MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION A
Contact Information

FOR APPLICANTS: The Health Connector has the discretion to deem as meeting Minimum Creditable Coverage (MCC) a health benefit plan that does not comply with the MCC standards set forth in the MCC Regulations (956 CMR 5.01-5.05) if such plan has an overall value at least equal to a Health Connector's Bronze-level plan and provides sufficiently robust and comprehensive coverage. The Health Connector expects that employers, plan sponsors, carriers, third party administrators, consultants, and brokers will self-assess and determine whether their (or their clients') plan(s) meet MCC standards. If you identify a deviation, please use this application to request that the Health Connector review and certify the health benefit plan(s) as meeting MCC requirements. If you determine that the plan meets the MCC standards set forth in the MCC Regulations and does not deviate in any of the ways identified under Section C of this application, do **NOT** submit this application to the Health Connector. The Health Connector does not conduct general compliance reviews and will **NOT** certify a plan if no deviation is identified. MCC Certifications remain valid so long as there are no material changes in the certified option and/or until such time that revisions to MCC Regulations result in new requirements not satisfied by the plan's design approved under this certification. The Health Connector does not process MCC Certifications for individuals. For additional information on MCC requirements, please see Administrative Bulletin 2022MCC. Electronic submission of this application and the plan's summary of benefits is preferred. If you have many plans (more than 50) to submit or have other questions, please contact the Health Connector at 1-617-933-3030. **For Massachusetts Applicants: This MCC Certification Application is independent of any requirements otherwise applicable under Massachusetts or federal insurance law, as enforced by the Massachusetts Division of Insurance (DOI). Being certified as meeting MCC requirements is not a substitute for any DOI requirements or review process, including but not limited to the requirements found in MGL c. 176J, and any questions regarding those requirements should be directed to the DOI.**

FOR INDIVIDUALS: **Do not fill out this form if you are an individual taxpayer.**

CONTACT INFORMATION:

Please provide contact information to whom questions about this application should be sent. (Print clearly.)

First Name _____ Last Name _____

Street Address _____ City _____ State _____ Zip Code _____

Email Address _____ Telephone Number _____

Company with whom you are employed _____

Name of plan sponsor, company, or employer for whom you are requesting MCC Certification (if different) _____

BACKGROUND INFORMATION (Optional: the answers to these questions have no bearing on the MCC Determination.)

1. Of the total number of employees covered under the plan listed in this application, how many are Massachusetts residents? _____

2. Is the Employer who is providing the plan listed in this application based in Massachusetts? □ No □ Yes

The deadline for submitting an MCC Certification Application
November 1, 2023.

MCC.Certification@mass.gov
Health Connector—MCC Review Unit
PO Box 960484, Boston, MA 02196
Telephone 1-617-933-3030 Fax 1-617-933-3070
***Business Hours:* Monday through Friday 9 am to 5 pm**

MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION B
Health Benefit Plan Information

1. What is the name of the health benefit plan/health coverage option for which you are seeking an MCC Certification?
Please complete a separate application for each health benefit plan/health coverage option (e.g., if you are seeking certification for an HMO and PPO, you will need to submit two applications).

_____ _____
Name Plan Anniversary Date

2. Was this plan previously submitted for MCC Certification? □ No □ Yes [If Yes, MCC Number _____]
Note: If this plan received MCC certification for 2020 and/or 2021 year(s) ***only*** *or has expanded any deviations previously certified, complete this application. If the plan was certified for 2020 and beyond and has not expanded any deviation, re-submission is not necessary. Please do not re-submit an application for a 2020+ plan that does not identify any new deviations.*

3. In order to be considered for MCC Certification, the plan must provide some level of coverage for **all core services** (i.e., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests) AND the plan must provide some level of coverage for each of the **broad range of medical benefits** listed in 956 CMR 5.03(2)(a)2. for the calendar year.

Does the health plan provide some level of coverage for each of the broad range of medical benefits listed below?
□ No □ Yes

"A broad range of medical benefits" shall include, at a minimum, coverage for:

a. Ambulatory patient services, including outpatient, day surgery and related anesthesia
b. Diagnostic imaging and screening procedures, including x-rays
c. Emergency services
d. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description)
e. Maternity and newborn care, including prenatal care, post-natal care, and delivery and inpatient services for maternity
f. Medical/surgical care, including preventive and primary care
g. Mental health and substance abuse services
h. Prescription drugs
i. Radiation therapy and chemotherapy

Note: If the health benefit plan fails to provide some level of coverage for each of the broad range of medical benefits listed above, the health benefit plan will automatically be denied MCC Certification. For example, if the health benefit plan does not provide coverage for prescription drugs, it will automatically be denied.

4. A health benefit plan is prohibited from placing an overall annual dollar cap on the amount of prescription drug coverage provided to a covered person.

