CHAPTER 10

DENTAL SERVICES

Authority

N.J.S.A. 17:1-8.1, 17:1-15(e), 17:48C-18 et seq., 17:48D-1 et seq., 17B:26-44.4 et seq. and 17B:27-51.10a et seq.

Source and Effective Date

R.2006 d.14, effective December 7, 2005.
See: 37 N.J.R. 3217(a), 38 N.J.R. 310(b).

Chapter Expiration Date

In accordance with N.J.S.A. 52:14B-5.1b, Chapter 10, Dental Services, expires on June 5, 2013. See: 43 N.J.R. 1203(a).

Chapter Historical Note

Chapter 10, Hospital-Medical-Dental Services, Subchapter 2, Employee's Dental Benefit Plans; Alternative Coverage, was adopted as R.1984 d.115, effective April 2, 1984. See: 15 N.J.R. 1350(a), 16 N.J.R. 735(a).

Subchapter 1, Dental Plan Organizations, was adopted as R.1985 d.374, effective July 15, 1985. See: 16 N.J.R. 2230(a), 17 N.J.R. 1768(a).

Pursuant to Executive Order No. 66(1978), Chapter 10, Hospital/Medical-Dental Services, was readopted as R.1990 d.384, effective July 12, 1990. As a part of R.1990 d.384, Chapter 10, Hospital/Medical-Dental Services, was renamed Dental Services, effective August 6, 1990. See: 22 N.J.R. 1691(a), 22 N.J.R. 2326(a).

Pursuant to Executive Order No. 66(1978), Chapter 10, Dental Services, was readopted as R.1995 d.422, effective July 10, 1995. See: 27 N.J.R. 1739(a), 27 N.J.R. 2937(a). Pursuant to Executive Order No. 66(1978), Chapter 10 expired on July 10, 2000.

Chapter 10, Dental Services, was adopted as new rules by R.2000 d.348, effective August 21, 2000. See: 32 N.J.R. 1998(a), 32 N.J.R. 3081(b).

Chapter 10, Dental Services, was readopted as R.2006 d.14, effective December 7, 2005. See: Source and Effective Date.

In accordance with N.J.S.A. 52:14B-5.1c, Chapter 10, Dental Services, was scheduled to expire on June 5, 2011. See: 43 N.J.R. 124(a).

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SUBCHAPTER 1. DENTAL PLAN ORGANIZATIONS

11:10-1.1 Purpose

(a) The Dental Plan Organization Act (N.J.S.A. 17:48D-1 et seq.) regulates persons and corporations which offer plans for the prepayment or postpayment of dental services. The Act provides for the licensing and supervision of dental plan organizations to protect enrollees of the plan and to assure that the services contracted for are actually delivered.

(b) Section 23 of the Act authorizes the Commissioner to promulgate rules and regulations to effectuate its purposes. This subchapter establishes rules to implement the Act. These rules are designed to facilitate compliance with the Act by clarifying its requirements. Specific standards are also prescribed to ensure that the purposes of the Act are fulfilled.

11:10-1.2 Scope and application

(a) This subchapter applies to dental plan organizations as defined in N.J.S.A. 17:48D-2c and N.J.A.C. 11:10-1.3. Such organizations may offer group and individual dental plans on a prepaid and postpaid capitation basis.

(b) If the dental plan organization utilizes more than one full-time equivalent dentist to serve dental plan enrollees, it is subject to the Act and this subchapter.

(c) An individual dentist in solo practice who capitates his services is not required to comply with the Act or this subchapter.

(d) An individual dentist in solo practice may apply for a certificate of authority to act as a DPO, and shall comply with all the requirements of this subchapter.

(e) Supplemental dental plans as defined at N.J.A.C. 11:10-1.3 are subject to the Act and this subchapter. A DPO may not offer a supplemental dental plan unless it can be actuarially demonstrated that the capitation rate for such a plan is proportionate to the rate for an identical plan that provides 100 percent full coverage for the same services provided under the supplemental plan.

(f) An organization which provides coverage of dental services exclusively on a fee-for-service basis cannot qualify as a dental plan organization. Such organizations may not operate in this State without a certificate of authority as a health insurer or hospital, medical, dental or health service corporation, since fee-for-service coverage is either insurance or service benefits.

Case Notes

District court could sign stipulated order of settlement which vacated summary judgment holding that ERISA preempted New Jersey Dental Plan Organization Act and accompanying regulations. Oracare DPO, Inc. v. Merin, C.A.3 (N.J.)1992, 972 F.2d 519.

11:10-1.3 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Capitation" means a method of compensation by a DPO to its participating primary dentists for services and supplies provided to members of the DPO on the basis of a fixed payment per member, together with such additional types of payments as are specifically approved by the Department as appropriate to recruit new participating dentists, recruit or retain participating dentists in underserved areas and/or eliminate disincentives for participating primary dentists to render quality dental care to members and to its participating specialist dentists for services and supplies provided to members of the DPO on the basis of either a fixed payment per member or a contractual fee schedule from an approved specialist pool. A plan that employs dentists whose salaries are paid by the DPO shall be considered a capitated plan.

