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| **Maine Bureau of Insurance** |
| Form Filing Review Requirements Checklist |
| TOI - H15G |
| Group Hospital/Surgical/Medical Expense |
| Revised – 10/1/2021 |
| Carriers must confirm compliance and IDENTIFY the LOCATION (Form number, Page number, Section, Paragraph, etc.) of the standard in the form in the last column. Any response of N/A requires that a carrier explain why the requirement is not applicable. |
| This checklist is intended to provide a summary of State and Federal requirements for the TOI listed above. Please see the laws/rules referenced in the checklist below for the full requirement. |

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| **REVIEW REQUIREMENTS** | **REFERENCES** |  | **COMPLIANCE** |
| **ADDITIONAL RATE FILING REQUIREMENTS** |  |  |  |
| Notice of Rate Increase | [Title 24-A § 2839](https://legislature.maine.gov/statutes/24-A/title24-Asec2839-A.html)-A | Requires that insurers provide a minimum of 60 days written notice to policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. See statute for the requirements for the notice. |  |
| **GENERAL POLICY PROVISIONS** |  |  |  |
| Applicant's statements | [Title 24-A § 2817](https://legislature.maine.gov/statutes/24-A/title24-Asec2817.html) | The following must be included :1. No statement made by the applicant for insurance shall avoid the insurance or reduce benefits thereunder unless contained in the written application signed by the applicant. 2. No agent has authority to change the policy or to waive any of its provisions.3. No change in the policy shall be valid unless approved by an officer of the insurer and evidenced by indorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. |  |
| Childhood Immunizations | [Title 24-A § 4302](https://legislature.maine.gov/statutes/24-A/title24-Asec4302.html)(1)(A)(5)  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | Childhood immunizations must be expressly covered or expressly excluded in all policies. If childhood immunizations are a covered benefit it must be expressly stated in the benefit section. If childhood immunizations are not a covered benefit then this must be expressly stated as an exclusion in the policy. |  |
| Classification, Disclosure, and Minimum Standards | [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | Must comply with all applicable provisions of [Rule 755](https://www.maine.gov/sos/cec/rules/02/031/031c755.doc) including, but not limited to, Sections 4, 5, 6(A), 6(G), 7(A), 7(B), 7(G), and 8. |  |
| Continuation of group coverage | [Title 24-A § 2809](https://legislature.maine.gov/statutes/24-A/title24-Asec2809-A.html)-A(11) | If the termination of an individual's group insurance coverage is a result of the member or employee being temporarily laid off or losing employment because of an injury or disease that the employee claims to be compensable under Workers Compensation, the insurer shall allow the member or employee to elect to continue coverage under the group policy at no higher level than the level of benefits or coverage received by the employee immediately before termination and at the member's or employee's expense or, at the member's or employee's option, to convert to a policy of individual coverage without evidence of insurability in accordance with this section. See complete details in §2809-A(11). |  |
| Continuity for individual who changes groups | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-B.html)-B | A person is provided continuity of coverage if the person was covered under a prior policy and the prior policy terminated within 180 days before the date the person enrolls or is eligible to enroll in the succeeding policy, or within 90 days before the date the person enrolls or is eligible to enroll in the succeeding contract. The succeeding carrier must waive any medical underwriting or preexisting conditions exclusion to the extent that benefits would have been payable under a prior contract or policy if the prior contract or policy were still in effect. |  |
| Continuity of coverage | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)  [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849.html)-B(7) | This section provides continuity of coverage to persons who were covered under the replaced contract or policy at any time during the 90 days before the discontinuance of the replaced contract or policy. Must certify in the cover letter and/or filing description that the underlying plan will comply with Maine’s continuity law. |  |
| Coordination of Benefits provisions (requirement applicable only if policy contains a coordination of benefits provision)Coordination of Benefits with Medicare and Medicaid | [Title 24-A § 2844](https://legislature.maine.gov/statutes/24-A/title24-Asec2844.html)(1-A)(B)(4)  [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(A)  [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(D)  [Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc)  [Bulletin 440](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/440.pdf) | Provisions relating to coordination of benefits payable under the contract and under other plans of insurance or of health care coverage under which a certificate holder or the certificate holder's dependents may be covered must conform to Bureau of Insurance [Rule 790](https://www.maine.gov/sos/cec/rules/02/031/031c790.doc).The statute also sets forth how coordination with Medicare and Medicaid is governed. Medicaid (MaineCare) is always secondary payer to the insurer. |  |
| Definition of Medically Necessary | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)-A(10-A) | Forms that use the term "medically necessary" or similar terms must include the following definition verbatim: A. Consistent with generally accepted standards of medical practice; B. Clinically appropriate in terms of type, frequency, extent, site and duration; C. Demonstrated through scientific evidence to be effective in improving health outcomes; D. Representative of "best practices" in the medical profession; and E. Not primarily for the convenience of the enrollee or physician or other health care practitioner. |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | 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. |  |
| Extension of Benefits | [Title 24-A § 2849](https://legislature.maine.gov/statutes/24-A/title24-Asec2849-A.html)-A  [Rule 590](https://www.maine.gov/sos/cec/rules/02/031/031c590.doc) | Provide an extension of benefits of 6 months for a person who is totally disabled on the date the group or subgroup policy is discontinued. For a policy providing specific indemnity during hospital confinement, "extension of benefits" means that discontinuance of the policy during a disability has no effect on benefits payable for that confinement. For purposes of determining eligibility for extension of benefits, "total disability" shall be defined no more restrictively than: A.in the case of an insured who was gainfully employed prior to disability, "the inability to engage in any gainful occupation for which he or she is reasonably suited by training, education, and experience;" or B.in the case of an insured who was not gainfully employed prior to disability, "the inability to engage in most normal activities of a person of like age in good health." |  |
| Grace Period | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707.html) | The policy must include a “Grace period” of not less than 7 days for weekly premium, 10 days for monthly premium, and 31 days for all other policies. |  |
| Guaranteed Issue & Renewal | [Title 24-A § 2808](https://legislature.maine.gov/statutes/24-A/title24-Asec2808-B.html)-B  [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850-B.html)-B | Renewal must be guaranteed to all individuals, to all groups and to all eligible members and their dependents in those groups except for failure to pay premiums, fraud or intentional misrepresentation. Small group plans are guaranteed issue and renewed, community rated, and standardized plans. |  |
| Health plan accountability | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) | Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, and utilization review standards. |  |
