**Maine Bureau of Insurance  
Form Filing Requirements Checklist**

**Individual Indemnity Other Than Hospital (H23I)**

**(Revised 03/17/2021)**

**Carries MUST confirm compliance and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING in the last column. N/A: Check this box if carrier believes a contract does not have to meet this requirement and EXPLAIN WHY in the last column.**

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| **State Benefit/Provision and/or ACA Requirement** | **State  Law/ Rule and/or  Federal Law** | **State Description of Requirement and/or ACA Description of Requirement** | **N/A**  **🡪** | **CONFIRM COMPLIANCE**  **AND IDENTIFY LOCATION OF STANDARD IN FILING**  **MUST EXPLAIN WHY REQUIREMENT** IS NOT APPLICABLE |
| **GENERAL REQUIREMENTS** | | | | |
| Electronic (SERFF) Submission Requirements | [24-A M.R.S.A. §2412 (2)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2412.html)  [Bulletin 360](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/360_0.pdfhttp:/www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/360_0.pdf) | All filings must be filed electronically, using the NAIC System for Electronic Rate and Form Filing (SERFF). See <http://www.serff.com>. | ☐ |  |
| FILING FEES | [24-A M.R.S.A. §601(17)](http://legislature.maine.gov/statutes/24-A/title24-Asec601.html) | $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. | ☐ |  |
| Grounds for disapproval | [24-A M.R.S.A. §2413](http://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | Seven categories of the grounds for disapproving a filing. | ☐ |  |
| Readability | [24-A M.R.S.A. §2441](http://legislature.maine.gov/statutes/24-A/title24-Asec2441.html) | Minimum of 50.  Riders, endorsements, applications all must be scored. They may be scored either individually or in conjunction with 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](http://legislature.maine.gov/statutes/24-A/title24-Asec2412.html)   [§2413](http://legislature.maine.gov/statutes/24-A/title24-Asec2413.html) | 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. | ☐ |  |
| **Excepted Benefit Requirements** | | | | |
| Coordination of Benefits | 42 CFR §  148.220(b)(4)  (ii) | There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage. | ☐ |  |
| New Sales Application Materials Notice | 42 CFR §  148.220(b)(4)  (iv) | A notice is displayed prominently in the application materials in at least 14 point type that has the following language:  “THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE.  This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate. | ☐ |  |
| Payment of Benefits | 42 CFR §  148.220(b)(4)  (iii) | The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage. | ☐ |  |
| Renewal Notice | 45 CFR §  148.220(b)(4)  (iv) | This applies to all insurers writing hospital indemnity policies or other fixed indemnity policies sold in the individual market in Maine, including association coverage and other coverage that is issued through non-employer groups.  A notice is displayed prominently in the application materials in at least 14 point type that has the following language:  **“THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE OR OTHER MINIMUM ESSENTIAL COVERAGE.**  This notice can be a separate sheet in the application package. It does not need to be in the application or in the policy or certificate. | ☐ |  |