"Commissioner" means the Commissioner of the Department of Banking and Insurance.

"Department" means the Department of Banking and Insurance.

"Dental Plan Organization" or "DPO" means a direct provider of dental services compensated on a prepaid or postpaid capitation basis, which provides such services to either individuals or groups. The provision of such services by the DPO is deemed to be a "non-delegable" duty. An arrangement whereby dental services are provided indirectly through "independent contractors" is not considered a DPO. An arrangement whereby compensation to dentists for dental services is provided exclusively on a fee-for-service basis is not considered a DPO. An arrangement whereby dental services are provided by entering into an agreement with providers, or by employing dentists, where the dentists agree to treat enrollees of the plan in their private offices or a central facility, is considered a DPO.

"Emergency" means procedures to evaluate and stabilize dental conditions of recent onset and severity accompanied by excessive bleeding, severe pain, or acute infections that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

"Fee-for-service" is a reimbursement arrangement in which the amount reimbursed for dental services is paid either to an insured (or subscriber) or to a provider of services and the amount is determined on the basis of the dental procedure performed and/or the amount charged by the dentist for the procedure. An example of a fee-for-service plan is one covering or indemnifying the services provided by dentists on the basis of a schedule of fees or percentage reimbursement of the fee charged, under which the dentist does not share in the "volume of service" risk assumed by the DPO.

"One Full-Time Equivalent Dentist" means one dentist working full time or an aggregation of hours spent by more than one dentist on DPO enrollees so as to equal a 40-hour week. A full-time general practitioner can serve a group of at least 1,500 enrollees and dependents combined. This number could vary by specialty and service performed; for example, an orthodontist may serve a smaller number of patients than a general practitioner.

"Postpaid capitation" means an arrangement whereby the primary dentist providing services is compensated by an annual distribution of the excess in a specialist pool in addition to the prepaid capitation.

"Prepaid capitation" means an arrangement whereby the dentist providing services is compensated through capitation on the basis of the presence of an enrollee regardless of whether services are provided.

"Primary dentist" means a dentist who is not a specialist.

"Specialist" means a dentist whose training and expertise are in a specific area of dentistry. Recognized clinical specialists in dentistry include, but are not limited to, endodontists, oral and maxillofacial surgeons, oral pathologists, orthodontists, periodontists and prosthodontists.

"Specialist pool" means a portion of the premium that is set aside to cover the cost of specialist services not provided by the primary care dentist and not paid on a prepaid capitation basis.

"Supplemental Dental Plan" means an arrangement in which a dentist or group of dentists agrees to relieve patients of paying any patient charges or copayments associated with dental insurance or other dental coverage for a predetermined fee. Supplemental dental plan also means an arrangement which covers less than 50 percent of an enrollee's dental expenses regardless of whether the enrollee has other coverage.

11:10-1.4 General rules

(a) To obtain an application for a certificate of authority as a dental plan organization, a written request for the appropriate forms must be submitted to the Commissioner. Applicants shall complete and return the forms with the supporting documents requested by the Department.

(b) The notice of significant modification of information submitted with the application required by N.J.S.A. 17:48D–4 shall include the document being modified and an explanation of the modification. Examples of modifications which are considered significant include, but are not limited to:

1. Changes in the DPO's organizational structure;

2. New officers, partners or members of the DPO's board of directors, board of trustees, executive committee or other governing board or committee;

3. Changes in the group or individual contract form issued by the DPO;

4. Adjustments to financial statements; and

5. A change in ownership.

(c) No DPO shall use a specialist pool unless it is filed with the Department for approval. The specialist pool filing shall be deemed approved upon the expiration of 30 days after it is filed unless disapproved in writing by the Commissioner within that time. All specialist pools shall comply with the following requirements:

1. A specialist pool may exist only when the specialists contract with the DPO to serve as participating dentists, but are not employees of the DPO;

2. The procedures for which specialists are responsible, and which are not provided by primary dentists, shall be identified in the contract between the specialist and the DPO. The contract shall be included in the request for approval submitted to the Department;

3. The specialist shall be paid on a contractual fee schedule basis. The contractual fee schedule shall be included in the specialist contract filed pursuant to N.J.A.C. 11:10–1.5, and in the request for approval filed with the Commissioner;

4. The schedule of charges filed pursuant to N.J.A.C. 11:10–1.12 shall identify, by plan, the proportion of the charges attributable to the specialist services, and shall be included in the request for approval filed with the Commissioner;

5. After addition of the charges and deductions for payments to specialists, any excess in the specialist pool shall be paid on an annual basis to the primary dentists and shall not be retained by the DPO. The method by which payment of the excess is to be made to the dentists shall be included with the request for approval filed with the Commissioner. Any changes in the methodology shall be filed with the Commissioner before its use;

6. The DPO shall be responsible for all payments for services provided by specialists. Payments shall be made from the specialist pool until all funds are depleted, and thereafter payments shall be made from the DPO's general funds; and

7. In conjunction with the filing of the annual report required by N.J.A.C. 11:10–1.7, each DPO having an approved specialist pool shall submit a separate financial accounting of the specialist pool for the preceding calendar year. The report shall set forth, by plan, the contributions to the pool, the payments made to specialists from the pool and the resulting excess or deficit. If an excess exists, the report shall indicate when the distribution of the excess will be made and whether the method of distribution remains unchanged from that originally filed with the Department.