Will the health benefit plan have an overall annual dollar cap on the amount of prescription drug coverage provided to a covered person? □ No □ Yes
Note: If Yes, the plan will automatically be denied MCC Certification. The actuarial equivalence provisions under the MCC Regulations do NOT apply to this type of deviation.

5. A health benefit plan that provides coverage for dependents is required to provide coverage for all core services and the "broad range of medical benefits" to all persons covered under that plan (e.g., a plan that covers dependents must provide coverage for maternity services for the pregnant daughter of the subscriber).

Will the health benefit plan provide coverage for all core services and "broad range of medical benefits" to all persons covered under that plan (e.g., If the plan covers dependents, will it provide coverage for maternity services for the pregnant daughter of the subscriber)? □ No □ Yes □ N/A (plan does not cover dependents)
Note: If No, the plan will automatically be denied MCC Certification. The actuarial equivalence provisions under the MCC Regulations do NOT apply to this type of deviation.

6. Is the health benefit plan for which you are requesting MCC Certification subject to a Collective Bargaining Agreement that was in effect on 1/1/2018? □ No □ Yes [If Yes, when does the Collective Bargaining Agreement expire? _____]

7. Is the plan a federally-qualified High Deductible Health Plan (HDHP) (i.e., is it HSA-compatible)? □ No □ Yes

8. When is the plan's next anniversary date (if applicable)? _____

MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION C
Deviations

Please identify the plan's deviation(s) from the MCC requirements listed in 956 CMR 5.03(2) and (3) for in-network services only. [You must answer these questions. You cannot answer by simply referring to the attached schedule/summary of benefits. Failure to identify any deviation below will result in the application being considered incomplete and it will NOT be processed. You may attach a separate document(s) to explain any issues further.]

Note: In order to be considered for MCC Certification, the health benefit plan must provide some level of coverage for all core services (i.e., physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests) AND the plan must provide some level of coverage for each of the broad range of medical benefits listed in 956 CMR 5.03(2)(a)2. for the applicable calendar year. If the health benefit plan fails to provide some level of coverage for all core services or the broad range of medical benefits, it will NOT be considered for certification and the application will be DENIED.

Please identify the health benefit plan's deviation(s) by checking all corresponding boxes that apply:

1. The health benefit plan has an overall **annual benefit maximum/limit** (i.e., a maximum amount of coverage for all services to be paid by the health insurer/plan sponsor in a given year). □

2. The health benefit plan has a **combined (**if applicable) **annual deductible** for **in-network** covered core services that is **more than**

□ **$2,850** for individual coverage and/or more than □ **$5,700** for family coverage.

Note: If the health benefit plan's deductible is more than $2,850 for individual coverage or more than $5,700 for family coverage but the employer funds a Health Reimbursement Arrangement (HRA) that results in a net deductible that is not more than $2,850 for individual coverage and not more than $5,700 for family coverage, then the combined coverage satisfies the MCC deductible requirement. For example, a health benefit plan's deductible is $4,000 for individual coverage and $8,000 for family coverage and the employer funds an HRA that provides $1,150 for an individual employee coverage and $2,300 for family coverage. This combination results in a net deductible of $2,850 for individual coverage and $5,700 for family coverage, and, therefore, this combination satisfies the MCC deductible requirement and you would NOT need to check the corresponding box (es) above. If, on the other hand, a health benefit plan's deductible is $4,000 for individual coverage and $8,000 for family coverage and the employer funds an HRA that provides $500 for an individual employee coverage and $1,000 for family coverage, then this combination results in a net deductible of $3,500 for individual coverage and $7,000 for family coverage and this combination would NOT satisfy (thereby deviating from) the MCC deductible requirement and you would need to check the corresponding box(es) above and answer question 1 on page 5.

3. The health benefit plan has an **out-of-pocket maximum** for **in-network** covered core services that is **more than** □ **$9,100** for individual coverage and/or more than □ **$18,200** for family coverage.

4. The health benefit plan **does NOT have an out-of-pocket maximum AND** for **in-network** covered core services requires □ **deductible(s)** and/or □ **co-insurance**.

Note: If the health benefit plan only requires co-pays and does not require a deductible and co-insurance, then an out-of-pocket maximum is not required. Co-pay only plans may skip question 5 below.

5. The health benefit plan **requires deductibles and/or co-insurance** for **in-network** covered core services, but the following cost-sharing for **in-network** covered services **does not count (accumulate)** toward the health benefit plan's out-of-pocket maximum.

*Note: A health benefit plan's calculation of an out-of-pocket maximum must include all of the following payments for in-network covered services: **co-pays, co-insurance and deductibles**.*

(a) **Deductibles** (only if the deductible **is not included** in the out-of-pocket maximum calculation and the sum of the deductible and out-of-pocket maximum is **more than** □ **$9,100** for individual coverage and/or **more than** □ **$18,200** for family coverage).