| Health Plan Improvement Act | [Title 24-A Chapter 56-A](https://legislature.maine.gov/statutes/24-A/title24-Ach56-Asec0.html) | These sections describe requirements for health plans offered in Maine. The requirements include, but are not limited to: access to clinical trials, access to prescription drugs, utilization review standards, and independent external review |  |
| HIV/AIDS/ARC | [Title 24-A § 2846](https://legislature.maine.gov/statutes/24-A/title24-Asec2846.html) | No insurance policy may provide more restrictive coverage for death resulting from AIDS, ARC, or HIV-related diseases that the death resulting from any other disease or sickness or exclude coverage for death resulting from AIDS, ARC, or HIV-related diseases, except through an exclusion under which deaths resulting from all sicknesses and diseases are treated the same. See also [Title 24-A § 2159](https://legislature.maine.gov/statutes/24-A/title24-Asec2159.html)(4) for further information on unfair discrimination. |  |
| Home health care coverage | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837.html)  [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M) | Policies that provide coverage on an expense incurred basis for inpatient hospital care shall make available coverage for home health care services by a home health care provider. The policy may contain a reasonable limitation on the number of home care visits and other services provided, but the number of such visits shall not be less than 90 in any continuous period of 12 months for each person covered under the policy. Each visit by an individual member of a home health care provider shall be considered as one home care visit. The statute also sets forth what “home health care services” includes, as well as exclusions. |  |
| Intoxicants and narcotics | [Title 24-A § 2728](https://legislature.maine.gov/statutes/24-A/title24-Asec2728.html)  [Title 24-A § 2829](https://legislature.maine.gov/statutes/24-A/title24-Asec2829.html)(3) | Policies cannot contain the following provision: “2728 and narcotics. The insurer is not liable for any loss sustained or contracted in consequence of the insured’s being intoxicated or under the influence of any narcotic or of any hallucinogenic drug, unless administered on the advice of a physician.” |  |
| Lifetime Limits and Annual Dollar Limits Prohibited - Lifetime or annual limits on the dollar value of Essential Health Benefits (EHB): \*2023 Plan Year Limits: Use current maximum out-of-pocket limits as prescribed by CMS final rule. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)  PHSA § 2711 ([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual),[45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1126).126) | A carrier offering an individual, small group or large group health plan, may not establish lifetime limits on the dollar value of benefits for any participant or beneficiary; or annual limits on the dollar value of essential benefits. Plans may not establish lifetime limits on the dollar value of essential health benefits: Ambulatory patient services, Emergency services, Hospitalization Maternity and newborn care, Mental health, and substance use disorder services, including behavioral health treatment, Prescription drugs Rehabilitative and habilitative services and devices, Laboratory services, Preventive and wellness services and chronic disease management, Pediatric services, including oral and vision care Issuers are not prohibited from using lifetime limits for specific covered benefits that are not EHB; issuers are not prohibited from excluding all benefits for a non-covered condition for all covered people, but if any benefits are provided for a condition, then no lifetime limit requirements apply. |  |
| Limits on priority liens/Subrogation | [Title 24-A § 2836](https://legislature.maine.gov/statutes/24-A/title24-Asec2836.html)  [Title 24-A § 2729](https://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html)-A | No policy shall provide for priority over the insured if the insured is entitled to receive reimbursement as a result of legal action or claim, except if that provision is approved by the superintendent, requires the 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. |  |
| Penalty for failure to notify of hospitalization | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-A.html)-A  [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1138).138(b) | No penalty allowed for failure to notify the insurer of insured's hospitalization for emergency treatment. (There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.) |  |
| PPOs – Payment for Non-preferred Providers (as applicable) | [Title 24-A § 2677-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | 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. |  |
| Prohibition against Absolute Discretion Clauses | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (11) | Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements. |  |
| Renewal provision | [Title 24-A § 2411](https://legislature.maine.gov/statutes/24-A/title24-Asec2411.html)  [Title 24-A § 2820](https://legislature.maine.gov/statutes/24-A/title24-Asec2820.html) | Policy must contain the terms under which the policy can or cannot be renewed prominently on first page of policy or certificate. |  |
| Required provisions | [Title 24-A § 2816](https://legislature.maine.gov/statutes/24-A/title24-Asec2816.html)  [Title 24-A § 2817](https://legislature.maine.gov/statutes/24-A/title24-Asec2817.html)  [Title 24-A § 2818](https://legislature.maine.gov/statutes/24-A/title24-Asec2818.html)  [Title 24-A § 2819](https://legislature.maine.gov/statutes/24-A/title24-Asec2819.html)  [Title 24-A § 2820](https://legislature.maine.gov/statutes/24-A/title24-Asec2820.html)  [Title 24-A § 2821](https://legislature.maine.gov/statutes/24-A/title24-Asec2821.html)  [Title 24-A § 2822](https://legislature.maine.gov/statutes/24-A/title24-Asec2822.html)  [Title 24-A § 2823](https://legislature.maine.gov/statutes/24-A/title24-Asec2823.html)  [Title 24-A § 2824](https://legislature.maine.gov/statutes/24-A/title24-Asec2824.html)  [Title 24-A § 2825](https://legislature.maine.gov/statutes/24-A/title24-Asec2825.html)  [Title 24-A § 2826](https://legislature.maine.gov/statutes/24-A/title24-Asec2826.html)  [Title 24-A § 2827](https://legislature.maine.gov/statutes/24-A/title24-Asec2827.html)  [Title 24-A § 2828](https://legislature.maine.gov/statutes/24-A/title24-Asec2828.html) | Application statements, notice of claim, proof of loss, assignment of benefits, renewal provisions |  |
| Statements In Application | [Title 24-A § 2818](https://legislature.maine.gov/statutes/24-A/title24-Asec2818.html) | There shall be a provision that all statements contained in any such application for insurance shall be deemed representations and not warranties. |  |
| Third Party 10 Day Notification prior to cancellation; restrictions on cancellation, termination or lapse due to cognitive impairment or functional incapacity | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-C.html)-C  [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html)-A  [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | An insurer shall provide for notification of the insured person and another person, if designated by the insured, prior to cancellation of a health insurance policy for nonpayment of premium. FOR INDIVIDUAL PLANS: Insurers must provide the following disclosure, notice and reinstatement rights:1. Insured has the right to elect a third party to receive notice and that the insurer will send them a third party notice request form to make that selection.2. Insured and designated individual will receive a 10 day notice of cancellation.3. Insured has the right to reinstatement of the contract if the insured suffers from cognitive impairment or functional incapacity and the ground for cancellation was the insured’s nonpayment of premium or other lapse or default on the part of the insured.4. Notice that if a request for reinstatement of coverage because of cognitive impairment or functional incapacity is denied, notice of denial shall be provided to the insured and to the person making the request, if different. The notice of denial shall include notification of the 30 day period following receipt of the notice during which a hearing before the Superintendent may be requested. FOR GROUP PLANS: Third Party Notice of Cancellation for group plans must be applied as follows: 1. If the entire cost of the insurance coverage is paid by the Policyholder, there is no requirement to send the Third Party Notice of Cancellation. 