(d) A request for approval of a specialist pool shall be submitted to the Department at the following address:

Chief, Managed Care Bureau
Office of Life and Health
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

Amended by R.1991 d.303, effective June 17, 1991 (operative July 1, 1991).
See: 23 N.J.R. 825(a), 23 N.J.R. 1948(a).
Deleted "$100.00"; added "as set forth in N.J.A.C. 11:1–32.4(a)7" in (b).
Amended by R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

11:10–1.5 Written agreements with dentists

(a) Every DPO shall enter into a written agreement with each dentist who will be providing dental services for plan enrollees, unless the dentist is employed by the DPO.

(b) DPOs shall file with the Commissioner at least 60 days prior to the planned date of use a copy of all written agreements with dentists and any amendments thereto. A written agreement or amendment to a written agreement may be used 60 days after filing unless the Commissioner has determined that the agreement or amendment is not sufficient financially for the DPO's provision of dental services. The Department shall notify the DPO in writing within 60 days of filing of any insufficiency in the agreement or amendment. Submissions of amended forms shall include two copies of the revised or amended form(s) or page(s) only, if practicable. One copy shall be marked to show the changes from the prior approved form, and one copy shall be unmarked.

(c) Agreements with dentists shall include:

1. The amount and method of compensation and the service to be provided;

2. The minimum number of hours per week which the dentist must make available for the treatment of plan enrollees or a statement that an appointment must be granted to an enrollee within 10 working days of the date of request;

3. A statement that treatment for an emergency must be granted within 24 hours of the emergency;

4. The DPO's program for the assurance of quality dental care;

5. The requirements for malpractice insurance coverage;

6. The date and term of the agreement;

7. With respect to primary dentists, a provision that a referral from the primary dentist or DPO is required for the provision of non-emergency specialty care by a specialist who is to be paid from the specialist pool; and

8. With respect to specialists who are to be paid from the specialist pool, a provision that a referral from a primary dentist or DPO is required to obtain payment for the provision of specialty care except in an emergency.

(d) Agreements with dentists shall not include:

1. Provisions creating or purporting to create, an "independent contractor" relationship between the DPO and the dentist, or otherwise attempting to restrict the responsibility of the DPO for the dental services provided by the dentist; or

2. Any compensation agreement on an exclusive fee-for-service basis or any other exclusive basis which shields the dentist from the volume of services risks assumed by the DPO.

11:10–1.6 Evidence of coverage and group contracts

(a) The DPO shall prepare and issue the evidence of coverage form to each enrollee. Covered groups may distribute the forms to its members on behalf of the DPO.

(b) An evidence of coverage form must contain all the information required by N.J.S.A. 17:48D–9. A card containing only basic identifying information is not sufficient to meet these requirements.

(c) No evidence of coverage, or group contract, or amendment thereto, may be issued or delivered until a copy of the form has first been filed with, and has not been disapproved by, the Commissioner. A form or amendment, which differs from that previously filed with the Commissioner, may not be issued until it has first been filed with, and has not been disapproved by, the Commissioner. All forms and amendments shall be filed at least 60 days prior to the planned date of issuance, and shall include a unique identifying form number which reflects the effective date of the form or revision. Submissions of amended forms shall include two copies of the amended form(s) or page(s) only, if practicable. One copy shall be marked to show the changes from the prior approved form, and one copy shall be unmarked.

(d) All evidence of coverage forms shall clearly identify the name of the dental plan organization on its cover and in the text.

(e) All exclusions, exceptions, limitations, items not covered and services not provided by the plan should be clearly identified in the evidence of coverage form and group contract forms.

(f) Coordination of benefits and non-duplication of benefits provisions, which limit payment to 100 percent of allowable expenses when more than one dental plan covers an enrollee, are not permitted in an evidence of coverage or group contract issued by a DPO unless the following conditions are met:

1. Enrollees are covered under a group, not an individual contract;

2. The provisions are not operative with respect to dental plans provided by another DPO;

3. The DPO follows the rules set forth at N.J.A.C. 11:4–28;

4. The funds recovered as a result of these provisions are credited directly against the charges payable by the group for the plan's services; and

5. Both the group contract and evidence of coverage include the coordination of benefits provisions.

(g) Non-duplication of benefits provisions are not permitted.

