE AND HEALTH
MANAGED CARE BUREAU

BIOGRAPHICAL AFFIDAVIT

Full name and Address of Entity (Do not use group name).
_____
_____
_____

In connection with the above-named Arrangement, I herewith make representations and supply information about myself as hereinafter set forth. (Attach addendum or separate sheet if space hereon is insufficient to answer any question fully.) IF ANSWER IS "NO" OR "NONE", SO STATE. DO NOT LEAVE ANY QUESTIONS UNANSWERED.

1. Affiant's Full Name. _____
_____

2. a. Have you ever had your name changed? _____ If yes, state the reason for the change. _____

b. Other names used at any time. _____
_____

3. Date and Place of Birth. _____
_____

4. Affiant's Business Address. _____
_____

Business Telephone Number. _____

5. List your residence for the last ten (10) years starting with your current address, stating:

Date Address City/State

_____
_____
_____
_____

6. Education: Dates, Names, Locations and Degrees

College _____
_____
Graduate Studies _____
_____
Others _____
_____

7. List memberships in Professional Societies/Association.

_____
_____
_____

8. Present or Proposed Position with the Applicant Entity.

_____
_____

9. List complete employment record (up to and including present jobs, positions, directorates, or officership) for the past twenty- (20) years, stating:

DATES EMPLOYER AND ADDRESS TITLE

_____
_____
_____
_____
_____

10. Present employer may be contacted. Yes No

Former employers may be contacted. Yes _____ No _____

11. a. Have you ever been in a position that required a fidelity bond? _____
If any claims were made on the bond, state details. _____
_____

b. Have you ever been denied an individual or position schedule fidelity bond, or had a bond cancelled or revoked? _____
_____

12. List any professional, occupational, and vocational licenses issued by any public or governmental licensing agency or regulatory authority which you presently hold or have held in the past (state date license issued, issuer of license, date terminated, reasons for termination). _____
_____

13. During the last ten (10) years, have you ever been refused a professional, occupational, or vocational license by any public or governmental licensing agency or regulatory authority, or has any such license held by you ever been suspended or revoked? _____
_____

If yes, state details. _____
_____
_____

14. List any insurers, prepaid dental plans, health care corporations, health maintenance organizations, or dental service corporations in which you control directly or indirectly or own legally or beneficially 10% or more of the outstanding stock (in voting power).
_____
_____

If any of the stock is pledged or hypothecated in any way, state details. _____
_____
_____

15. Will you or members of your immediate family subscribe to own, beneficially or of record, shares of stock of the application entity or its affiliates? _____
_____

If any of the shares or stock are pledged or hypothecated in any way, state details.
_____
_____

16. Have you ever been adjudged bankrupt? _____

If so, give details. _____
_____

17. Have you ever been convicted, had a sentence imposed or suspended, had a pronouncement of a sentence suspended, been pardoned for conviction of or pleaded guilty or no contest to any criminal information, indictment or complaint, other than minor traffic violations? _____

If yes, state details. _____
_____
_____

18. Have you ever been an officer, director, trustee, investment committee member, key employee, or controlling stockholder of any entity which, while you occupied any such position or capacity with respect to it, became insolvent or was placed under supervision or in receivership, rehabilitation, liquidation, conservatorship, or bankruptcy? _____

If yes, state details. _____
_____
_____

19. Has the certificate of authority or license to do business of any insurer, prepaid dental plan, health care corporation, dental service corporation or health maintenance organization of which you were an officer or director or key management person ever been suspended or revoked while you occupied such position? _____

If yes, state details. _____
_____
_____

Dated and signed this _____day of _____, _____ at _____. I hereby certify under penalty of perjury that I am acting on my

own behalf, and that the foregoing statements are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

State of _____ County of _____

Personally appeared before me the above named _____ personally known to me, who being duly sworn, deposes and says that he executed the above instrument and that the statements and answers contained therein are true and correct to the best of his knowledge and belief.

Subscribed and sworn to before me this _____day of _____, _____.

(SEAL) **_____**
(Notary Public)

My Commission Expires_____

TABLE 1: DSC INSURANCE COVERAGES

Name of DSC _____

Re-Insurance	Carrier	Entity Covered	Brief Description of Coverage	Premiums	Dates Policies are in effect	Other Arrangements to cover risk
Re-Insurance						
Risk of Insolvency						
Malpractice						
General Liability						
Casualty						
Fire						
Theft						
Fidelity Bonds						
Directors and Officers Liability						