2. If the entire cost of the insurance coverage is paid by the Certificate holder and is direct billed, the insurer must include notification in the policy/certificate to advise the member of their rights. 3. If the entire cost of the insurance coverage is paid by the Certificate holder and is made via payroll deduction, then [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc), § 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. 4. If a portion of the cost of the insurance coverage is paid by the Policyholder and the remainder is paid by the Certificate holder and is made via payroll deduction, then [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc), § 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights. Please review [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) and add the required language to the certificate. Additionally, pursuant to [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) § 6(A)(7), the requirement may be satisfied by including the notice of reinstatement right in an application that is incorporated into the contract. |  |
| Third Party Notice, Cancellation and Reinstatement | [Title 24-A § 2707](https://legislature.maine.gov/statutes/24-A/title24-Asec2707.html)-A  [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847.html)-C  [Title 24-A § 5016](https://legislature.maine.gov/statutes/24-A/title24-Asec5016.html)  [Rule 580](https://www.maine.gov/sos/cec/rules/02/031/031c580.doc) | Third party notice of cancellation and reinstatement for cognitive impairment or functional incapacity. |  |
| Time for Suits | [Title 24-A § 2828](https://legislature.maine.gov/statutes/24-A/title24-Asec2828.html) | There shall be a provision that no action at law or in equity shall be brought to recover on the policy prior to the expiration of 60 days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all, unless brought within 2 years from the expiration of the time within which proof of loss is required by the policy. |  |
| Limitations on exclusions and waiting periods | [Title 24-A § 2850](https://legislature.maine.gov/statutes/24-A/title24-Asec2850.html) | A preexisting condition exclusion may not exceed 12 months, including the waiting period, if any. This section goes on to describe restrictions to preexisting condition exclusions. |  |
| **ELIGIBILITY / ENROLLMENT** |  |  |  |
| Coverage for Dependent Children Up to Age 26 | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-B.html)-B | A group health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 26 years of age. |  |
| Definition of Dependent | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833.html) | Defined as under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with the policyholder, member or spouse of the policyholder or member, no financial dependency requirement, court ordered coverage |  |
| Dependent children with mental or physical illness. | [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833-A.html)-A  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-B.html)-B | Requires health insurance policies to continue coverage for dependent children up to 26 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. |  |
| Dependent Coverage | [Title 24-A § 2809](https://legislature.maine.gov/statutes/24-A/title24-Asec2809.html) | Coverage for family members or dependents of an individual in the insured group may not exclude those minor children of the individual who do not reside with that individual.  Coverage for family members or dependents of an individual in the insured group may provide for the continuation of benefit provisions after the death of the such individual. |  |
| Dependent special enrollment period | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834-B.html)-B  [Title 24-A § 4222-B](https://legislature.maine.gov/statutes/24-A/title24-Asec4222-B.html) (11) | Enrollment for qualifying events. |  |
| Domestic partner benefits | [Title 24-A § 2832](https://legislature.maine.gov/statutes/24-A/title24-Asec2832-A.html)-A | Contracts must make available to group policyholders the option for additional benefits for the domestic partner of a certificate holder at appropriate rates and under the same terms and conditions as are provided to spouses of married certificate holders under a group policy. This section provides criteria defining "domestic partner" for purposes of this requirement and what evidence may be required as a condition of eligibility. |  |
| Extension of dependent coverage to age 26 | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-B  PHSA § 2714([75 Fed Reg 27122](https://www.federalregister.gov/documents/2010/05/13/2010-11391/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-dependent), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1120).120) | A carrier offering a health plan subject to the requirements of the federal Affordable Care Act that provides dependent coverage of children shall continue to make such coverage available for an adult child until the child turns 26 years of age, consistent with the federal Affordable Care Act. An insurer shall provide notice to policyholders regarding the availability of dependent coverage under this section upon each renewal of coverage or at least once annually, whichever occurs more frequently. Notice provided under this subsection must include information about enrolment periods and notice of the insurer’s definition of and benefit limitations for preexisting conditions. Eligible children are defined based on their relationship with the participant. Limiting eligibility is prohibited based on: financial dependency on primary subscriber, residency, student status, employment, eligibility for other coverage, marital status. Terms of the policy for dependent coverage cannot vary based on the age of a child. |  |
| Newborn coverage | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834.html) | Newborns must be automatically covered under the plan from the moment of birth for the first 31 days. An adopted child is deemed to be newly born to the adoptive parents from the date of the signed placement agreement. |  |
| **CLAIMS** |  |  |  |
| Assignment of Benefits | [Title 24-A § 2827](https://legislature.maine.gov/statutes/24-A/title24-Asec2827-A.html)-A  [Title 24-A § 2755](https://legislature.maine.gov/statutes/24-A/title24-Asec2755.html) | Permits insureds to assign benefits directly to their provider of care. Applies to medical and dental expense incurred plans. Does not include indemnity plans. |  |
| Calculation of health benefits based on actual cost | [Title 24-A § 2185](https://legislature.maine.gov/statutes/24-A/title24-Asec2185.html) | If the insurer has negotiated discounts with providers, the insurer 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 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. |  |
| Claims for Office Visits that include Preventive Health Services | [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=a3bb635afd7624f532acfe878eec552b&pitd=20180719&node=pt45.1.147&rgn=div5#se45.1.147_1130).130 (a)(1) [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(15) | Policies and certificates must include clear explanations regarding how claims will be paid for office visits that include preventive health services, and the policyholder’s cost sharing may not be greater than the following:  If an item or service described in 45 CFR §147.130 (a)(1):  1. Is billed separately (or is tracked as individual encounter data separately) from an office visit, then a plan or issuer may impose cost-sharing requirements with respect to the office visit.  2. Is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then a plan or issuer may not impose cost-sharing requirements with respect to the office visit.  Services related to a specific health concern, condition or injury may be separately billed as an office visit and may be subject to cost-sharing requirements as provided in the health plan. |  |