(h) Provisions which exclude coverage for services provided by other dental plans or by dental insurance are not permitted in a contract issued by a DPO.

(i) No DPO may cover dental services exclusively on a fee-for-service, expense incurred or indemnity basis. A DPO shall offer primary dental services directly (that is, not on an indemnity, expense incurred or fee-for-service basis), and may do so only on a capitation basis. A DPO may also arrange for the provision of dental services on a fee-for-service, expense incurred or indemnity basis by purchasing coverage or such service from a duly authorized insurer, or a hospital, medical, dental or health service corporation. Specialists may be paid on a contractual fee-for-service basis when such payments are made from a specialist pool approved by the Department.

(j) An evidence of coverage issued to a non-group enrollee is subject to the plain language requirements of N.J.S.A. 56:12–1 et seq. All evidences of coverage, including those issued to enrollees of a group, should be written in a simple, clear, understandable and easily readable way. In writing an evidence of coverage form to be issued to an enrollee of a group, a DPO may use the guidelines set forth in N.J.S.A. 56:12–10 to assure compliance with this subsection.

11:10–1.7 Financial reporting

(a) Every DPO shall submit a quarterly report of its activities for each of the first three calendar quarters ending March, June and September within 45 days of the end of each quarter on a form prescribed by the Commissioner to the addresses set forth in (e) below.

(b) A DPO which also maintains a non-dental plan practice shall segregate its non-dental plan activities from its dental plan activities and report its dental plan activities only in the quarterly and annual report forms prescribed by the Commissioner. Non-dental plan activities include those activities involving private practice dentistry.

(c) A DPO which is engaged in a non-dental plan practice shall also report the activities of the entire organization in financial reports prepared by its accountant within 15 working days of completion of the report, but no later than June 1 of each year. The assets of the entire organization of which the DPO is a part are considered to be assets of the DPO.

(d) All financial reports from DPOs which are not incorporated shall include a breakdown of the personal finances of its proprietors and the finances of the dental plan.

(e) An annual financial report of the DPO shall be prepared by an independent certified public accountant or independent public accountant on a statutory basis and attested to by an officer of the DPO. This report shall include full disclosure of all assets and liabilities of the DPO, the terms and conditions thereof, and the sources and disposition of all funds for the calendar year immediately preceding. The report shall be completed as prescribed by the National Association of Insurance Commissioners (NAIC) Annual Statement Instructions Health that is applicable to the reporting year, and shall be completed on a statutory accounting basis (SAP) in accordance with the NAIC Accounting Practices and Procedures Manual applicable to the reporting year. The Instructions and the Manual are incorporated herein by reference. Copies of the Instructions and Manual may be obtained from the NAIC Publications Department, 2301 McGee Street, Kansas City, MO 64108–2660. Telephone number: 816–783–8300. Revisions may be obtained on the NAIC website at www.publdist@naic.org. Three copies of the report shall be submitted on or before March 1 of each year to the following address:

HMO Financial Operations
Office of Financial Examinations
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

(f) If a DPO's records have been audited by an independent certified public accountant, the audited financial report shall be certified by the certified public accountant having conducted the audit and shall be forwarded to the Department on or before June 1 of each year.

Amended by R.2003 d.151, effective April 7, 2003.
See: 34 N.J.R. 4049(a), 35 N.J.R. 1558(a).
Rewrote (e).

11:10–1.8 General surplus

(a) Every DPO shall accumulate and maintain a minimum general surplus as set forth in this subsection, of which $50,000 shall be deposited with the Commissioner pursuant to N.J.A.C. 11:2–32 either within 90 days of the approval of the certificate of authority or by December 31, 2000, whichever is later:

1. For the reporting year ending December 31, 2000, the amount of the minimum general surplus shall be the greater of $50,000 or .5 percent of the current annual premium;

2. For the reporting year ending December 31, 2001, the amount of the minimum general surplus shall be the greater of $75,000 or .75 percent of the current annual premium;

3. For the reporting year ending December 31, 2002 and thereafter, the amount of the minimum general surplus shall be the greater of $100,000 or one percent of the current annual premium; and

4. For a newly-approved DPO, the initial amount of the minimum general surplus shall be calculated pursuant to (a)1 through 3 above based on the calendar year of approval.

(b) The surplus in excess of the deposit set forth in (a) above shall be invested pursuant to N.J.S.A. 17B:20–1 et seq.

(c) The general surplus shall be maintained over and above its reserves, liabilities and special contingent surplus.

(d) The Commissioner may waive all or a part of the general surplus requirement if the DPO maintains a contract(s) with an insurer, or a hospital medical, dental or health service corporation which is sufficient to assure the performance of its obligations.

