**Maine Bureau of Insurance  
Form Filing Review Requirements Checklist  
Group Similar Supplemental (H25G)**

**Revised 10/01/2021**

**GROUP PLANS THAT SUPPLEMENT OTHER COVERAGE:**

**#1.** Coverage that supplements employer group major medical coverage by providing coverage of deductible, coinsurance, or copays must comply with all applicable state mandated benefits.

#**2.** Coverage that supplements employer group major medical coverage by providing benefits only for items or services that are not covered by the primary coverage and that are not essential health benefits (see 45 CFR §146.145(b(5)(i)(C)) is not required to cover all state mandates.

#**3.** Coverage that supplements retirees’ Medicare A&B benefits but is not a Medicare Supplement plan. If the plan strictly supplements Medicare and does not provide any additional coverage not provided by Medicare, then state mandated benefits do not apply.

**CARRIERS MUST CONFIRM COMPLIANCE and IDENTIFY the LOCATION (page number, section, paragraph, etc.) of the STANDARD IN FILING in the last column. If a carrier feels a contract does not have to meet this requirement carrier MUST explain why in the last column.\* (e.g., do not provide dependent coverage, do not provide dental, no RX coverage unless group purchases, etc.).**

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| REVIEW REQUIREMENTS | **REFERENCE** | | DESCRIPTION OF REVIEWSTANDARDS REQUIREMENTS | | **CONFIRM COMPLIANCE**  **AND IDENTIFY LOCATION OF STANDARD IN FILING**  **AND EXPLAIN IF REQUIREMENT** IS INAPPLICABLE\* | | |
| **General Submission Requirements** | | | | | | | |
| Electronic (SERFF) Submission Requirements | | [24-A M.R.S.A. §2412 (2)](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. | | ☐ |  |
| **General Policy Provisions** | | | | | | | |
| Applicant's statements | | 24-A M.R.S.A. [§2817](http://legislature.maine.gov/statutes/24-A/title24-Asec2817.html) | | No statement made by the applicant for insurance shall void the insurance or reduce benefits unless contained in the written application signed by the applicant; and a provision that no agent has authority to change the policy or to waive any of its provisions; and that no change in the policy shall be valid unless approved by an officer of the insurer and evidenced by endorsement on the policy, or by amendment to the policy signed by the policyholder and the insurer. | | ☐ |  |
| Childhood Immunizations | | [24-A M.R.S.A. §4302(1)(A)(5)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4302.html) | | 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. | | ☐ |  |
| Compliance | | 42 U.S.C. § 300gg-91(c)(4) | | Provide a numerical demonstration that this policy and riders meets the requirement for an excepted benefit under the ACA (42 U.S.C. § 300gg-91(c)(4) “coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan”). Federal Department of Labor Field Assistance Bulletin 2007-04 for the safe harbor requires the cost of supplemental coverage not exceed 15 percent of the cost of the plan's primary coverage | | ☐ |  |
| Continuity of Care | | [24-A M.R.S.A. §4303(7)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html) | | If a contract between a carrier and a provider is terminated or benefits or coverage provided by a provider is terminated because of a change in the terms of provider participation in a health plan and an enrollee is undergoing a course of treatment from the provider at the time of termination, the carrier shall provide continuity of care in accordance with the requirements in paragraphs A to C. | | ☐ |  |
| Continuation of group coverage | | 24-A M.R.S.A. [§2809-A(11)](http://legislature.maine.gov/statutes/24-A/title24-Asec2809-A.html) | | 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. | | ☐ |  |
| Continuity on replacement of group policy | | 24-A M.R.S.A. [§2849](http://legislature.maine.gov/statutes/24-A/title24-Asec2849.html) | | 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. | | ☐ |  |
| Coordination of Benefits | | [24-A M.R.S.A. §2844](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2844.html)  [Rule 790](http://www.maine.gov/sos/cec/rules/02/031/031c790.doc) | | Medicaid is always secondary. | | ☐ |  |
| Definition of Medically Necessary | | 24-A M.R.S.A. [§4301-A,](http://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html)  [Sub-§10-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html) | | 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. | | ☐ |  |
| Definition of Supplemental Health Coverage; minimum standards | | [Rule 755, Sec. 6(L)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) & 9(G) | | “Supplemental health coverage” is a policy or contract, other than a policy or contract covering only a specified disease or diseases, that provides benefits that are less than the minimum standards for benefits required under Subsections B, C, D, E, F, G, I and K. These policies or contracts may be delivered or issued for delivery in this state only if the outline of coverage required by Section 7(M) of this rule is completed and delivered as required by Section 7(B) of this rule and the policy or certificate is clearly labeled as a supplemental policy or certificate as required by Section 7(A)(17). A policy covering a single specified disease or combination of diseases shall meet the requirements of Section 6(J) and shall not be offered for sale as a “limited” or “supplemental” coverage.  Supplemental coverage is not limited benefit health insurance if it is substantially similar to one of the following types of coverage:   1. Basic hospital expense coverage as defined in Section 6, Subsection B; 2. Basic medical-surgical expense coverage as defined in Section 6, Subsection C; 3. Basic hospital/medical-surgical expense coverage as defined in Section 6, Subsection D; 4. Major medical expense coverage as defined in Section 6, Subsection F; or 5. Basic medical expense coverage as defined in Section 6, Subsection G.   For purposes of this subsection, “substantially similar” means that, in the judgment of the Superintendent, there are only minor differences between the supplemental coverage and coverage that would meet the minimum standards of Section 6, Subsections B, C, D, F, or G. | |  |  |
