OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Discount Medical Plan Organization Application for Certificate of Registration (Biennial Application)

SUBMISSION FORMAT: Applications must be submitted in electronic format only, via email to OHIC.CERT@ohic.ri.gov. If the PDF file is over 20 MB, Applicants must notify OHIC via email for further submission instructions. Paper Applications will not be accepted.

The electronic copy of the Application must be formatted as:

- A single searchable PDF file (not separate individual files, and not in .TIFF format);
- With a bookmark feature that lists all the Sections in the Application and the specific documents within each Section to allow for navigation among each document (whereby you can click on the bookmarked item to go to the item); and
- With the **Discount Medical Plan Organization Application** form completed to include the references for the documents which address each Application question, including the **PDF PAGE NUMBERS** where they may be found within the application.

Confidentiality Requests:

Confidentiality is granted in rare circumstances and in accordance with past OHIC rulings on confidentiality. A blanket request for confidentiality of an entire application, or any request not sufficiently supported by factual and legal analysis will be rejected. If your company requests that requesting portions of the Discount Medical Plan Organization Application to be deemed confidential by OHIC, please follow the below instructions.

1. **Specific standards:** The request must be accompanied by supporting factual and legal analysis with respect to:
    a. Whether the specific information for which confidential treatment is requested satisfies the statutory criteria of a "trade secret" under **§ 6-41-1,** or the criteria of any other statute upon which the request for confidential treatment is based; and
    b. Whether the interests of the carrier in maintaining the confidentiality of the information outweighs the interests of the public in a transparent regulatory process in compliance with **§ 42-62-13.**

2. **Process:** The request must include:
    a. The factual and legal analysis required noted above,
    b. A specific list of items to which confidentiality is requested,
    c. A copy of the entire, un-redacted document(s); and
    d. A copy of the document(s) with proposed redactions.

The following entities are NOT subject to the requirements set forth in RIGL 27-74. Thus, these entities do not need to **submit a Discount Medical Plan Organization Application for Certificate of Registration:**

- Pursuant to § 27-74-4, A discount medical plan organization that is a licensed health insurer or health maintenance organization or a nonprofit hospital and medical service corporation is not required to obtain a certificate of registration under § 27-73-5, except that any of its affiliates that operate as a discount medical plan organization in this state shall obtain a certificate of registration under § 27-73-5 and comply with all other provisions of this act.
- Pursuant to § 27-74-3(6), a plan that does not charge a membership or other fee to use the plan's discount medical card is not considered to be a Discount Medical Plan.
- A Discount Medical Plan which offers ONLY pharmacy service discounts (and no other medical or ancillary services) is not required to apply for a Certificate of Registration in the state of Rhode Island.

Discount Medical Plan Organization
Application for Certificate of Registration
(Biennial Application)

☐ Initial Application $250.00 ☐ Renewal Application $250.00

Make check payable to: "Office of the Health Insurance Commissioner General Treasurer, State of Rhode Island"

Section 1 – Applicant Information

Discount Medical Plan Organization Name			
Business Address (Physical Location)	City	State	Zip
Business Mailing Address (if different from above)	City	State	Zip
FEIN Number	Toll Free Assistance #	Internet Website Address	
Location of Organization's Books and Records for RI Business	City	State	Zip

Type of Organization ☐ Corporation ☐ LLC ☐ LLP ☐ Partnership ☐ Sole Proprietorship ☐ Other (attach documents)

Date Organization was Incorporated or Formed	State Organization was Incorporated or Formed

Identify all Names, Trade Names, Service Marks, or other means by which a consumer can identify the Discount Medical Plan that the Applicant offers or intends to offer, inclusive of all names under which the Applicant will be marketed in Rhode Island. (Applicant may attach a separate sheet of paper if necessary)

Identify any D/B/As under which the Applicant will be operating.

Section 2 – Applicant Primary Contact Information (Officer, Owner, Partner, Director or Board Member)

Primary Contact First Name	Contact MI	Primary Contact Last Name	Suffix
Title	Business Phone Number	Business Email Address	
Mailing Address	City	State	Zip

Section 3 – Contact Information for Agent for Service of Process

Contact First Name	Contact MI	Contact Last Name	Suffix
Title	Business Phone Number	Business Email Address	
Mailing Address (if other than provided in Section 1)	City	State	Zip

Section 4 – Applicant Background Information

- In accordance with the instructions on page 1, the Applicant must provide a full explanation for any questions answered "yes" as an attachment to this Application.

1. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity been denied a certificate of registration, license or permit to operate as a Medical Discount Plan, or has any such certificate of registration, license or permit to operate ever been suspended, non-renewed, revoked, cancelled or surrendered for any disciplinary reason in any state?	☐ Yes	☐ No
2. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity been under investigation by any regulatory authority or subject to any regulatory action, including cease and desist orders or similar actions within the last five years?	☐ Yes	☐ No
3. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer ever been charged with or convicted of committing a crime? "Crime" includes a misdemeanor, felony or a military offense. You may exclude misdemeanor traffic citations and juvenile offenses.	☐ Yes	☐ No
4. Is the Applicant, or any Owner, Partner, Officer, Board Member, Director or Authorized Producer of the business entity a defendant in any lawsuit?	☐ Yes	☐ No
5. Has any demand been made, or judgment rendered against the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity for overdue monies by a provider of health care services, health care provider network, pharmacy or pharmaceutical network, supplier of health care equipment, insurer or authorized producer?	☐ Yes	☐ No
6. Has the Applicant, or any Owner, Partner, Officer, Board Member, Director, Affiliate or Authorized Producer of the business entity had an insurance agency contract or any other business relationship with an insurance company terminated for any alleged misconduct?	☐ Yes	☐ No
7. Has the Applicant's or any Affiliate's license, certificate of registration or other form of authority to operate a Discount Medical Plan Organization in another jurisdiction ever been denied, suspended, non-renewed, revoked, cancelled, surrendered, or subjected to any judicial, administrative, regulatory action including but not limited to rehabilitation, liquidation, receivership, conservatorship, federal bankruptcy proceeding, state insolvency or supervision in any state?	☐ Yes	☐ No
8. Has the Applicant changed its name or ever merged and/or consolidated with any other entity?	☐ Yes	☐ No
9 Has the Applicant ever declared bankruptcy? Is the Applicant currently in rehabilitation, receivership or liquidation?	☐ Yes	☐ No

Section 5 – Product Information and Miscellaneous Information

- In accordance with the instructions on page 1, the Applicant must provide a complete response for each request below **as an attachment** to this Application.
- **Renewal Applicants:** Complete responses MUST be submitted, OHIC will **not** accept references to responses or materials submitted as part of prior Applications submitted to the office.
- **Renewal Applicants**: If changes to a previously submitted Application response document are made, the Applicant must include a red-lined version of the previously submitted Application response document and a clean version of the Application response document.

1. Describe the fees, dues, charges, periodic charges, processing fees or other consideration that members are to be charged in exchange for access to this discount plan.
2. Provide a complete description of each distinct discount service being offered or to be offered to Rhode Island enrollees under the Discount Medical Plan. (e.g., physician medical services, hospital services, laboratory services, radiology services, dental services, vision services, chiropractic services, and other specified services).
3. Provide a description of the member complaint procedures established by the Discount Medical Plan, evidencing compliance with RIGL § 27-74-11(e)(2)(xi). The complaint procedure must evidence that the members will be provided contact information for OHIC's Consumer Assistance Program:

   RIPIN
   300 Jefferson Blvd Suite 300 Warwick, RI 02888
   (401) 270-0101
   https://ripin.org/
4. Provide a list of all complaints received against the DMPO within the previous two (2) years, categorized by state and complaint topic. A complaint is defined as any oral or written expression of dissatisfaction.
5. List below all states in which the Applicant or an Affiliate holds or has applied for a license, registration, or certificate of authority to transact business as a Discount Medical Plan Organization. Provide the license or certification number(s).
6. Describe the Applicant's experience and expertise to operate a Discount Medical Plan.
7. List all Marketers authorized by Applicant to sell, market, promote, distribute, or solicit a Discount Medical Plan established by the Applicant, to include the Marketer Name, full mailing address, phone number, email address, and website if applicable.
8. List below the participating provider or participating providers included in the provider network that provides **medical** services in this state and a list of the services the participating provider and/or participating provider network offers. Confirm this information is on the website address provided. If the website is password protected or for customers only, please provide any necessary credentials for OHIC to fully review the site.