11:10–1.9 Expense limitation

(a) To achieve compliance with the expense limits set forth in N.J.S.A. 17:48D–14, every DPO shall:

1. Use at least 70 percent of its gross contract and certificate income in the first year of operation, 75 percent in the second year, and 80 percent in all subsequent years for the direct provision of professional dental services to enrollees;

2. Set its per enrollee retention in conformity with the statutory limits in constructing its schedule of charges.

(b) Expenditures for the direct provision of professional dental services are, in general, that portion of the DPO's total expenses which would exist if the DPO were simply a dental practice and if enrollees were the patients of that practice. Monies paid to dentists for their time, for the cost of their assistants, hygienists, and other support personnel, for their laboratory costs, malpractice insurance, and for all other necessary costs of offices and equipment which are not required for the non-dental care delivery activities of a DPO are examples of such dental expenditures.

(c) Portions of expenditures such as rent, utilities, building maintenance, accounting, real estate taxes, payroll taxes, depreciation, amortization, employee benefits, interest and bad debts, which a dentist or dental group incurs in delivering dental care, may also be counted as expenditures for dental services as long as a reasonable method of allocating these expenditures to the dental and non-dental functions is used.

(d) Gross contract and certificate income not needed for the direct provision of dental care shall be considered as retention and will be subject to the limitations of N.J.S.A. 17:48D–14. Two examples of items of retention are profits and marketing costs.

(e) Copayment income shall not be considered gross contract and certificate income in determining compliance with the expense limitations unless the DPO providers are employees or associates of the DPO. The costs of providing the dental services to which the copayments apply shall be included with other dental service costs. For the purpose of this subsection, copayment income means the fees that a DPO collects for the portion of the dental services which is not covered under the dental plan contract.

(f) For purposes of determining the applicable expense limitation pursuant to N.J.S.A. 17:48D–14, the DPO's first year of operation shall be the year the DPO obtains its initial certificate of authority.

11:10–1.10 Complaints and other communications

(a) Complaint systems required of every DPO (see N.J.S.A. 17:48D–12) shall provide that a written response shall be furnished to the enrollee within 15 working days after its receipt of a written complaint. The DPO's response shall, based on the information available to it at the time of response, be complete and accurate.

(b) Every DPO shall, based on the information available to it, provide the Department with a complete and accurate written response to any inquiry from the Department within 15 working days after its receipt of such inquiry.

(c) Every DPO shall furnish an appropriate reply to all other communications which reasonably suggest that a response is expected within 15 working days of receipt.

(d) Every DPO shall retain all written complaints and correspondence relating thereto for at least three years after the date of the last correspondence in file.

11:10–1.11 Fidelity bonds and malpractice insurance

(a) The minimum amount of the fidelity bond on each director, officer, partner or employee of the DPO required by N.J.S.A. 17:48D–8 shall be $50,000.

1. Every DPO shall increase the bond amount as appropriate whenever its risk of loss for individual employee theft is greater than $50,000.

2. The fidelity bond shall name the DPO and the State of New Jersey as dual obligees.

(b) All dentists serving enrollees of a DPO shall be insured against professional liability or for malpractice in an amount not less than $1,000,000 per occurrence and $3,000,000 in the aggregate.

(c) The fidelity bond and the malpractice policy shall be obtained only from insurers which are authorized to conduct business in New Jersey.

11:10–1.12 Schedule of charges

(a) Every new or revised schedule of charges must be filed with the Commissioner at least 60 days prior to its effective date. A DPO shall not use a schedule of charges which has been disapproved by the Commissioner.

(b) All filings of charges must include sufficient information to enable the Commissioner to determine whether the charges are not excessive, inadequate or unfairly discriminatory. All details, used in the development of rates, must accompany the filing, including:

1. Actuarial principles;

2. Assumptions and methods of calculation; and

3. Method of development of the dental portion of the charges.

i. Development shall be based upon actual utilization of the DPO, or on comparable experience if the DPO does not yet have adequate utilization. Included in this development shall be projections based on trends observed within the DPO, the profession of dentistry or the overall economy.

(c) Every filing of a schedule of charges shall include projections of the following information:

1. The schedule of charges to be used by the DPO during the period that the charges are to be effective;

2. The portion of the charge to be used for the direct provision of professional dental services to enrollees (N.J.A.C. 11:10–1.9(b) and (c)), including the contribution to the specialist pool where applicable;

3. The portion of the charges to be used for retention (N.J.A.C. 11:10–1.9(d)), except for the items of retention referred to in (c)4 below; and

4. Anticipated profits and losses, surplus additions and reductions, each of which shall be itemized separately.

(d) Every filing of a revised schedule of charges shall include the information required by (a) through (c) above, the percentage increase or decrease requested and the prior experience under the old rates itemized as described in (c) above.

(e) A schedule of charges, in addition to meeting any other requirements imposed by statute or regulation, must meet the following criteria:

1. The ratio of retention to the charge falls within the limitations set forth by N.J.S.A. 17:48D–14; and,

2. The portion of charges intended for professional dental services meets the standards prescribed by N.J.A.C. 11:10–1.9(a)1.