| Credit toward Deductible | [Title 24-A § 2844](https://legislature.maine.gov/statutes/24-A/title24-Asec2844.html)(3) | When an insured is covered under more than one expense-incurred health plan, payments made by the primary plan, payments made by the insured and payments made from a health savings account or similar fund for benefits covered under the secondary plan must be credited toward the deductible of the secondary plan. This subsection does not apply if the secondary plan is designed to supplement the primary plan. |  |
| Explanations Regarding Deductibles | [Title 24-A § 2413](https://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | All policies must include clear explanations of all of the following regarding deductibles: Whether it is a calendar or policy year deductible. Clearly advise whether non-covered expenses apply to the deductible. Clearly advise whether it is a per person or family deductible or both. |  |
| Forms for proof of loss/Claim Forms | [Title 24-A § 2825](https://legislature.maine.gov/statutes/24-A/title24-Asec2825.html)  [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx)(9) | There shall be a provision that the insurer will furnish to the policyholder such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished before the expiration of 15 days after the insurer received notice of any claim under the policy, the person making such claim shall be deemed to have complied with the requirements of the policy as to proof of loss upon submitting within the time fixed in the policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made. (There is no specific HMO requirement for this benefit/provision, but it is a benchmark plan requirement.) |  |
| Maximum Allowable Charges | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(8) | If benefits for covered services are limited to a maximum amount based on any combination of usual, customary and reasonable charges or other similar method, the carrier must: (1) Clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment; and (2) Provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. Must clearly disclose that the insured or enrollee may be subject to balance billing as a result of claims adjustment and provide a toll-free number that an insured or enrollee may call prior to receiving services to determine the maximum allowable charge permitted by the carrier for a specified service. The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred. |  |
| Notice of Claim/Proof of Loss | [Title 24-A § 2823](https://legislature.maine.gov/statutes/24-A/title24-Asec2823.html)  [Title 24-A § 2824](https://legislature.maine.gov/statutes/24-A/title24-Asec2824.html) | There shall be a provision that written notice of sickness or of injury must be given to the insurer within 30 days 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. |  |
| Payment of Benefits | [Title 24-A § 2814](https://legislature.maine.gov/statutes/24-A/title24-Asec2814.html) | All benefits shall generally be payable to the person insured, or to his designated beneficiary or beneficiaries, or to his estate. |  |
| Penalty for noncompliance with utilization review | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-D.html)-D | A policy may not have a penalty of more than $500 for failure to provide notification under a utilization review program. |  |
| Physical Examination/Autopsy | [Title 24-A § 2826](https://legislature.maine.gov/statutes/24-A/title24-Asec2826.html) | Physical examination/autopsy  The following must be included:  Physical examination and autopsy: The insurer at its own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law. |  |
| Proof of Loss | [Title 24-A § 2824](https://legislature.maine.gov/statutes/24-A/title24-Asec2824.html) | In a claim for loss of time for disability, written proof of such loss must be furnished to the insurer within 30 days after the commencement of the period for which the insurer is liable, and that subsequent written proofs of the continuance of such disability must be furnished to the insurer at such intervals as the insurer may reasonably require. In a claim for any other loss, written proof of such loss must be furnished to the insurer within 90 days after the date of such loss. Failure to furnish such proof within such time shall not invalidate nor reduce any claim, if it shall be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible. (No Time Limit) |  |
| Protection from Balance Billing | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (8-A) | If the carrier has a provider network, an enrollee's responsibility for payment under a managed care plan when covered health care is rendered by participating providers must be limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance. If the enrollee has paid their share of the charge as specified in the plan, the carrier shall hold the enrollee harmless from any additional amount owed to a participating provider for covered health care. |  |
| Enhance Access to a Second Opinion for Health Care Services or Treatment | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | An enrollee in a health plan may not be required to obtain a 2nd opinion from a provider that practices in the same office location as the enrollee's provider, even if that office is the only in-network provider for the service. A carrier may not apply a greater deductible, coinsurance or copayment for the 2nd opinion than if they received the 2nd opinion in-network. |  |
| Prior Authorization Requirements for Physical and Occupational Therapy Services | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(1)  [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)-A | A carrier may not require prior authorization for rehabilitative or habilitative services, including, but not limited to, physical therapy services, occupational therapy services or chiropractic services, for the first 12 visits of each new episode of care. This does not limit the right of a carrier to deny a claim when an appropriate review concludes that the services or treatment were not medically necessary. |  |
| **GRIEVANCES & APPEALS** |  |  |  |
| Expedited request for external review | [Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html) | An enrollee is not required to exhaust all levels of a carrier's internal grievance procedure before filing a request for external review if the carrier has failed to make a decision on an internal grievance within the time period required, or has otherwise failed to adhere to all the requirements applicable to the appeal pursuant to state and federal law, or the enrollee has applied for expedited external review at the same time as applying for an expedited internal appeal. |  |
| Grievance & appeals procedures | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) (4)  [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 8  [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 9 | Specifically describes grievance & appeal procedures required in the contract, as well as the required available external review procedures |  |
| Right to waive the right to a second level appeal/grievance | [Title 24-A § 4312](https://legislature.maine.gov/statutes/24-A/title24-Asec4312.html) | Enrollees have the right to waive the right to a second level appeal/grievance and request an external review after the first level appeal decision. |  |
| Timeline for second level grievance review decisions | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(4) | Decisions for second level grievance reviews must be issued within 30 calendar days if the insured has not requested to appear in person before authorized representatives of the health carrier. |  |
| **PROVIDERS / NETWORKS** |  |  |  |
| Certified nurse practitioners, certified midwives, and certified nurse (aka: Advanced midwives Practice Registered Nurse) | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-H.html)-H  [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(5) | Coverage for services provided by nurse practitioners, certified midwives, and certified nurse midwives and allows nurse practitioners to serve as primary care providers. |  |