9. Attach sample contracts (for each distinct discount product), made or to be made between the applicant or any providers or provider networks regarding the provision of **medical services** to RI customers. To the extent the applicant contracts with a provider network, for any of the distinct discount products, also attach sample contracts made or to be made between the provider network and any providers regarding the provisions of medical services to RI customers.

In compliance with RIGL 27-74-9 (b)(1-3), the sample provider agreement(s) must include the following:
(1) A list of the medical services and products to be provided at a discount,
(2) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and
(3) That the provider will not charge members more than the discounted rates.

** A contract and/or fee schedule that does not explicitly ensure that the member will receive a discount from each provider's usual and customary rate will not satisfy this requirement.*

10. List below the participating provider or participating providers included in the provider network that provides **ancillary** services in this state and a list of the services the participating provider and/or participating provider network offers. Confirm this information is on the website address provided. If the website is password protected or for customers only, please provide any necessary credentials for OHIC to fully review the site.

11. Attach sample contracts (for each distinct discount product), made or to be made between the applicant or any providers or provider networks regarding the provision of **ancillary services** to RI customers. To the extent the applicant contracts with a provider network, for any of the distinct discount products, also attach sample contracts made or to be made between the provider network and any providers regarding the provisions of ancillary services to RI customers.

In compliance with RIGL 27-74-9 (b)(1-3), the sample provider agreement(s) must include the following:
(1) A list of the ancillary services and products to be provided at a discount,
(2) The amount or amounts of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and
(3) That the provider will not charge members more than the discounted rates.

** A contract and/or fee schedule that does not explicitly ensure that the member will receive a discount from each provider's usual and customary rate will not satisfy this requirement.*

12. Provide a description of the reimbursement process the Applicant uses when a member cancels their membership within the first thirty (30) days pursuant to RIGL § 27-74-8(b).

13. Provide a member enrollment form that evidences compliance with each element of RIGL § 27-74-11(c)(3) (i-v).

14. Provide sample advertising, marketing materials, and brochures the Applicant intends to use in Rhode Island. All materials must be truthful and not misleading in fact or in implication pursuant to RIGL § 27-74-11(a).

15. Describe how the DMPO will be advertised and/or promoted and/or marketed to RI members, inclusive of any targeted populations, groups, or entities.

16. Provide a sample copy of documentation given to prospective members which outlines the limitations or restrictions on the refund of any processing fees or periodic charges associated with the discount medical plan, pursuant to RIGL § 27-74-11(e)(1).

17. Provide a sample copy of the documentation given to new members which outlines the Terms and Conditions of the discount medical plan, inclusive of all requirements set forth in RIGL § 27-74-11(e)(2) (i-xii).

18. Provide the current number of discount medical plan members in the State of Rhode Island. Additionally, provide the current number of discount medical plan members nationwide.

19. If applicable, identify in an addendum to this application any material changes to previously submitted marketing materials, member applications, consumer disclosures, plan offerings, and/or provider contracts since the Applicant's last Application submission.

Section 6– Applicant Attestation

I,_____, am a duly authorized officer of the above-identified Discount Medical Plan Organization (DMPO). I do hereby attest that I am knowledgeable as to the current laws and regulations applicable to the Discount Medical Plan Organization Act (the Act), including R.I General Laws §27-74. To the best of my knowledge and belief, I hereby attest that the DMPO is in compliance and will maintain compliance with such laws and regulations.

