

Maine Bureau of Insurance
Form Filing Review Requirements Checklist
NON-QUALIFIED/NON-CERTIFIED - DENTAL PLANS - INDIVIDUAL (H10I)
Outside the Marketplace
(Revised 3/20/2015)

Confirm compliance and IDENTIFY the LOCATION (Page Number, Section, Paragraph, etc.) of the STANDARD in the last column.
 N/A: Check this box if a contract does not have to meet this requirement and EXPLAIN WHY in the last column.

BENEFIT/PROVISION REQUIREMENT	REFERENCE	STATE DESCRIPTION OF REQUIREMENT	N/A →	IDENTIFY LOCATION OF STANDARD IN FILING AND EXPLAIN IF REQUIREMENT IS INAPPLICABLE
GENERAL SUBMISSION REQUIREMENTS				
Electronic (SERFF) Submission Requirements	24-A M.R.S.A. §2412 (2) Bulletin 360	All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See http://www.serff.com .	<input type="checkbox"/>	
FILING FEES	24-A M.R.S.A. §601(17)	\$20.00 for Rate filings, rating rules filings, insurance policy, forms, riders, endorsements and certificates. See General Instructions page in SERFF for additional information on filing fee structure. Filing fees must be submitted by EFT in SERFF at the time of submission of the filing. All filings require a filing fee unless specifically excluded per 24-A M.R.S.A. §4222(1), and/or are a required annual report.	<input type="checkbox"/>	
Grounds for disapproval	24-A M.R.S.A. §2413	Seven categories of the grounds for disapproving a filing.	<input type="checkbox"/>	
Readability	24-A M.R.S.A. §2441	Minimum of 50. Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with	<input type="checkbox"/>	

		the policy/certificate to which they will be attached. Exceptions: Federally mandated forms/language, Groups > 1000, Group Annuities as funding vehicles. Scores must be entered on form schedule tab in SERFF.		
Variability of Language	24-A M.R.S.A. §2412 §2413	Forms with variable bracketed information must include all the possible language that might be placed within the brackets. The use of too many variables will result in filing disapproval as Bureau staff may not be able to determine whether the filing is compliant with Maine laws and regulations.	<input type="checkbox"/>	
GENERAL POLICY PROVISIONS				
Explanations for any Exclusion of Coverage for work related sicknesses or injuries	24-A M.R.S.A. §2413	If the policy excludes coverage for work related sicknesses or injuries, clearly explain whether the coverage is excluded if the enrollee is exempt from requirements from state workers compensation requirements or has filed an exemption from the workers compensation laws.	<input type="checkbox"/>	
Free look period	24-A M.R.S.A. §2717	10 day free look.	<input type="checkbox"/>	
General format	24-A M.R.S.A. §2703	Readability, term of policy described, cost disclosed, form number in bottom left corner.	<input type="checkbox"/>	
Grace Period	24-A M.R.S.A. §2809-A §2707 Bulletin 288	There shall be a provision that a grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.	<input type="checkbox"/>	
Legal actions	24-A M.R.S.A. §2828 §2715	No action can be brought to recover on the policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the policy. No such action shall be brought after the expiration of 3	<input type="checkbox"/>	

		years (for individual plans) (2 years for group plans) after the time written proof of loss is required to be furnished.		
Misstatement of age	24-A M.R.S.A. §2720	Misstatement of age: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age	<input type="checkbox"/>	
Notice of Rate Increase	24-A M.R.S.A. §2839 §2735-A	Requires that insurers provide a minimum of 60 days written notice to affected policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. It specifies the requirements for the notice. See these sections for more details. Reasonable notice must be provided for other types of policies.	<input type="checkbox"/>	
Outline of Coverage – Dental Requirements	Rule 755, Sec. 7(N)	This subsection describes the required provisions and disclosures for the Outline of Coverage for Dental Coverage.	<input type="checkbox"/>	
Outline of Coverage - General Requirements	Rule 755, Sec. 7(B)	This subsection contains general requirements and disclosures for Outlines of Coverage.	<input type="checkbox"/>	
PPO Benefit level differential	24-A M.R.S.A. §2677-A	There cannot be more than a 20% differential in benefits between preferred and non-preferred providers. Superintendent can grant waiver for the 20%, in particular for designated providers for cost or quality.	<input type="checkbox"/>	
Renewal provision	24-A M.R.S.A. §2820 §2738	Policy must contain the terms under which the policy can or cannot be renewed.	<input type="checkbox"/>	
Required disclosure statements on policies/certificates	Rule 755, Sec. 7(A)(22)	All dental plan policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:	<input type="checkbox"/>	

		“Notice to Buyer: This [policy] [certificate] provides dental benefits only.”		
Third Party Notice, Cancellation and Reinstatement	24-A M.R.S.A. §2847-C 24-A M.R.S.A. §2707-A Rule 580	Third party notice of cancellation and reinstatement for cognitive impairment or functional incapacity.	<input type="checkbox"/>	
Time limit on defenses	24-A M.R.S.A. §2706	After 3 years from the date of issue of policy no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability, commencing after the expiration of such 3-year period.	<input type="checkbox"/>	
ELIGIBILITY/ENROLLMENT				
Definition of Dependent	24-A M.R.S.A. §2742	Children (including stepchildren, adopted children or children placed for adoption) under the age of 19. Cannot use financial dependency as a requirement for eligibility. Adopted, or placed for adoption children are to be provided the same benefits as natural dependent children and stepchildren.	<input type="checkbox"/>	
Dependent Children - Offer	24-A M.R.S.A. §2847-R §2766	All group dental insurance policies, contracts and certificates that offer dependent coverage must offer the opportunity to enroll a dependent child in the dental insurance coverage during the following periods: A. From birth to 30 days of age; and B. Any open or annual enrollment period.	<input type="checkbox"/>	
Dependent Children Up to Age 25	24-A M.R.S.A. §2833-B	An individual or group health maintenance organization contract that offers coverage for dependent children must offer such coverage	<input type="checkbox"/>	