(b) **Co-insurance on medical services** (e.g., member co-insurance for mental health/substance abuse/chemical dependency that **does not count** toward the out-of-pocket maximum). □

(c) **Co-pays** (e.g., emergency room co-pay that **does not count** toward the out-of-pocket maximum). □

6. The health benefit plan requires **deductibles** for **in-network** covered core services and **fails to comply with the preventive care coverage requirements** under 956 CMR 5.03(2)(h) because it:

(a) **does not cover in-network preventive care** visits prior to the deductible. □ **OR**

SECTION C (continued)
Deviations

(b) requires co-payments or co-insurance **greater than** other routine office visit charges □ **OR**

(c) covers **in-network preventive care visits** prior to the deductible but the coverage frequency of preventive care visits **is not in accordance with nationally recognized preventive care guidelines** that are comparable to the Massachusetts Health Quality Partners' (MHQP) Preventive Care guidelines (adult and pediatric). □

7. The health benefit plan is a **high deductible health plan (HDHP)** that:

(a) does not comply with federal requirements under section 223 of the Internal Revenue Code. □

(b) **does not meet** the requirements under 956 CMR 5.03(1)(a), (f), (g), and (h). □

(c) **is not associated** with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) □
Note: If a federally-qualified HDHP meets the requirements of the MCC Regulations and is offered with an HSA or HRA, it is deemed to meet MCC requirements and does not require an MCC Application.

8. The health benefit plan requires **deductibles** for **in-network** covered core services and it **caps/limits annual coverage for certain in-network preventive care services** prior to deductible (e.g., adult routine physical exams are covered pre-deductible up to $500 per year). □

9. The health benefit plan provides prescription drug coverage subject to a **separate prescription drug deductible** that is more than □ **$350** for individual coverage and/or more than □ **$700** for family coverage.

10. The health benefit plan has an **indemnity schedule of benefits** for coverage of core services (e.g., the plan will only pay for a maximum of $500/day for an inpatient hospitalization). □
Note: "Core services" includes physician services, inpatient acute care services, day surgery, and diagnostic procedures and tests.

11. The health benefit plan has an **overall annual dollar cap for prescription drug coverage**. □
Note: If a plan imposes an overall annual maximum benefit limitation based on dollar amount for prescription drugs, the plan will automatically be denied MCC Certification.

12. The health benefit plan covers dependents but **does not cover maternity services for all dependents** (e.g., including the pregnant daughter of a subscriber). □
Note: If a plan covers dependents but does not cover maternity services for all dependents, the plan will automatically be denied MCC Certification.

The Health Connector will only process an application for MCC Certification that identifies a plan's deviation(s). The Health Connector does not perform general reviews of health plans for their compliance with the MCC Regulations, 956 CMR 5.01-5.05. If the plan does not deviate in any of the ways listed in Section C of this MCC Certification Application, the plan meets MCC standards and you do not need to seek any form of approval or certification from the Health Connector. You must answer these questions. Failure to answer these questions will result in an incomplete application that will not be processed. You may attach separate document(s) to explain issues further, but you may not answer questions by referring to the plan's schedule/summary of benefits.

*** IF YOU DID NOT IDENTIFY ANY DEVIATION ***

MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION D
Plan Benefit Information

Please provide the following information regarding **MEMBER** cost sharing for **IN-NETWORK** covered services only.

1. **Does the plan have a tiered network?** □ No □ Yes
   If yes, provide the average cost share amounts based on projected utilization for each of the tiers to answer the following questions.

2. **Does the plan have a Deductible?** □ No □ Yes
   If separate Deductibles,
   Medical: Individual _____ Family _____
   Rx: Individual _____ Family _____
   If Combined Medical and Rx Deductible: Individual _____ Family _____
   Other: Individual _____ Family _____
   If other, please add a description. _____

3. **Does the plan have an Out-of-Pocket (OOP) maximum?** □ No □ Yes
   If separate OOP maximums,
   Medical: Individual _____ Family _____
   Rx: Individual _____ Family _____
   If Combined Medical and Rx OOP max: Individual _____ Family _____
   Other: Individual _____ Family _____
   If other, please add a description. _____

4. **Does the OOP maximum include the Deductible amount?** □ No □ Yes

5. **Is this a federally-qualified HDHP (a high deductible health plan that complies with section 223 of the Internal Revenue Code)?** □ No □ Yes

6. **Is the plan associated with an HSA (Health Savings Account)?** □ No □ Yes
   If the employer is contributing to an HSA on behalf of the employee, what is the amount?

   HSA amount: Individual _____ Family _____

7. **Does the employer fund an HRA (Health Reimbursement Arrangement)?** □ **No** □ **Yes**

   HRA amount: Individual _____ Family _____

8.