Furthermore, I hereby attest and swear under oath that:

a. All of the information submitted in this Application and attachments are true and complete. I am aware that submitting false information or omitting pertinent or material information in connection with this Application is grounds for revocation or denial of registration and may subject the DMPO and/or the Officer completing this Certification to administrative or criminal penalties.
b. The DMPO will maintain in force a surety bond in its own name in an amount not less than fifty thousand dollars ($50,000) or in lieu of the bond, provide evidence to OHIC of its compliance with § 27-74-6 (b).
c. The DMPO has read and understands the provider agreement requirements and provisions outlined under § 27-74-9 (b) and (c) and has provided evidence within this Application of the amount or amounts of the discounts, or, alternatively, a fee schedule that reflects each provider's discounted rates (discounted from each provider's usual and customary charges) and further confirms it has provided OHIC with the relevant items outlined in Section 5 of the DMPO Application to evidence its compliance with these statutory provisions.
d. In the event a member chooses to file a complaint and/or concern with the DMPO, all website and membership materials provided to members include the DMPO's phone number and email address in which a member may contact the DMPO for assistance.
e. The DMPO's website and membership materials provide clear notice to every member that if the member remains dissatisfied after completing the DMPO's internal complaint resolution process, the member may contact OHIC and its consumer assistance partner RIPIN. Further, the DMPO will provide the contact information for both OHIC and RIPIN at the time of enrollment.
f. All advertisements, marketing materials, brochures, discount medical plan cards and any other communications of the DMPO provided to prospective members and members are truthful, not misleading in fact or in implication, and comply with all provisions set forth in § 27-74-11.
g. Except as otherwise provided in The Act or as a disclaimer of any relationship between discount medical plan benefits and insurance, the DMPO does not use in its advertisements, marketing materials, brochures and discount medical plan cards the term "insurance".
h. The DMPO approves in writing all advertisements marketing materials, brochures and discount cards used by marketers to market, promote, sell or distribute the discount medical plan prior to their use.
i. The DMPO understands that it is bound by and responsible for the activities of any marketer conducting business on behalf of the DMPO, in compliance with § 27-74-10 (c).
j. Upon request from OHIC, the DMPO will submit all advertising, marketing materials and brochures regarding a DMPO.
k. The DMPO will notify OHIC immediately whenever the DMPO's certificate of registration, or other form of authority, to operate as a DMPO in another jurisdiction is suspended, revoked or nonrenewed in that state.
l. The DMPO will notify the Commissioner immediately whenever the DMPO is under investigation or the subject of any pending action in a jurisdiction outside of Rhode Island.
m. The DMPO will provide OHIC with at least thirty (30) days' advance notice of any change in the DMPO's name and addresses in accordance with § 27-74-12.
n. The DMPO is aware of and will promptly comply with its obligation to submit reports, documentation, and other information, as requested, to OHIC in accordance with §§ 27-74-10 and 27-74-13.
o. The Rhode Island Health Insurance Commissioner is authorized to give any information concerning the DMPO, as permitted by law, to any federal, state or municipal agency, or any other organization and the DMPO hereby releases the State of Rhode Island, the Rhode Island Health Insurance Commissioner and any person acting on their behalf from any and all liability of whatever nature by reason of furnishing such information.

Signature: _____ Date: _____

Printed Name: _____

Notary Information

State of:____ County of: _____

The foregoing instrument was acknowledged before me this _____ Day of _____ , 20 _____ , By

_____ , and
who is personally known to me, or who produced the following identification: _____

Notary Public Signature: _____

[SEAL] Printed Notary Name: _____

My Commission Expires:

Section 7 – Attachments (Applicant must submit the following additional documentation with the application for it to be deemed complete)

1. Certificate of incorporation or formation
2. Current certificate of registration as a foreign entity issued by the RI Secretary of State Certified copy of Charter and Bylaws
3. Certified copy of Operating/Partnership Agreement
4. Other Organization formation documents not listed above:_____
5. Copy of Errors & Omissions Insurance (Binder pages to include carrier, limits, policy period)
6. Copy of Directors & Officers Insurance (Binder page to include carrier, limits, policy period)
7. Copy of the Applicant's audited financial statements or unaudited financial statements with signed federal tax return for the most recent year.
8. Provide a list of all Officers, Directors and Board Members of the Discount Medical Plan Organization with their address and phone number.
9. Provide a list of all contractual arrangements or other arrangements with other Discount Medical Plan Organizations by providing name, address, phone number and describe arrangement.
10. Proof of surety bond or deposit pursuant to R.I. Gen. Laws § 27-74-6 need not be filed with this application, however, such documentation must be provided prior to approval of registration.
11. An organizational chart including all entities within the ultimate parent company structure, if applicable.