| Chiropractic Services | [Title 24-A § 2840-A](https://legislature.maine.gov/statutes/24-A/title24-Asec2840-A.html) | Benefits must be included for the services of chiropractors, to the extent that the services are within the lawful scope of practice of a chiropractor licensed in this State, if the same services would be covered if provided by a physician. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor. |  |
| Coverage for Services Provided by Certified Registered Nurse Anesthetists | [Title 24-A § 4320](https://legislature.maine.gov/legis/statutes/24-A/title24-Asec4320-Q.html)-Q | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. |  |
| Coverage of Optometrists | [Title 24-A § 2841](https://legislature.maine.gov/statutes/24-A/title24-Asec2841.html) | Benefits must be made available for the services of optometrists if the same services would be covered if performed by physician. |  |
| Dentists | [Title 24-A § 2437](https://legislature.maine.gov/statutes/24-A/title24-Asec2437.html) | Must include benefits for dentists’ services to the extent that the same services would be covered if performed by a physician. |  |
| Inadequate Network | [Rule 850](https://www.maine.gov/sos/cec/rules/02/031/031c850.docx) § 7(B)(5) | If the carrier has an insufficient number or type of participating providers to provide a covered benefit, the carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers. |  |
| Independent Practice Dental Hygienists | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-Q.html)-Q | 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. |  |
| Mental health services provided by certain professionals | [Title 24-A § 2835](https://legislature.maine.gov/statutes/24-A/title24-Asec2835.html) | A covered person is entitled to reimbursement for services performed by one of the following professionals if the policy reimburses for those services and those services are within the professional’s lawful scope of practice:  • Psychologist licensed to practice in Maine;  • Certified social worker licensed for independent practice of social work in Maine;  • Licensed clinical professional counselor licensed for independent practice of counseling in Maine;  • Licensed nurse certified by the American Nurses’ Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing;  • Marriage and family therapist licensed as such in Maine;  • Licensed pastoral counselor licensed as such in Maine. |  |
| Registered nurse first assistants | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-I.html)-I | Benefits must be provided for coverage for surgical first assisting benefits or services shall provide coverage and payment under those contracts to a registered nurse first assistant who performs services that are within the scope of a registered nurse first assistant's qualifications. |  |
| **GENERAL HEALTH CARE TREATMENT / COVERAGE** |  |  |  |
| Anesthesia for Dentistry | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-K.html)-K | Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons. |  |
| Breast reduction and symptomatic varicose vein surgery | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-L.html)-L | Coverage must be offered for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary. |  |
| Clinical Trials | [Title 24-A § 4310](https://legislature.maine.gov/statutes/24-A/title24-Asec4310.html)  PHSA § 2709 | A carrier may not deny a qualified enrollee participation in an approved clinical trial or deny, limit or impose additional conditions on the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial. A non-grandfathered health plan may not discriminate on the basis of participation in a clinical trial and must cover routine patient costs of individuals in clinical trials for treatment of cancer or other life-threatening conditions. |  |
| Colorectal Cancer Screening | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-N.html)-N | Coverage must be provided for colorectal cancer screening for asymptomatic individuals who are: At average risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society; or At high risk for colorectal cancer. “Colorectal cancer screening” means all colorectal cancer examinations and laboratory tests recommended by a health care provider in accordance with the most recently published colorectal cancer screening guidelines of a national cancer society. If a colonoscopy is recommended by a health care provider as the colorectal cancer screening test in accordance with this section and a lesion is discovered and removed during that colonoscopy, the health care provider must bill the insurance company for a screening colonoscopy as the primary procedure. |  |
| Comprehensive Health Coverage; Essential Health Benefits | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-D.html)-D  ACA 1302(b) | A carrier offering a health plan in this State shall, at a minimum, provide coverage that incorporates an essential health benefits package consistent with the requirements of this section. All non-grandfathered individual and small group plans must provide essential health benefits. SEE SEPARATE CHECKLIST FOR SPECIFIC BENEFITS. |  |
| Coverage for Breast Cancer Treatment and Reconstructive Surgery | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-C.html)-C | Coverage with for inpatient breast cancer treatment must be provided for the duration determined by the attending physician.  Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. |  |
| Emergency Services, definitions of “Emergency Services” and “Emergency Medical Condition” – Must be Verbatim | [Title 24-A § 4301](https://legislature.maine.gov/statutes/24-A/title24-Asec4301.html)-A(4-A) & (4-B)  [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(5)  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-C.html)-C | The plan must cover emergency services without prior authorization.  Cost-sharing requirements, such as a deductible, copayment amount or coinsurance rate, for out-of-network services are the same as requirements that would apply if such services were provided in network , and any payment made by an enrollee pursuant to this section must be applied to the enrollee's in-network cost-sharing limit. The enrollee's responsibility for payment for covered out-of-network emergency services must be limited so that if the enrollee has paid the enrollee's share of the charge as specified in the plan for in-network services, the carrier shall hold the enrollee harmless from any additional amount owed to an out-of-network provider for covered emergency services and make payment to the out-of-network provider in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-C.html)-C (as amended by PL 2019, Ch. 668) or, if there is a dispute, in accordance with [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-E.html)-E (as enacted by PL 2019, Ch. 668).“Emergency service” means a health care item or service furnished or required to evaluate and treat an emergency medical condition that is provided in an emergency facility or setting. “Emergency medical condition” means the sudden and, at the time, unexpected onset of a physical or mental health condition, including severe pain, manifesting itself by symptoms of sufficient severity, regardless of the final diagnosis that is given, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe: A. That the absence of immediate medical attention for an individual could reasonably be expected to result in:(1) Placing the physical or mental health of the individual or, with respect to a pregnant woman, the health of the pregnant woman or her unborn child in serious jeopardy;(2) Serious impairment of a bodily function; or(3) Serious dysfunction of any organ or body part; or B. With respect to a pregnant woman who is having contractions, that there is:(1) Inadequate time to effect a safe transfer of the woman to another hospital before delivery; or(2) A threat to the health or safety of the woman or unborn child if the woman were to be transferred to another hospital. Before a carrier denies benefits or reduces payment for an emergency service based on a determination of the absence of an emergency medical condition or a determination that a lower level of care was needed, the carrier shall conduct a utilization review done by a board certified emergency physician who is licensed in this State, including a review of the enrollee's medical record related to the emergency medical condition subject to dispute. If a carrier requests records related to a potential denial of or payment reduction for an enrollee's benefits when emergency services were furnished to an enrollee, a provider has an affirmative duty to respond to the carrier in a timely manner. This does not apply when a reduction in payment is made by a carrier based on a contractually agreed upon adjustment for healthcare service. |  |