	§2742-B	until the dependent child is 25 years of age.		
Dependent children with mental or physical illness	24-A M.R.S.A. §2742-A	Requires health insurance policies to continue coverage for dependent children up to 24 years of age who are unable to maintain enrollment in college due to mental or physical illness if they would otherwise terminate coverage due to a requirement that dependent children of a specified age be enrolled in college to maintain eligibility.	<input type="checkbox"/>	
CLAIMS				
Assignment of Benefits	§2827-A 24-A M.R.S.A. §2755	Permits insureds to assign benefits directly to their provider of care. Applies to medical and dental expense incurred plans. Does not include indemnity plans.	<input type="checkbox"/>	
Calculation of health benefits based on actual cost	24-A M.R.S.A. §2185	All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized.	<input type="checkbox"/>	

Claim forms	24-A M.R.S.A. §2710	The insurer will furnish claim forms to the claimant. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of this policy for filing of claim forms.	<input type="checkbox"/>	
Coordination of Benefits and Evidence of Coverage	24-A M.R.S.A. §2723-A Rule 790	Lists items that are required to be placed in an Evidence of Coverage. Also §9 states: Evidences of coverage may contain a provision for coordination of benefits, provided that such provision shall not relieve an HMO of its duty to provide or arrange for a covered health care service to an enrollee solely because the enrollee is entitled to coverage under any other contract, policy or plan, including coverage provided under government programs. Medicaid is always secondary.	<input type="checkbox"/>	
Explanations Regarding Deductibles	24-A M.R.S.A. §2413	All policies must include clear explanations of all of the following regarding deductibles: <ol style="list-style-type: none"> 1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. 	<input type="checkbox"/>	

<p>lifetime Limits and Annual Aggregate Dollar Limits Prohibited</p>	<p>24-A M.R.S.A. §4318</p>	<p>An individual or group health plan may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group.</p> <p>A carrier may however offer a health plan that limits benefits under the health plan for specified health care services on an annual basis.</p>	<p><input type="checkbox"/></p>	
<p>Limits on priority liens/Subrogation</p>	<p>§2729-A</p>	<p>Does this policy have subrogation provisions? If yes see provision below:</p> <p>Subrogation requires prior written approval of the insured and allows such payments only on a just and equitable basis and not on the basis of a priority lien. Applies to point of service contracts in the HMO but doesn't apply to closed network arrangements.</p>	<p><input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> Please provide citation for section in policy</p> <hr/> <p>No <input type="checkbox"/></p>
<p>Notice of claim</p>	<p>24-A M.R.S.A. §2823</p> <p>§2709</p>	<p>There shall be a provision that written notice of sickness or of injury must be given to the insurer within 20 days (30 days for group) after the date when such sickness or injury occurred. Failure to give notice within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.</p>	<p><input type="checkbox"/></p>	
<p>Payment of Claims</p>	<p>24-A M.R.S.A. §2436</p>	<p>A claim for payment of benefits under a policy or certificate of insurance delivered or issued for delivery in this State is payable within 30 days after proof of loss is received by the insurer.</p>	<p><input type="checkbox"/></p>	

GRIEVANCES & APPEALS

Grievance procedure	24-A M.R.S.A. §2747			

PROVIDERS/NETWORKS

Dental hygiene therapist	24-A MRSA §2765-A	<p>1. An insurer that issues individual dental insurance or health insurance that includes coverage for dental services shall provide coverage for dental services performed by a dental hygiene therapist licensed under Title 32, chapter 16, subchapter 3-C when those services are covered services under the contract and when they are within the lawful scope of practice of the dental hygiene therapist.</p> <p>2. Limits; coinsurance; deductibles. A contract that provides coverage for the services required by this section may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles and exclusions to the extent that these provisions are not inconsistent with the requirements of this section.</p> <p>3. Coordination of benefits with dental insurance. If an enrollee eligible for coverage under this section is eligible for coverage under a dental insurance policy or contract and a health insurance policy or contract, the insurer providing dental insurance is the primary payer responsible for charges under subsection 1 and the insurer providing individual health insurance is the secondary payer.</p>	<input type="checkbox"/>	
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		4. Application. The requirements of this section apply to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed on or after January 1, 2015 in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.		
Independent Practice Dental Hygienists	24-A M.R.S.A. §2847-Q §2765	Coverage must be provided for dental services performed by a licensed independent practice dental hygienist when those services are covered services under the contract and when they are within the lawful scope of practice of the independent practice dental hygienist.	<input type="checkbox"/>	
Network approval	24-A M.R.S.A. §2673-A Rule 360 Rule 850	All managed care arrangements except MEWAs must be filed for adequacy & compliance with Rule 850 & Rule 360 access standards.	<input type="checkbox"/>	
GENERAL DENTAL SERVICES/COVERAGE				
Emergency services	24-A M.R.S.A. §2847-A §2749-A	No prior authorization can be required for emergency services.	<input type="checkbox"/>	