| Denial of referral by direct primary care providers prohibited | | [24-A M.R.S. §4303(22)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html)  [Bulletin 434](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/434.pdf) | | A carrier may not deny payment for any health care service covered under an enrollee's health plan based solely on the basis that the enrollee's referral was made by a direct primary care provider who is not a member of the carrier's provider network.  “Direct primary care provider” means an individual who is a licensed physician or osteopathic physician or other advanced health care practitioner who is authorized to engage in independent medical practice in this State, who is qualified to provide primary care services and who chooses to practice direct primary care by entering into a direct primary care service agreement with patients. The term includes, but is not limited to, an individual primary care provider or a group of primary care providers. [22 M.R.S. § 1771(1)(B)](http://legislature.maine.gov/legis/statutes/22/title22sec1771.html).  **Applicable deductible, coinsurance, or copayment:**  For a covered health care service that was referred by a direct primary care provider, a carrier may not apply a deducible, coinsurance, or copayment greater than the applicable deductible, coinsurance, or copayment that would apply to the same health care service if the service was referred by a participating primary care provider.  **Information that may be requested by a carrier:**  A carrier may require an out-of-network direct primary care provider making a referral to provide information demonstrating that the provider is a direct primary care provider through a written attestation or a copy of a direct primary care agreement with an enrollee and may request additional information as necessary. | | ☐ |  |
| Designation of Classification of Coverage | | [24-A M.R.S.A. §2694](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2694.html)  [Rule 755, Sec. 6](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | | 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. | | ☐ |  |
| Disclosure | | [Rule 755, Sec. 7(A)(17)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | | All supplemental health policies and certificates shall display prominently by type, stamp, or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the [policy][certificate] the following:  **“Notice to Buyer: This is a supplemental health [policy][certificate]. This [policy][certificate] provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.”** | |  |  |
| 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. | | ☐ |  |
| Explanations Regarding Deductibles | | [24-A M.R.S.A. §2413](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2413.html) | | All policies must include clear explanations of all of the following regarding deductibles:   1. Whether it is a calendar or policy year deductible. 2. Clearly advise whether non-covered expenses apply to the deductible. 3. Clearly advise whether it is a per person or family deductible or both. | | ☐ |  |
| Extension of Benefits | | 24-A M.R.S.A. [§2849-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2849-A.html)  [Rule 590](http://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 | | [24-A M.R.S.A. §2809-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2809-A.html)  [Bulletin 288](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/288.pdf) | | 30 or 31 days. | | ☐ |  |
| Guaranteed Renewal | | 24-A M.R.S.A. [§2850-B](http://legislature.maine.gov/statutes/24-A/title24-Asec2850-B.html) | | 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. | | ☐ |  |
| Limitations & Exclusions | | 45 CFR  156.115 | | Limitations and exclusions must be substantially similar or more favorable to the insured as found in the Maine EHB benchmark plan. | | ☐ |  |
| Health plan accountability | | [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc) | | Standards in this rule include, but are not limited to, required provisions for grievance and appeal procedures, emergency services, access and utilization review standards. | | ☐ |  |
| Notice of Policy Changes and Modifications | | [24-A M.R.S.A. §2850(B)(3)(I)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2850-B.html) | | A carrier may make minor modifications to the coverage, terms and conditions of the policy consistent with other applicable provisions of state and federal laws as long as the modifications meet the conditions specified in this paragraph and are applied uniformly to all policyholders of the same product. | | ☐ |  |
| Notice of Rate Increase | | [24-A M.R.S.A.](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2839.html)  [§2839](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2839.html)  [§2839-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2839-A.html) | | Requires that insurers provide a minimum of 60 days written notice to affected policyholders prior to a rate filing for individual health insurance or a rate increase for group health insurance. It specifies the requirements for the notice. See these sections for more details. Reasonable notice must be provided for other types of policies. | | ☐ |  |
| Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies | | 24-A M.R.S.A. [§5013](http://legislature.maine.gov/statutes/24-A/title24-Asec5013.html), [Rule 275, Sec. 17(E)](http://www.maine.gov/sos/cec/rules/02/031/031c275.doc) | | There must be a notice predominantly displayed on the first page of the policy that states: "THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company." | | ☐ |  |
| Outline of Coverage | | [Rule 755, Sec. 7(M)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | | An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates that do not meet the minimum standards of Sections 7B, C, D, E, F, G, I and K of this rule. The items included in the outline of coverage must appear in the sequence prescribed:  [COMPANY NAME]  SUPPLEMENTAL HEALTH COVERAGE  BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES  OUTLINE OF COVERAGE  (1) Read Your [Policy][Certificate] Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR[POLICY][CERTIFICATE] CAREFULLY!  (2) Supplemental health coverage is designed to provide limited or supplemental coverage.  (3) [A brief specific description of the benefits, including dollar amounts. The description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment provisions applicable to the benefits described. If benefits vary according to the type of accidental cause, the outline of coverage shall prominently set forth the circumstances under which benefits are payable that are less than the maximum amount payable under the policy.]  (4) [A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or, in any other manner, operate to qualify payment of the benefits described in Paragraph (3) above.]  (5) [A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.] | |  |  |
| Penalty for failure to notify of hospitalization | | 24-A M.R.S.A. [§2847-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-A.html) | | No penalty for hospitalization for emergency treatment. | | ☐ |  |
| Penalty for noncompliance with utilization review | | 24-A M.R.S.A. [§2847-D](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-D.html) | | penalty of more than $500 for failure to provide notification under a utilization review program | | ☐ |  |
| Prohibited practices | | [24-A M.R.S.A. §2736-C(3)(A)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2736-C.html)  2850-B(3) | | An enrollee may not be cancelled or denied renewal except for fraud or material misrepresentation and/or failure to pay premiums for coverage. | | ☐ |  |
| Prohibition against Absolute Discretion Clauses | | [24-A M.R.S.A. §4303(11)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) | | Carriers are prohibited from including or enforcing absolute discretion provisions in health plan contracts, certificates, or agreements. | | ☐ |  |
| Prohibition on Discrimination | | [24-A MRSA §4320-L](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-L.html) | | 1. Nondiscrimination. An individual may not, on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability, be excluded from participation in, be denied benefits of or otherwise be subjected to discrimination under any health plan offered in accordance with this Title. A carrier may not in offering, providing or administering a health plan:  A. Deny, cancel, limit or refuse to issue or renew a health plan or other health-related coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability;  B. Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, sexual orientation, gender identity, age or disability in a health plan or other health-related coverage;  C. Deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for any health services that are ordinarily or exclusively available to individuals of one sex to a transgender individual based on the fact that the individual's sex assigned at birth, gender identity or gender otherwise recorded is different from the one to which such health services are ordinarily or exclusively available;  D. Have or implement a categorical coverage exclusion or limitation for all health services related to gender transition; or  E. Otherwise deny or limit coverage, deny or limit coverage of a claim or impose additional cost sharing or other limitations or restrictions on coverage for specific health services related to gender transition if such denial, limitation or restriction results in discrimination against a transgender individual.  Nothing in this subsection is intended to determine or restrict a carrier from determining whether a particular health service is medically necessary or otherwise meets applicable coverage requirements in any individual case.  2. Meaningful access for individuals with limited English proficiency. A carrier shall take reasonable steps to provide meaningful access to each enrollee or prospective enrollee under a health plan who has limited proficiency in English.  3. Effective communication for persons with disabilities. A carrier shall take reasonable steps to ensure that communication with an enrollee or prospective enrollee in a health plan who is an individual with a disability is as effective as communication with other enrollees or prospective enrollees. | | ☐ |  |
| 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 \_\_\_ | | ☐ |  |
| Renewal of policy | | 24-A M.R.S.A. [§2820](http://legislature.maine.gov/statutes/24-A/title24-Asec2820.html) | | There shall be a provision stating the conditions for renewal. | | ☐ |  |
| Representations in Applications | | 24-A M.R.S.A. [§2818](http://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. | | ☐ |  |