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| **General Policy Provisions** | | | | |
| Classification of Coverage, Disclosure, and Minimum Standards | [24-A M.R.S.A. §2694](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2694.html)  [Rule 755](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | These rules establish minimum standards for benefits under individual and group health insurance. These rules clarify the meaning of limited benefits health insurance as referred to in chapters 33, 35 and 56-A.  The following minimum standards for benefits are prescribed for coverage noted in the following subsections. An individual health insurance policy or group health insurance policy or certificate of coverage shall not be delivered or issued for delivery in this state unless it meets the required minimum standards for hospital confinement indemnity coverage or the Superintendent finds that the policies or certificates are approvable as supplemental health insurance and the outline of coverage complies with the outline of coverage in Section 7(M) of this rule.  The heading of the cover letter of any form filing subject to this rule shall state the category of coverage set forth in 24-A M.R.S.A. § 2694 that the form is intended to be in.  This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in 24-A M.R.S.A. § 2694.  The requirements set forth in this section are in addition to any other applicable requirements as specified in Section 3(D).  Must comply with all applicable provisions of Rule 755 for Major Medical coverage including, but not limited to, Sections 4, 5, 6(A), 6(F), and Sections 7(A), 7(B), and 7(G).  Must comply with all applicable provisions of Rule 755 for hospital confinement indemnity coverage including, but not limited to, Sections 4, 5, 6(A), 6(E), 7(A), 7(B), and 7(B)(F), specifically:  **Sec. 4**. Policy Definitions.  **Sec. 5**. Prohibited Policy Provisions  A policy may not contain a probationary or waiting period greater than 30 days from the effective date of coverage, except a waiting period of up to 6 months may be imposed for diseases and conditions related to hernia, reproductive organ disorder, varicose veins, adenoids, appendix and tonsils. However, the 6-month exception is not allowed where these conditions are treated on an emergency basis.  **Sec. 6(A).** General Rules.  **Sec. 7 (A)(1)** Application disclosure: All applications for coverages specified in Sections 6B, C, D, E, G, I, J, K and L shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant’s signature block on the application as follows:  **“The [policy] [certificate] provides limited benefits. Review your [policy][certificate] carefully.”**  **Sec. 7(A)(4)** Each policy of individual health insurance and group health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.  **Sec. 7(A)(8)** If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as “Preexisting Condition Limitations.”  **Sec. 7(A)(10)** All individual policies, except nonrenewable accident policies, shall have a notice prominently printed on the first page of the policy or certificate or attached to it stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within ten days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the policyholder or certificateholder is not satisfied for any reason. Ten days is a minimum; longer periods are permitted.  **Sec. 7(A)13(a)** Outlines of coverage delivered in connection with policies defined in this rule as hospital confinement indemnity (Section 6E), specified disease (Section 6J), or supplemental health coverages (Section 6L) to persons eligible for Medicare by reason of age shall contain, in addition to the requirements of Subsections F and J, the following language, which shall be printed on or attached to the first page of the outline of coverage:  **“This IS NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.”**  **(b)** An insurer shall deliver to persons eligible for Medicare any notice required under Bureau of Insurance Rule Chapter 275(17)(D).  **Sec. 7(B)** Outline of Coverage Requirements  **(1)** An insurer shall deliver an outline of coverage to an applicant or enrollee in the sale of individual health insurance, group health insurance, dental plans, and vision plans as required in 24-A M.R.S.A. § 2695. This requirement shall not apply to group major medical policies and certificates issued to employer groups as described in 24-A M.R.S.A. § 2804 and labor union groups as described in 24-A M.R.S.A. § 2805. Except as provided in Section 10, all outlines of coverage used in this state require the approval of the Superintendent.  **(2)** If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than twelve (12) point type, immediately above the company name:  **“NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon [application][enrollment], and the coverage originally applied for has not been issued.”**  **(3)** In any case where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the Superintendent for prior approval.  **(4)** An outline of coverage may take the form or an advertisement provided that it satisfies the standards specified for outlines of coverage in 24-A M.R.S.A. § 2695(8) as well as this rule. | ☐ |  |
| Death with Dignity | [22 M.R.S. § 2140(19)](http://www.mainelegislature.org/legis/statutes/22/title22sec2140.html) | The sale, procurement or issuance of any health or accident insurance or the rate charged for any health or accident policy may not be conditioned upon or affected by the making or rescinding of a request by a qualified patient for medication that the patient may self-administer to end the patient's life in accordance with this Act. | ☐ |  |
| Explanations for any Exclusion of Coverage for work related sicknesses or injuries | [24-A M.R.S.A. §2413](http://www.mainelegislature.org/legis/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. | ☐ |  |
| Free look period | 24-A M.R.S.A. [§2717](http://legislature.maine.gov/statutes/24-A/title24-Asec2717.html) | There shall be a provision in the policy or in a separate rider attached thereto when delivered, stating in substance that the person to whom the policy is issued shall be permitted to return the policy within 10 days of its delivery to such person and to have a refund of the premium paid if after examination of the policy the purchaser is not satisfied with it for any reason. | ☐ |  |
| General format | [24-A M.R.S.A. §2703](http://legislature.maine.gov/statutes/24-A/title24-Asec2703.html) | Readability, term of policy described, cost disclosed, form number in bottom left corner. | ☐ |  |