| Eye Care Services | [Title 24-A § 4314](https://legislature.maine.gov/statutes/24-A/title24-Asec4314.html) | Patient access to eye care providers when the plan provides eye care services. |  |
| Hearing aids | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-O.html)-O | Coverage is required for the purchase of hearing aids for each hearing-impaired ear, in accordance with the following: The hearing loss must be documented by a physician or audiologist licensed in this State. The hearing aid must be purchased in accordance with federal and state laws, regulations and rules for the sale and dispensing of hearing aids. The policy or contract may limit coverage to $3,000 per hearing aid for each hearing-impaired ear every 36 months. |  |
| Hospice Care Services | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-J.html)-J | Hospice care services must be provided to a person who is terminally ill (life expectancy of 12 months or less). Must be provided whether the services are provided in a home setting or an inpatient setting. See section for further requirements. |  |
| Preventive health services  Preventive health services without cost-sharing requirements including deductibles, co-payments, and co-insurance. | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A  [Rule 191](https://www.maine.gov/sos/cec/rules/02/031/031c191.docx) § 9(M)  PHSA § 2713 ([75 Fed Reg 41726](https://www.federalregister.gov/documents/2010/07/19/2010-17242/interim-final-rules-for-group-health-plans-and-health-insurance-issuers-relating-to-coverage-of), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5).130) | Must, at a minimum, provide coverage for, and may not impose cost-sharing requirements for, the following preventive services: The evidence-based items or services that have a rating of A or B in the recommendations of the USPSTF or equivalent rating from a successor organization; With respect to the individual insured, immunizations that have a recommendation from the federal DHHS, CDC, Advisory Committee on Immunization Practices; With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the most recent version of the comprehensive guidelines supported by the federal DHHS, HRSA; and With respect to women, such additional preventive care and screenings not described in paragraph A, provided for in the comprehensive guidelines supported by the federal DHHS, HRSA women's preventive services guidelines. If one of the recommendations referenced above is changed during a plan year, a carrier is not required to make changes to that health plan during the plan year. SEE SEPARATE CHECKLIST FOR SPECIFIC SERVICES. |  |
| Prostate cancer screening | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-H.html)-H  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | Coverage required for prostate cancer screening: Digital rectal examinations and prostate-specific antigen tests covered if recommended by a physician, at least once a year for men 50 years of age or older until age 72. |  |
| Telehealth Services | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) | Carrier must provide coverage for telehealth services if the service would be covered if it were provided through in-person consultation and as long as the provider is acting within the scope of practice of the provider’s license with regard to telehealth services.  Can’t put any restriction on the prescribing of medication through telehealth that could otherwise be prescribed in-person.  The availability of health care services may not be considered for the purposes of demonstrating provider network adequacy. |  |
| Require Private Insurance Coverage for Donor Breast Milk | [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-V | Coverage for medically necessary pasteurized donor breast milk is required. |  |
| **WOMEN & MATERNITY** |  |  |  |
| Maternity and newborn care; newborn children coverage | [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834.html)  [Title 24-A § 2834](https://legislature.maine.gov/statutes/24-A/title24-Asec2834-A.html)-A  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A  [45 CFR § 148.170](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.148&rgn=div5#se45.1.148_1170) | Benefits must be provided for maternity (length of stay) and newborn care, in accordance with "Guidelines for Perinatal Care" as determined by attending provider and mother. Benefits may not be restricted to less than 48 hours following a vaginal delivery/96 hours following a cesarean section. An issuer is required to provide notice unless state law requires coverage for 48/96-hour hospital stay, requires coverage for maternity and pediatric care in accordance with an established professional medical association, or requires that decisions about the hospital length of stay are left to the attending provider and the mother. Policies and certificates providing coverage on an expense-incurred basis must provide that benefits are payable for a newly born child of the insured or subscriber from the moment of birth for the first 31 days. This must include coverage of injury or sickness or other benefits provided by the policy, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If payment of premium is required to provide coverage for a child, the policy may require that notice of birth and payment of the premium be furnished within 31 days after the date of birth in order to have coverage continue beyond the 31-day period. The payment may be required to be retroactive to the date of birth. |  |
| Maternity benefits for unmarried women | [Title 24-A § 2832](https://legislature.maine.gov/statutes/24-A/title24-Asec2832.html)  [Title 24-A § 2833](https://legislature.maine.gov/statutes/24-A/title24-Asec2833.html)  [Title 24-A § 4234](https://legislature.maine.gov/statutes/24-A/title24-Asec4234.html) | Coverage must provide the same maternity benefits for unmarried women certificate holders, and the minor dependents of certificate holders with dependent or family coverage, as is provided married certificate holders with maternity coverage and the wives of certificate holders with maternity coverage. Coverage issued in accordance with the requirements of section 2832 (above) must provide unmarried women certificate holders with the option of coverage of their children from the date of birth. A certificate holder who, pursuant to the laws of this State or any other state, has been adjudicated or has acknowledged himself to be the father of an illegitimate child must be given the option of coverage for that child from the date of his adjudication or acknowledgement of paternity. This optional coverage must be the same as that provided the children of a married certificate holder with family or dependent coverage. Financial dependency of dependent children may not be required as condition for coverage eligibility. "Dependent children" means children who are under 19 years of age and are children, stepchildren or adopted children of, or children placed for adoption with, the certificate holder, member or spouse of the certificate holder or member. Coverage must also provide the same benefits to dependent children placed for adoption with the certificate holder or spouse of the certificate holder under the same terms and conditions as apply to natural dependent children or stepchildren of the certificate holder, irrespective of whether the adoption has become final. The statute defines “placed for adoption.” |  |