Covered Services	**Subject to Deductible**	**Subject to Copayment**		**Subject to Coinsurance**		**If more than one cost share, order the cost share will apply**
	Yes or No	**Yes or No**	**Amount**	**Yes or No**	**Percent**	
Primary Care Physician (PCP) Office Visit						
Specialist Office Visit						
Physical/Occupational Therapy						
Speech Therapy						

SECTION D (cont.)
Plan Benefit Information

8cont. What is the member's liability for the following in-network benefits?

Covered Services	Subject to Deductible	Subject to Copayment		Subject to Coinsurance		If more than one cost share, order the cost share will apply
	Yes or No	Yes or No	Amount	Yes or No	Percent	
Hospital Inpatient						
Hospital Outpatient						
Emergency Room						
Lab						
X-ray						
Imaging						

If Hospital Inpatient is subject to copay, does the copay apply □ per admit □ per day
If per day, what is the maximum number of days subject to a copay _____

9. Do you have a tiered payment schedule for prescription drugs? □ No □ Yes How many tiers? _____

Tier	Description (e.g., generic, preferred brand, non-preferred brand, specialty drugs)	Subject to Deductible	Subject to Copayment		Subject to Coinsurance			
		Yes or No	Yes or No	Amount	Yes or No	Percent	Max per script (Y/N)	Amount
1								
2								
3								
4								
5								

MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION E
Actuarial Attestation/Certification

1. Are you providing an actuarial attestation/certification that the health benefit plan meets or exceeds a Bronze-level plan offered through the Health Connector? □ No □ Yes

You are not required to provide an actuarial attestation unless requested by the Health Connector. You may, however, provide one voluntarily as part of this application. An actuarial attestation/certification showing equal or greater value than a Health Connector Bronze Plan does not guarantee MCC Certification approval. It is still in the Health Connector's discretion to determine (based on the totality of the information provided) whether the plan should be deemed to meet MCC requirements.

The attestation must be made by a qualified actuary who is a member of the American Academy of Actuaries. Applicants may use qualified outside actuaries, including (but not limited to) actuaries employed by the plan administrator or an insurer providing benefits under the plan. If an applicant uses an outside actuary, the attestation can be submitted directly by the outside actuary or by the plan sponsor. The attestation must be signed by a qualified actuary and must state that the attestation is true and accurate to the best of the attester's knowledge and belief. If you have any questions concerning an actuarial attestation, please see Administrative Bulletin 2022. Generally, the Health Connector prefers to see supporting calculations showing relative value expressed as a percent or fraction of the Bronze plan(s). While the Health Connector has no specific requirements with regard to the content of actuarial certifications (other than details provided in Administrative Bulletin 2022), the Health Connector has received the following certification in another case, which the Health Connector has found acceptable. We offer this as an example only:

"Attached is a spreadsheet highlighting certain benefits under the Plan and the Connector's Bronze Plans. We have calculated the relative value of the medical benefits provided by the Plan as 11.7% larger than the median benefit provided by the Bronze Plans. Therefore, it is our opinion that the Plan is significantly more generous than the median benefit provided by the Bronze Plans and has a greater actuarial value."

2. If you are providing an actuarial attestation/certification, please provide the contact information for the individual who is attesting or certifying that the actuarial value of your plan meets or exceeds a Connector Bronze-level plan.

Full Name (First, Last)	Name of Firm (if applicable)
Email	Telephone Number

MCC CERTIFICATION APPLICATION FOR PLAN YEARS BEGINNING ON OR AFTER 1/1/2023

SECTION F
Applicant's Summary and Signature

Provide any additional information supporting your application for MCC Certification. You may attach additional pages.

_____

_____

_____

_____

_____

_____

_____

_____

_____

You must include a summary of the plan's schedule of benefits for review. Please do not include the full summary plan document unless specifically requested by the Health Connector. Electronic submission of this application and the plan's schedule of benefits is preferred. By electronic submission, you agree to have the application processed electronically.

SIGN BELOW

Under penalties of perjury, I declare that to the best of my knowledge and belief this application and enclosures are true, correct and complete. I attest that I am authorized to submit this application and the information contained herein or attached to this application as/on behalf of the applicant listed in Section A of this application for the purpose of this MCC Certification request. I understand that if the Health Connector determines that any claims made in this MCC Certification Application are false, the Health Connector may revoke any MCC Certification the applicant may receive with regard to this application.

_____

Your Signature Date

_____

Print Name

Please send the application and a copy of the plan benefit summary

by email to:
MCC.Certification@mass.gov

by fax to:
1-617-933-3070

by mail to:
Health Connector-MCC Review Unit
PO Box 960484
Boston, MA 02196

The deadline for submitting an MCC Certification Application
November 1, 2023.