| 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. §2847-C](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-C.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.  **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 Certificateholder 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 Certificateholder and is made via payroll deduction, then Rule 580, Sec. 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 Certificateholder and is made via payroll deduction, then Rule 580, Sec. 5 (3) would apply and the insurer must include this notification in the policy/certificate to advise the member of their rights.   Therefore, please review Rule 580 and add the required language to the certificate.   Additionally, pursuant to Rule 580 Sec. 6(A)(7), the requirement may be satisfied by including the notice of reinstatement right in an application that is incorporated into the contract. | | ☐ |  |
| Time for suits | | [24-A M.R.S.A. §2828](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2828.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 2-year period. | | ☐ |  |
| **Eligibility/Enrollment** | | | | | | | |

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| Coverage for Dependent Children Up to Age 26 | [24-A M.R.S.A. §2833-B](http://legislature.maine.gov/statutes/24-A/title24-Asec2833-B.html) | A group health insurance policy that offers coverage for dependent children must offer such coverage until the dependent child is 26 years of age. | ☐ |  |
| Dependent coverage | 24-A M.R.S.A. [§2809](http://legislature.maine.gov/statutes/24-A/title24-Asec2809.html) | May not use residency as a requirement for dependents. | ☐ |  |
| Dependent special enrollment period | 24-A M.R.S.A. [§2834-B](http://legislature.maine.gov/statutes/24-A/title24-Asec2834-B.html) | Enrollment for qualifying events. | ☐ |  |
| Domestic Partner Coverage | [24-A M.R.S.A. §2832-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2832-A.html) | Coverage must be offered for domestic partners of individual policyholders or group members. This section establishes criteria defining who is an eligible domestic partner. | ☐ |  |
| Individual certificates | [24-A M.R.S.A. §2821](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2821.html) | There shall be a provision that the insurer shall issue to the policyholder, for delivery to each member of the insured group, an individual certificate or printed information setting forth in summary form a statement of the essential features of the insurance coverage of such employee or such member and in substance the provisions of sections 2821 to 2828. The insurer shall also provide for distribution by the policyholder to each member of the insured group a statement, where applicable, setting forth to whom the benefits under such policy are payable. If dependents are included in the coverage, only one certificate or printed summary need be issued for each family unit. | ☐ |  |
| **Claims & Utilization Review** | | | | |
| Assignment of benefits | [24-A M.R.S.A. §2827-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2827-A.html) | All policies providing benefits for medical or dental care on an expense-incurred basis must contain a provision permitting the insured to assign benefits for such care to the provider of the care. An assignment of benefits under this section does not affect or limit the payment of benefits otherwise payable under the policy. | ☐ |  |
| Calculation of health benefits based on actual cost | [24-A M.R.S.A. §2185](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2185.html) | Policies must comply with the requirements of 24-A §2185 which requires calculation of health benefits based on actual cost. All health insurance policies, health maintenance organization plans and subscriber contracts or certificates of nonprofit hospital or medical service organizations with respect to which the insurer or organization has negotiated discounts with providers must provide for the calculation of all covered health benefits, including without limitation all coinsurance, deductibles and lifetime maximum benefits, on the basis of the net negotiated cost and must fully reflect any discounts or differentials from charges otherwise applicable to the services provided. With respect to policies or plans involving risk-sharing compensation arrangements, net negotiated costs may be calculated at the time services are rendered on the basis of reasonably anticipated compensation levels and are not subject to retrospective adjustment at the time a cost settlement between a provider and the insurer or organization is finalized. | ☐ |  |
| Credit toward Deductible | [24-A M.R.S.A. §2844(3)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2844.html) | 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. | ☐ |  |
| Examination, autopsy | 24-A M.R.S.A. [§2826](http://legislature.maine.gov/statutes/24-A/title24-Asec2826.html) | There shall be a provision that the insurer has the right to examine the insured as often as it may reasonably require during the pendency of claim and also has the right to make an autopsy in case of death where it is not prohibited by law. | ☐ |  |
| Explanation and notice to parent | [24-A M.R.S.A. §2823-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2823-A.html) | If the insured is covered as a dependent child, and if the insurer is so requested by a parent of the insured, the insurer shall provide that parent with: An explanation of the payment or denial of any claim filed on behalf of the insured, except to the extent that the insured has the right to withhold consent and does not affirmatively consent to notifying the parent; An explanation of any proposed change in the terms and conditions of the policy; Reasonable notice that the policy may lapse, but only if the parent has provided the insurer with the address at which the parent may be notified. In addition, any parent who is able to provide the information necessary for the insurer to process a claim must be permitted to authorize the filing of any claims under the policy. | ☐ |  |
| Forms for proof of loss | 24-A M.R.S.A. [§2825](http://legislature.maine.gov/statutes/24-A/title24-Asec2825.html) | 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 | ☐ |  |