| Obstetrical and gynecological care | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-F.html)-F  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A  PHSA § 2719A([75 Fed Reg 37188](https://www.federalregister.gov/documents/2010/06/28/2010-15278/patient-protection-and-affordable-care-act-preexisting-condition-exclusions-lifetime-and-annual), [45 CFR § 147](https://www.ecfr.gov/cgi-bin/text-idx?SID=985c38eeddaa13128929637cc7ec919e&pitd=20180719&node=pt45.1.147&rgn=div5).138) | Benefits must be provided for annual gynecological exam without prior approval of primary care physician. A group health plan, or health insurance issuer offering group or individual health insurance coverage, described in paragraph (2) may not require authorization or referral by the plan, issuer, or any person (including a primary care provider described in paragraph (2)(B)) in the case of a female participant, beneficiary, or enrollee who seeks coverage for obstetrical or gynecological care provided by a participating health care professional who specializes in obstetrics or gynecology. |  |
| Pap tests | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-E.html)-E  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-A  PHSA § 2713 (45 CFR 147)  ACA 1001 | Benefits must be provided for cervical cancer screening tests. |  |
| Screening Mammograms | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-A.html)-A  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)-A | If radiological procedures are covered. Benefits must be made available for screening mammography at least once a year for women 40 years of age and over. A screening mammogram also includes an additional radiologic procedure recommended by a provider when the results of an initial radiologic procedure are not definitive. |  |
| **COMPLIANCE WITH THE AFFORDABLE CARE ACT – See PPACA Uniform Compliance Summary for specific requirements.** |  |  |  |
| ACA (Affordable Care Act) | [Title 24-A § 4309](https://legislature.maine.gov/statutes/24-A/title24-Asec4309-A.html)-A  [Bulletin 394](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/394.pdf) | A carrier shall comply with all applicable requirements of the ACA. |  |
| Rebates | [Title 24-A § 4319](https://legislature.maine.gov/statutes/24-A/title24-Asec4319.html) | Carriers must provide rebates in the large group, small group and individual markets to the extent required by the ACA. |  |
| **INFANTS & CHILDREN** |  |  |  |
| Autism Spectrum Disorders | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-T.html)-T | Group health insurance policies and certificates must provide coverage for autism spectrum disorders, as defined in this section, for a covered individual who is 10 years of age or under in accordance with the requirements set forth in this section. |  |
| Early Childhood Intervention | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-S.html)-S | Group health insurance policies and certificates must provide coverage for children's early intervention services in accordance with the requirements of this section. "Children's early intervention services" is defined in this section. |  |
| Infant Formula | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-P.html)-P  [Title 24-A § 4256](https://legislature.maine.gov/statutes/24-A/title24-Asec4256.html) | Coverage of amino acid-based elemental infant formula must be provided when a physician has diagnosed and documented one of the following: Symptomatic allergic colitis or proctitis; Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; A history of anaphylaxis Gastroesophageal reflux disease that is nonresponsive to standard medical therapies Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider Cystic fibrosis; or Malabsorption of cow milk-based or soy milk-based formula Medical necessity is determined when a licensed physician has submitted documentation that the amino acid-based elemental infant formula is the predominant source of nutritional intake at a rate of 50% or greater and that other commercial infant formulas, including cow milk-based and soy milk-based formulas, have been tried and have failed or are contraindicated. Coverage for amino acid-based elemental infant formula under a policy, contract or certificate issued in connection with a health savings account may be subject to the same deductible and out-of-pocket limits that apply to overall benefits under the policy, contract or certificate. |  |
| Medical food coverage for inborn error of metabolism | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-D.html)-D | Must provide coverage for metabolic formula and up to $3,000 per year for prescribed modified low-protein food products. |  |
| **MENTAL HEALTH & SUBSTANCE ABUSE SERVICES / COVERAGE** |  |  |  |
| Mental health coverage | [Title 24-A § 2843](https://legislature.maine.gov/statutes/24-A/title24-Asec2843.html)  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320.html)-D  [Rule 330](https://www.maine.gov/sos/cec/rules/02/031/031c330.doc) | The contract must provide coverage for treatment of certain mental illnesses (including substance use disorders), as diagnosed by specific providers, and the coverage must meet the following parity requirements:  • benefits for treatment and diagnosis of mental illnesses must be provided under terms and conditions that are no less extensive than the benefits provided for medical treatment for physical illness;  • providers may be required to furnish data substantiating that initial/continued treatment is medically necessary, and in determining medical necessity, the same criteria must be used for medical treatment for mental illness as for physical illness under the policy;  • if benefits for physical illness are provided on an expense-incurred basis, the benefits required for mental illness may be delivered separately under a managed care system;  • contracts may not have separate maximums, deductibles, coinsurance amounts, out-of-pocket limits in a benefit period of not more than 12 months, or separate office visit limits, for physical illness and mental illness;  • contracts may not impose a limitation on benefits for mental illness unless the same limitation is also imposed for physical illness;  • copayments for mental illness must be actuarially equivalent to any coinsurance requirements or, if there are no coinsurance requirements, may not be greater than any copayment or coinsurance for physical illness; and  • a medication management visit associated with a mental illness must be covered in the same manner as a medication management visit for treatment of a physical illness and may not be counted in the calculation of any maximum outpatient treatment visit limits.  The contract must provide for medically necessary health care for a person suffering from mental illness, and such medically necessary health care must include, but is not limited to:  • inpatient care;  • day treatment services;  • outpatient services; and  • home health care services. |  |
| Mental health services provided by certain professionals | [Title 24-A § 2835](https://legislature.maine.gov/statutes/24-A/title24-Asec2835.html) | A covered person is entitled to reimbursement for services performed by one of the following professionals if the policy reimburses for those services and those services are within the professional’s lawful scope of practice:  • Psychologist licensed to practice in Maine;  • Certified social worker licensed for independent practice of social work in Maine;  • Licensed clinical professional counselor licensed for independent practice of counseling in Maine;  • Licensed nurse certified by the American Nurses’ Association as a clinical specialist in adult psychiatric and mental health nursing or as a clinical specialist in child and adolescent psychiatric and mental health nursing;  • Marriage and family therapist licensed as such in Maine;  • Licensed pastoral counselor licensed as such in Maine. |  |
| Substance Abuse Disorder Treatment | [Title 24-A § 2842](https://legislature.maine.gov/statutes/24-A/title24-Asec2842.html)  [Rule 320](https://www.maine.gov/sos/cec/rules/02/031/031c320.doc) | If the contract provides coverage for hospital care, the contract must provide coverage for the treatment of substance use disorder pursuant to a treatment plan, which must, at a minimum, include: 1) residential treatment at a hospital or free-standing residential treatment center that is licensed, certified or approved by the State; and 2) outpatient care rendered by state licensed, certified or approved providers. Treatment or confinement at a facility may not preclude further/additional treatment at another eligible facility if the benefit days used do not exceed the total number of benefit days provided for under the contract.  (not required for contracts issued to employers with 20 or fewer employees insured under the contract) |  |