(f) A schedule of charges for a supplemental dental plan is also subject to (a) through (e) above. In determining whether such charges comply with (a) through (e) above, the Department shall consider whether the charges for a supplemental dental plan are proportionately equivalent to the charges for a dental plan providing greater benefits. For example, charges for a supplemental dental plan covering 20 percent of dental expenses must be no more than one-fifth of the charges for a plan covering 100 percent of these dental expenses.

Amended by R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

11:10–1.13 Renewal of Certificate of Authority

(a) Every request by a DPO for renewal of its Certificate of Authority shall be in writing and received by the Department at least 60 days prior to the renewal date.

(b) A request for renewal of a DPO Certificate of Authority shall include at least the following items:

1. The completed Certificate of Authority Renewal Affidavit set forth as Appendix A to this chapter, incorporated herein by reference, signed by a principal officer of the DPO responsible for conducting the affairs of the DPO and notarized; and

2. The completed Certificate of Authority Renewal Request Form set forth as Appendix B to this chapter, incorporated herein by reference, containing all the information required therein.

(c) The items set forth in (b) above shall be submitted to the Department at the following address:

Chief, Managed Care Bureau
Office of Life and Health
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625–0325

New Rule, R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

11:10–1.14 Enforcement

(a) Any DPO which violates any provision of this subchapter shall be subject to the appropriate penalty for violations of N.J.S.A. 17:48D–1 et seq., including suspension, nonrenewal or revocation of its certificate of authority.

(b) Any DPO that fails to reply to any inquiry of the Commissioner or fails to file quarterly or annual reports pursuant to this subchapter shall be subject to penalties pursuant to N.J.S.A. 17B:21–2.

Recodified from 11:10–1.13 by R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

11:10–1.15 Separability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

Recodified from 11:10–1.14 by R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

SUBCHAPTER 2. EMPLOYEE'S DENTAL BENEFIT PLANS; ALTERNATE COVERAGE

11:10–2.1 Purpose

P.L. 1983, Chapters 142 through 145, require that each employer or other organization subject thereto offer its employees or members the option of selecting alternate coverage which permits covered persons to obtain dental services from any dentist of their choice whenever the employer is contributing to a dental plan contract (as described in N.J.A.C. 11:10–2.2(a)). These statutes also direct the Commissioner to promulgate rules and regulations to effectuate their purposes. This subchapter is being promulgated to meet this statutory mandate and to implement the notification requirements of the statutes.

11:10–2.2 Scope and application

(a) This subchapter applies to each employer or other organization which:

1. Employs or has 25 or more employees or members during the full preceding calendar year; and

2. Contributes to a dental plan contract.

(b) Insurers, dental plan organizations, and dental service corporations which are authorized to enter into contracts providing dental coverage are also subject to this subchapter.

Amended by R.1985 d.220, effective May 6, 1985.
See: 17 N.J.R. 45(a), 17 N.J.R. 1129(b).
Subsection (b) deleted and (c) recodified to (b).

11:10–2.3 Definitions

The following words and terms, when used in this subchapter, have the following meanings unless the context clearly indicates otherwise:

"Alternative coverage" means a plan that permits covered persons to obtain dental services from any licensed dentist.

"Dental plan contract" means any contract issued by a health insurer, dental plan organization, or dental service corporation which restricts covered persons in selecting the providers of dental services to a single provider or a limited number of providers.

"Enrollment period" means a period of time, of not less than one month's duration, prior to the renewal of a dental plan contract during which employees or members are afforded the option to be covered under the dental plan contract or alternative coverage.

"Other organization" means a group of 25 or more members to which a dental plan contract has been or is to be issued including, but not limited to, labor unions and associations.

"Renewal" means to begin a new term of the contract or to add an amendment to the contract.

New Rule, R.1985 d.220, effective May 6, 1985.
See: 17 N.J.R. 45(a), 17 N.J.R. 1129(b).
Old section 2.3 recodified to 2.4.

11:10–2.4 Notification of affected parties

(a) An insurer, dental plan organization and dental service corporation shall provide to each employer or other organization to which this subchapter applies a copy of N.J.S.A. 17:48D–9.1 and 9.2 (as appropriate) and this subchapter at the time of offering a dental plan contract as defined in this subchapter.

(b) Every employer and other organization subject to this subchapter shall offer in writing to its employees or members and their eligible dependents the option of selecting coverage which permits dental services to be obtained from any licensed dentist as an alternative to the coverage provided under a dental plan contract. For new dental plan contracts being provided for the first time, this option shall be offered during the period for enrolling the employees or members in the new plan. For existing dental plan contracts, this option shall be offered during an enrollment period preceding the renewal date of the contract. Employers and other organizations which have offered this option to existing employees or members shall also offer this option to new employees or members at the time they are enrolled in a dental plan contract.

(c) Employers and other organizations to which this subchapter applies, shall post in a conspicuous manner, written notice of the coverage option and the text of P.L. 1983, Chapters 142–145, whichever chapter is applicable.