| Lifetime Limits and Annual Aggregate Dollar Limits Prohibited | [24-A M.R.S.A. §4318](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4318.html) | An individual or group health plan may not include a provision in a policy, contract, certificate or agreement that purports to terminate payment of any additional claims for coverage of health care services after a defined maximum aggregate dollar amount of claims for coverage of health care services on an annual, lifetime or other basis has been paid under the health plan for coverage of an insured individual, family or group.  A carrier may however offer a health plan that limits benefits under the health plan for specified health care services on an annual basis. | ☐ |  |
| Limits on priority liens/subrogation | [24-A M.R.S.A. §2836](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2836.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. | ☐ |  |
| Notice of claim | 24-A M.R.S.A. [§2823](http://legislature.maine.gov/statutes/24-A/title24-Asec2823.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 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 noncompliance with utilization review | 24-A M.R.S.A. [§2847-D](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-D.html) | May not have a penalty of more than $500 for failure to provide notification under a utilization review program. | ☐ |  |
| Protection from Surprise Bills | [Title 24-A § 4303-C](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-C.html)(as amended by [P.L. 2021, ch. 241](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78606))  [Title 24-A § 4303-E](https://legislature.maine.gov/statutes/24-A/title24-Asec4303-E.html)  Title 24-A § 4303-F(as enacted by [P.L. 2021, ch. 241](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78606))  [Rule 365](https://www.maine.gov/sos/cec/rules/02/031/031c365.docx) | With respect to a “surprise bill” (defined below) or a bill for covered emergency services rendered by an out-of-network provider:  1. A carrier shall require an enrollee to pay only the applicable coinsurance, copayment, deductible or other out-of-pocket expense that would be imposed for health care services if the services were rendered by a network provider. The carrier shall calculate any coinsurance amount based on the median network rate for that service per paragraph B.  2. If a carrier has an inadequate network, as determined by the superintendent, the carrier shall ensure that the enrollee obtains the covered service at no greater cost to the enrollee than if the service were obtained from a network provider or shall make other arrangements acceptable to the superintendent.  3. Until December 31, 2023, unless the carrier and out-of-network provider agree otherwise, a carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the rate required by section 4303-F. | ☐ |  |
| UCR Definition, Required Disclosure, Protection from Balance Billing by Participating Providers | 24-A M.R.S.A. [§4303(8)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)  [§4303(8)(A)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) | The data used to determine this charge must be Maine specific and relative to the region where the claim was incurred.  Maximum allowable charges. All policies, contracts and certificates executed, delivered and issued by a carrier under which the insured or enrollee may be subject to balance billing when charges exceed a maximum considered usual, customary and reasonable by the carrier or that contain contractual language of similar import must be subject to the following.  A. 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.  Protection from balance billing by participating providers.   An enrollee's responsibility for payment under a managed care plan must be limited as provided in this subsection.  A. The terms of a managed care plan must provide that the enrollee's responsibility for the cost of covered health care rendered by participating providers is limited to the cost-sharing provisions expressly disclosed in the contract, such as deductibles, copayments and coinsurance, and that if the enrollee has paid the enrollee's 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. | ☐ |  |
| Utilization Review &  Notice Requirements for Health Benefit Determinations | [24-A M.R.S.A. §4304](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4304.html)  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc)(8)  [Bulletin 397](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/397.pdf) | Utilization Review Disclosure Requirements  The carrier shall include a clear and reasonably comprehensive description of its utilization review procedures, including:   * Procedures for obtaining review of adverse benefit determinations;   + A Statement of rights and responsibilities of covered persons with respect to those procedures in the certificate of coverage or member handbook; * The statement of rights shall disclose the member’s right to request in writing and receive copies of any clinical review criteria utilized in arriving at any adverse health care treatment decision. * Carrier shall include a summary of its utilization review procedures in materials intended for prospective covered persons; * Carriers requiring enrollees to initiate utilization review provide on its membership cards a toll-free telephone number to call for utilization review decisions.   Notices advising enrollees that services have been determined to be medically necessary must also advise whether the service is covered.  Once a service has been approved, the approval cannot be withdrawn retrospectively unless fraudulent or materially incorrect information was provided at the time prior approval was granted.  Also, if benefits are denied and the enrollee appeals, the carrier cannot deny the appeal without a written explanation addressing the issues that were raised by the enrollee. |  |  |