| **PRESCRIPTION DRUGS** |  |  |  |
| Continuity of Prescription Drugs | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(7)(A) | If an enrollee has been undergoing a course of treatment with a prescription drug by prior authorization of a carrier and the enrollee’s coverage with one carrier is replaced with coverage from another carrier pursuant to section 2849-B, the replacement carrier shall honor the prior authorization for that prescription drug and provide coverage in the same manner as the previous carrier until the replacement carrier conducts a review of the prior authorization for that prescription drug with the enrollee’s prescribing provider. Policies must include a notice of the carrier’s right to request a review with the enrollee’s provider, and the replacing carrier must honor the prior carrier’s authorization for a period not to exceed 6 months if the enrollee’s provider participates in the review and requests the prior authorization be continued. The replacing carrier is not required to provide benefits for conditions or services not otherwise covered under the replacement policy, and cost sharing may be based on the copayments and coinsurance requirements of the replacement policy. |  |
| Contraceptives | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-G.html)-G | If the plan provides coverage for prescription drugs or outpatient medical services, it must cover all prescription contraceptives approved by the federal FDA or for outpatient contraceptive services, respectively, to the same extent coverage is provided for other prescription drugs or outpatient medical services. The coverage must include coverage for contraceptive supplies in accordance with the requirements set forth in this section. "Outpatient contraceptive services" and "contraceptive supplies" are defined in this section.  Exclusion for religious employer: this section authorizes an exclusion for this coverage for a "religious employer," as defined in this section, and requires written notice of the exclusion to insureds and prospective insureds. |  |
| Coverage for HIV Prevention Drugs | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-D.html)-D | A. If the FDA has approved one or more HIV prevention drugs that use the same method of administration, a carrier must cover at least one approved drug for each method of administration with no out-of-pocket cost.  B. A carrier is not required to cover pre- or post-exposure prophylaxis drug dispensed or administered by an out-of-network pharmacy provider unless the enrollee's health plan provides an out-of-network pharmacy benefit.  C. A carrier may not prohibit a pharmacy from dispensing or administering any HIV prevention drugs. |  |
| Diabetes supplies | [Title 24-A § 2847](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-E.html)-E | Contracts and certificates must cover medically appropriate and necessary equipment, limited to insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets, and the out-patient self-management training and educational services used to treat diabetes, if a physician certifies that the equipment and services are necessary, and the diabetes out-patient self-management training and educational services are provided through ambulatory diabetes education facilities authorized by the State's Diabetes Control Project within the Bureau of Health. |  |
| No Prior Authorization or step therapy for mental illness drugs | [Title 24-A § 4304](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)(2-C)  [Title 24-A § 4320](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html)-N | Carrier must approve all prior authorizations for drugs to treat serious mental illness. No step therapy for such drugs. Serious mental illness means mental illness must result in serious functional impairment that substantially interferes with or limits one or more major life activities. |  |
| Off-label use of prescription drugs for cancer and HIV or AIDS | [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-F.html)-F  [Title 24-A § 2837](https://legislature.maine.gov/statutes/24-A/title24-Asec2837-G.html)-G | If providing coverage for prescription drugs, must provide coverage for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS. |  |
| Prescription drug coverage out-of-pocket limit | [Title 24-A § 4317](https://legislature.maine.gov/statutes/24-A/title24-Asec4317-A.html)-A | If prescription drug coverage does not include prescription drugs subject to coinsurance under the total out-of-pocket limit for all benefits under the plan, the carrier must establish a separate out-of-pocket limit not to exceed $3,500 per year for prescription drugs subject to coinsurance (to the extent not inconsistent with the ACA).  This requirement does not prohibit or limit a carrier’s ability to establish specialty tiers for prescription drug coverage, make medical necessity determinations, or enforce prior authorization/utilization review procedures. |  |
| Prosthetic devices to replace an arm or leg. | [Title 24-A § 4315](https://legislature.maine.gov/statutes/24-A/title24-Asec4315.html)  [42 USC 1395m](https://www.law.cornell.edu/uscode/text/42/1395m) | Coverage must be provided, at a minimum, for prosthetic devices to replace, in whole or in part, an arm or leg to the extent that they are covered under the Medicare program. Coverage for repair or replacement of a prosthetic device must also be included. Exclusion for micro-processors was removed effective 1/2011.1. Definition. As used in this section, "prosthetic device" means an artificial device to replace, in whole or in part, an arm or a leg. 2. Required coverage. A carrier shall provide coverage for prosthetic devices in all health plans that, at a minimum, equals, except as provided in subsection 8, the coverage and payment for prosthetic devices provided under federal laws and regulations for the aged and disabled pursuant to 42 United States Code, Sections 1395k, 1395l and 1395m and 42 Code of Federal Regulations, Sections 414.202, 414.210, 414.228 and 410.100. Covered benefits must be provided for a prosthetic device determined by the enrollee's provider, in accordance with section 4301-A, subsection 10-A, to be the most appropriate model that adequately meets the medical needs of the enrollee. 8. Health savings accounts. Benefits for prosthetic devices under health plans issued for use in connection with health savings accounts as authorized under Title XII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 may be subject to the same deductibles and out-of-pocket limits that apply to overall benefits under the contract.(h) Payment for prosthetic devices and orthotics and prosthetics (1) General rule for payment (A) In general Payment under this subsection for prosthetic devices and orthotics and prosthetics shall be made in a lump-sum amount for the purchase of the item in an amount equal to 80 percent of the payment basis described in subparagraph (B). (B) Payment basis Except as provided in subparagraphs (C), (E), and (H)(i), the payment basis described in this subparagraph is the lesser of— (ii) the actual charge for the item; or (iii) the amount recognized under paragraph (2) as the purchase price for the item. Coverage should be applied as follows:1. Coinsurance shall NOT exceed 20%, AFTER deductible in the plan. 2. HSA’s are NOT subject to the 20% requirement but coinsurance may not exceed that for other services. 3. DME and other prosthetic devices are NOT subject to the 20%, so it would be helpful to clarify in the schedule of benefits, summary of benefits and coverage, and the plan and benefits template how each category is paid out. 4. Out Of Network is NOT subject to 20%, unless there is no in-network available then OON should be billed as in-network i.e. 20%. |  |
| Disclosure to Enrollees of Cash Price | [Title 24-A § 4303](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)(25) | A carrier may not prohibit a provider from providing an enrollee with the option of paying the provider's discounted cash price for health care services. |  |