Amended by R.1985 d.220, effective May 6, 1985.
See: 17 N.J.R. 45(a), 17 N.J.R. 1129(b).
Recodified from 2.3.
Administrative correction.
See: 34 N.J.R. 1453(a).

11:10–2.5 General rules

(a) Each health insurer, dental service corporation, or dental plan organization shall, at the time a dental plan contract is offered or at the time of renewal, obtain written verification from each employer or other organization of compliance with P.L. 1983, c.142 through 145, and this subchapter.

(b) Each employer or other organization, at the time of offering or renewal of a dental plan contract shall furnish to the health insurer, dental service corporation, or dental plan organization written verification of compliance with P.L. 1983, c.142 through 145 and this subchapter.

(c) Each employer or other organization at the time of offering or renewal of a dental plan contract shall provide in the written notice required by N.J.A.C. 11:10–2.4(b) and (c) an outline of the differences in coverages and cost to the employee or members and their eligible dependents between a dental plan contract and the alternative coverage.

(d) The alternative coverage may be provided through an insurance contract, on a self-funded basis, or by any means which meets the approval of the Commissioner.

(e) Each employer or other organization shall contribute to the alternative coverage an amount equal to the premium or cost which it pays or contributes to the dental plan contract. Such contribution shall be adjusted when the premium or cost which it pays or contributes to the dental plan changes.

New Rule, R.1985 d.220, effective May 6, 1985.
See: 17 N.J.R. 45(a), 17 N.J.R. 1129(b).

11:10–2.6 Separability

If any provision of this subchapter, or its application to any person or circumstances, is held invalid, the remainder of this subchapter and its application to other persons or circumstances shall not be affected.

Amended by R.1985 d.220, effective May 6, 1985.
See: 17 N.J.R. 45(a), 17 N.J.R. 1129(b).
Recodified from 2.4.

APPENDIX A

CERTIFICATE OF AUTHORITY
RENEWAL AFFIDAVIT

State of _____

County of _____

The undersigned, being duly sworn according to law upon his/her oath deposes and says:

I, _____ in my capacity as
(Affiant's full printed name—no initials)
_____, on behalf of
(Affiant's title)
_____, which is located at
(Name of dental plan organization)
_____
(Street and City where dental plan organization is located)
in New Jersey, do hereby make application for the renewal of the Certificate of Authority of the above-named dental plan organization, which Certificate of Authority shall otherwise expire on _____
(Expiration date and year)

I do hereby certify on this _____ day of _____, 19___, under penalty of perjury that I am a principal officer of the above-named dental plan organization, and that all statements made herein and in the Certificate of Authority Renewal Request Form attached hereto and incorporated herein are true and correct to the best of my knowledge and belief.

_____
(Signature of Affiant)

Subscribed and duly sworn before me, the undersigned authority, on this _____ day of _____, 19___.

(Seal) _____
(Notary Public)

My Commission Expires _____

New Rule, R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

APPENDIX B

DENTAL PLAN ORGANIZATION CERTIFICATE OF AUTHORITY RENEWAL REQUEST FORM

Full Name and Address of Dental Plan Organization

_____
_____
_____

Provide relevant information to each numbered item below. If an item is not applicable, mark it as nonapplicable or NA. Failure to respond to all items may delay the review process. If you need more space than is provided to answer any item, attach additional pages to complete the answer. Please number answers in accordance with the item number. Submit all documents required to be attached to this form with this form, indicating the item number to which the document is responsive. When completed, and no later than 60 days prior to the date of expiration of the current Certificate of Authority, submit this form and all attachments, the Certificate of Authority Renewal Affidavit and the required renewal fee to:

Chief, Managed Care Bureau
Office of Life and Health
New Jersey Department of Banking and Insurance
20 West State Street
PO Box 325
Trenton, NJ 08625-0325

1. List, in reverse chronological order, any changes which have been made in the past three (3) years to the articles of incorporation, articles of association, partnership agreement, shareholder agreement, bylaws and other documents regulating the conduct or internal affairs of the DPO. Specify the date of change and document changed, date submitted to the Department and the date of the Department's approval, if applicable.

_____
_____
_____

2. List any new officers, partners or members of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee, who have been hired, elected or appointed within the past three (3) years. (Provide full name; date of hire, election or appointment; and date of submission of Biographical Affidavit (NAIC form) to the Department.)

_____
_____
_____

If Biographical Affidavit has not been submitted to the Department, so indicate and submit with this renewal request form. Please use NAIC format for Biographical Affidavit.

3. Have any professional, occupational or vocational licenses of any officer, partner or members of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee been amended or, terminated within the past three (3) years?
YES ___ NO ___
If yes, attach a list indicating name, position, type of license, date of amendment or termination and an explanation.