| Genetic Information Protections | [24-A M.R.S.  § 2159-C(3)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2159-C.html)  [24-A M.R.S. § 2159-C(4)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2159-C.html) | An insurer may not make or permit any unfair discrimination against an individual in the application of genetic information or the results of a genetic test in the issuance, withholding, extension or renewal of an insurance policy.  An insurer may not request, require, purchase or use information obtained from an entity providing direct-to-consumer genetic testing without the informed written consent of the individual who has been tested. | ☐ |  |
| Grace Period | 24-A M.R.S.A. [§2707](http://legislature.maine.gov/statutes/24-A/title24-Asec2707.html) | 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. | ☐ |  |
| Legal actions | [24-A M.R.S.A. §2715](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2715.html) | No action at law or in equity shall be brought to recover on this policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of 3 years after the time written proof of loss is required to be furnished. | ☐ |  |
| Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies | [24-A M.R.S.A. §5013](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec5013.html)  [Rule 275, Sec. 17(E)](http://www.maine.gov/sos/cec/rules/02/031/031c275.doc) | The notice shall either be printed or attached to the first page of the  outline of coverage delivered to insureds under the policy, or if no  outline of coverage is delivered, to the first page of the policy or  certificate delivered to insureds. The notice shall be in no less than  twelve (12) point type and shall contain the following language:  **“THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE**  **SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for**  **Medicare, review the Medicare Supplement Buyer's Guide**  **available from the company. If you have a Medicare supplement**  **policy or major medical policy, this coverage may be more than you**  **need. For information call the Bureau of Insurance at 1**  **800-300-5000.”** | ☐ |  |
| Preexisting Conditions | [Rule 755(8)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | If a policy or certificate contains any limitations with respect to preexisting conditions, the limitation shall appear as a separate paragraph of the policy or certificate and be labeled as “**PREEXISTING CONDITION LIMITATION.**” | ☐ |  |
| Probationary or waiting period | [Rule 755(5)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | A policy may not contain a probationary or waiting period greater than 30 days from the effective date of coverage, except a waiting period of up to 6 months may be imposed for diseases and conditions related to hernia, reproductive organ disorder, varicose veins, adenoids, appendix and tonsils. However, the 6-month exception is not allowed where these conditions are treated on an emergency basis. | ☐ |  |
| Rate Filing | [24-A M.R.S.A. §2736](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2736.html) | 1. Filing of rate information. Every insurer shall file for approval by the superintendent every rate, rating formula, classification of risks and every modification of any formula or classification that it proposes to use in connection with individual health insurance policies and certain group policies specified in section 2701.  2. Filing; information.  When a filing is not accompanied by the information upon which the insurer supports such filing, or the superintendent does not have sufficient information to determine whether such filing meets the requirements that rates not be excessive, inadequate or unfairly discriminatory, the superintendent shall require the insurer to furnish the information upon which it supports the filing. | ☐ |  |
| Rebates | [§2160](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2160.html)  [§2163-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2163-A.html)  [Bulletin 382](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/382.pdf) | Are there any provisions that give the insured a benefit not associated with indemnification or loss?”  Yes \_\_\_  No \_\_\_ | ☐ |  |
| Reinstatement | [24-A M.R.S.A. §2708](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2708.html) | There shall be a provision that if any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. | ☐ |  |
| Renewal provision | 24-A M.R.S.A. [§2738](http://legislature.maine.gov/statutes/24-A/title24-Asec2738.html) | Policy must contain the terms under which the policy can or cannot be renewed prominently on first page of policy or certificate. | ☐ |  |
| Representations on Applications | [24-A M.R.S.A. §2411](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2411.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 | 24-A M.R.S.A. [§2707-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2707-A.html),  [Rule 580](http://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.  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. | ☐ |  |
| Time limit on certain defenses | [24-A M.R.S.A. §2706](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2706.html) | There shall be a provision that from the date of issue of a 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, as defined in the policy, commencing after the expiration of such 3-year period. | ☐ |  |
| **Eligibility/Enrollment** | | | | |
| Definition of Dependent | [24-A M.R.S.A.](http://legislature.maine.gov/statutes/24-A/title24-Asec2742.html)  [§2742](http://legislature.maine.gov/statutes/24-A/title24-Asec2742.html) | 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. | ☐ |  |
| **Claims & Utilization Review** | | | | |
| Claim forms | [24-A M.R.S.A. §2710](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2710.html) | There shall be a provision that the insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. 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 as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made. | ☐ |  |
| Examination, autopsy | [24-A M.R.S.A. §2714](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2714.html) | There shall be a provision that 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 prohibited by law. | ☐ |  |
| Limits on priority liens/subrogation | 24-A M.R.S.A. [§2729-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2729-A.html) | Does this policy have subrogation provisions? If yes, see provisions below:  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. | ☐ | **Yes**  **Please provide citation for section in policy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **No** |
| Notice of Claim | [24-A M.R.S.A. §2709](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2709.html) | There shall be a provision that written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. | ☐ |  |
| Payment of Claims | [24-A M.R.S.A. §2436](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2436.html) | 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. | ☐ |  |
| Penalty for failure to notify of hospitalization | [24-A M.R.S.A. §2749-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2749-A.html) | No penalty for hospitalization for emergency treatment. | ☐ |  |