4. Has any officer, partner or member of the DPO's Board of Directors, Board of Trustees, Executive Committee or other governing board or committee or any other person responsible for conducting the affairs of the DPO:
   a. Been indicted or convicted of a crime, misdemeanor or disorderly person offense in this State, other state, or by the federal government?
   YES ___ NO ___
   If yes, attach a certified copy of the indictment or judgment of conviction, which may be obtained from the clerk of the court where the conviction was entered.
   b. Had any business or professional license been suspended or revoked?
   YES ___ NO ___
   If yes, attach a copy of the order of suspension or revocation from the professional or governmental authority.
   c. Filed for bankruptcy, been declared bankrupt or made an assignment for benefit of creditors?
   YES ___ NO ___
   If yes, attach a copy of the bankruptcy petition, complaint in bankruptcy, or complaint in action for assignment to creditors.

5. Have any changes been made or any new contracts or agreements been made with any consultant, finder or business manager within the past three (3) years?
YES ___ NO ___

If yes, attach a list including a brief description of the change, date of submission to and date of approval by the Department.

6. Have any changes been made to provider contracts in the past three (3) years?
   YES ____ NO ____
   If yes, attach a list including a brief description of the change, date of submission to and date of approval by the Department.
7. In reverse chronological order, specify the number of "full-time equivalent dentists", as defined at N.J.A.C. 11:10–1.3, under contract with the DPO as of the date of the submission of this form and December 31 of the two immediately preceding years:

   Current _____: _____
   12/31/____: _____
   12/31/____: _____

8. Attach a list of any changes which have been made to the form of any group or non-group contract or evidence of coverage within the past three (3) years, specifying the type of form, form number, date submitted to the Department and date of Department approval.
9. List the number of group and non-group contracts in force and the group and non-group enrollees' count as of the date of this form and at December 31 of the prior two (2) years.

	Group Contracts	Group employees	Group dependents	NonGroup contracts	NonGroup subscribers	NonGroup dependents
Current____:						
12/31/____:						
12/31/____:						

10. List in reverse chronological order how many types of benefit plans currently are being offered, and the number available on December 31 of the two immediately preceding years.

    Current _____: _____
    12/31/____: _____
    12/31/____: _____

11. Give a brief description of any changes made to the schedule of charges within the past three (3) years listing dates of submission to the Department.

    _____
    _____
    _____

12. For plans utilizing a rate book methodology, submit a copy of the rate book and a certification that states the date last filed with the Department and that all plans currently inforce have been rated using this methodology (note any exceptions and the reason).

    _____
    _____
    _____

13. Have any changes been made to any marketing or advertising materials in the past three (3) years?
    YES ____ NO ____
    If yes, has the material been submitted to the Department?

    If no, attach copies with this renewal request form.

14. As of the date of this form and December 31 of the prior two years, list the number of complaints (see N.J.S.A. 17:48D–12) made during the year and the number outstanding.

	Complaints Made	Complaints Outstanding
Current _____:		
12/31/____:		
12/31/____:		

15. On a year-to-date basis, list the gross contract and certificate income, the percentage of gross contract and certificate income used for the direct provision of professional dental services to enrollees (as defined at N.J.A.C. 11:10–1.9) and the profit or loss after income taxes, for the quarter ending on or before the date of this form and the December 31 of the prior two years.

	Gross Contracts and Certificate Income	Dental Expense	Dental Expense Percent	Administrative Expense	Administrative Expense %	Profit or Loss
Qtr. Ending ____:						
12/31/____:						
12/31/____:						

16. List the total surplus, as of the quarter ending on or before the date of this form and December 31 of the prior two years.

	Total Surplus
Qtr. Ending _____:	
12/31/____:	
12/31/____:	

17. In compliance with N.J.A.C. 11:10–1.8, the general surplus, as of the quarter ending on or prior to the date of this form, has been maintained as follows:

Balance Sheet Item	Amount
Total	

18. In compliance with N.J.S.A. 17:48D–7, the special contingent surplus, as of the quarter ending on or prior to the date of this form, has been maintained as follows:

Balance Sheet Item	Amount
Total	

19. In compliance with N.J.A.C. 11:10–1.12(c)2, the specialist pool surplus, as of the quarter ending on or before the date of this submission and December 31 of the prior two years.

	TOTAL SPECIALIST POOL
Qtr. Ending: _____	
12/31/____	
12/31/____	

20. Pursuant to N.J.A.C. 11:10–2.5(a), have you received written verification from each employer or other organizations as set forth at N.J.A.C. 11:10–2.2 that they are in compliance with N.J.A.C. 11:10–2 and N.J.S.A. 17:48D–9.1 and 9.2?
    YES ____ NO ____
    If no, explain the actions you will take to acquire such verifications.

    _____
    _____
    _____

_____ (Date)

_____ (Signature)

_____ (Type Name)

_____ (Title)

New Rule, R.1994 d.200, effective April 18, 1994.
See: 26 N.J.R. 738(a), 26 N.J.R. 1661(a).

Administrative Correction.
See: 34 N.J.R. 1453(a).