| **Grievances & Appeals** | | | | |
| Clinical peer definition | [24-A M.R.S § 4304(7)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4304.html)  [24-A M.R.S § 4301-A(4)](http://legislature.maine.gov/statutes/24-A/title24-Asec4301-A.html) | An appeal of a carrier’s adverse health care treatment decision must be conducted by a clinical peer.  The clinical peer may not have been involved in making the initial adverse health care treatment decision unless information not previously considered during the initial review is provided on appeal.  An adverse health care treatment decision does not include a carrier’s rescission determination or initial coverage eligibility determination.  “Clinical peer” means a physician or other licensed health care practitioner who holds a nonrestricted license in a state in the U.S., is board certified in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review, and whose compensation does not depend, directly or indirectly, upon the quantity, type, or cost of the medical condition, procedure, or treatment that the practitioner approves or denies on behalf of the carrier. | ☐ |  |
| External review requests | [24-A M.R.S.A. §4312](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4312.html)  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc) | 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. Claimant must have at least 1 year to file for external review after receipt of the notice of adverse benefit determination. | ☐ |  |
| Grievance and appeals procedures | [24-A M.R.S.A. §4303(4)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html)  [Rule 850 Sec. 8 & 9](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc) | The policy must contain the procedure to follow if an insured wishes to file a grievance regarding policy provisions or denial of benefits. Specifically describe grievance & appeal procedures required in the contract, as well as the required available external review procedures.  **All policies must contain all grievance and appeal procedures as**  **referenced in Rule 850:**  **First Level Appeals of Adverse Health Care Treatment Decisions:**   * Carrier must allow the covered person to review the claim file and to present evidence and testimony as part of the internal appeals process. * Carrier must provide the covered person, free of charge, with any new or additional evidence considered, relied upon, or generated by the carrier (or at the direction of the carrier) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond. * Before a carrier can issue a final internal adverse benefit determination based on a new or additional rationale, the covered person must be provided with the rationale, free of charge, sufficiently in advance of the decision to give the covered person a reasonable opportunity to respond. * The carrier must provide the covered person the name, address, and telephone number of a person designated to coordinate the appeal on behalf of the health carrier. * The carrier must make the rights in this subparagraph known to the covered person within 3 working days after receiving an appeal. * Appeals shall be evaluated by an appropriate clinical peer or peers. * The clinical peer/s shall not have been involved in the initial adverse determination, unless the appeal presents additional information the decision maker was unaware of at the time of rendering the initial adverse health care treatment decision. * The clinical peer may not be a subordinate of a clinical peer involved in the prior decision.   **Standard appeals**:   * Shall notify in writing both the covered person and the attending or ordering provider of the decision within 30 days following the request for an appeal. * Additional time is permitted where the carrier can establish the 30-day time frame cannot reasonably be met due to the carrier’s inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier.   + Shall provide written notice of the delay to the covered person and the attending or ordering provider.   + The notice shall explain the reasons for the delay. In such instances, decisions must be issued within 30 days after the carrier’s or designee’s receipt of all necessary information.   **Expedited Appeals:**   * Expedited appeals shall be evaluated by an appropriate clinical peer or peers. * The clinical peer/s shall not have been involved in the initial adverse health care treatment decision. * The clinical peer may not be a subordinate of a clinical peer involved in the prior decision. * Shall provide expedited review to all requests concerning an admission, availability of care, continued stay or health care service for a covered person who has received emergency services but has not been discharged from a facility. * Shall transmit all necessary information between the carrier or the carrier’s designated URE and the covered person or the provider by telephone, facsimile, electronic means or the most expeditious method available. * Shall make a decision and notify the covered person and the provider via telephone within 72 hours after the review is initiated. * If the initial notification was not in writing, the carrier shall provide written confirmation of its decision concerning an expedited review within 2 working days. * An adverse decision shall contain the notice requirements of an adverse health care treatment decision as set forth in Rule 850(G)(1)(c). * Expedited reviews are not required for Retrospective Adverse Health Care Treatment Decisions. * Expedited review of Concurrent Review Determination of emergency services or of an initially authorized admission or course of treatment, the service shall be continued without liability to the covered person until the covered person has been notified of the decision.   **An Adverse Health Care Treatment Decision Notice shall include:**   * The principal reason or reasons for the decision; * Reference to the specific plan provisions on which the decision is based; * Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and a statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request; * A description of any additional material or information necessary for the covered person to perfect the * claim and an explanation as to why such material or information is necessary; * The instructions and time limits for initiating an appeal or reconsideration of the decision; * If the adverse health care treatment decision is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either: * An explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant’s medical circumstances, * Or a statement that such an explanation will be provided free of charge upon request; * What criterion was relied upon in making the adverse health care treatment decision, provide either: * The specific rule, guideline, protocol, or other similar criterion, or * A statement referring to the rule, guideline, protocol, or * Other similar criterion that was relied upon in making the adverse decision; and * Explain that a copy will be provided free of charge to the covered person upon request; * Phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration and/or requesting clinical rationale and review criteria; * Description of the expedited review process applicable to claims involving urgent care; * Availability of any applicable office of health insurance consumer assistance or ombudsman * established under the federal Affordable Care Act; * Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier’s internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24-A M.R.S.A. §4303(13) and any rules adopted pursuant thereto; and * Any other information required pursuant to the federal Affordable Care Act. * The carrier or the carrier’s designated URE shall respond expeditiously to requests for information.   **Second Level Appeals of Adverse Health Care Treatment Decisions:**   * Shall provide the opportunity for a second level appeal to covered persons who are dissatisfied with a first level appeal decision. * Persons covered under individual health insurance plans must be notified of the right to request an external review without exhausting the carrier’s second level appeal process. * The same notice may be given to persons covered under group plans if the carrier permits them to bypass the second level of appeal. * The carrier shall appoint a panel for each second level appeal, which shall include one or more panelists who are disinterested clinical peers. * A second level appeal decision adverse to the covered person must have the concurrence of a majority of the disinterested clinical peers on the panel. * If the covered person has requested to appear in person the procedures for conducting a second level panel review shall include the following: * The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review. * The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. * The health carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier’s expense, by conference call, video conferencing, or other appropriate technology. * The covered person shall be notified in writing at least 15 days in advance of the review date. * The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. * Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential and privileged from disclosure to the covered person. * A covered person has the right to: * Attend the second level review; * Present his or her case to the review panel; * Submit supporting material both before and at the review meeting; * Ask questions of any representative of the health carrier; * Be assisted or represented by a person of his or her choice; and * Obtain his or her medical file and information relevant to the appeal free of charge upon request. * If the insurer will have an attorney present to argue its case against the covered person: * The carrier shall so notify the covered person at least 15 days in advance of the review, and * Advise the covered person of his or her right to obtain legal representation. * The covered person’s right to a fair review shall not be made conditional on the covered person’s appearance at the review. * The review panel shall: * Issue a written decision to the covered person within 5 working days after completing the review meeting. * A decision adverse to the covered person shall include the requirements set forth in Rule 850 subparagraph 8(G)(1)(c).   **An Adverse Health Care Treatment Appeal Decision shall contain:**   * The names, titles and qualifying credentials of the person or persons evaluating the appeal; * A statement of the reviewers’ understanding of the reason for the covered person’s request for an appeal; * Reference to the specific plan provisions upon which the decision is based; * The reviewers’ decision in clear terms and the clinical rationale in sufficient detail for the covered person to respond further to the health carrier’s position; * A reference to the evidence or documentation used as the basis for the decision, including the clinical review criteria used to make the determination. * The decision shall include instructions for requesting copies, free of charge, of information relevant to the claim, including any referenced evidence, documentation or clinical review criteria not previously provided to the covered person. * Where a covered person had previously submitted a written request for the clinical review criteria relied upon by the health carrier or the carrier’s designated URE in rendering its initial adverse decision, the decision shall include copies of any additional clinical review criteria utilized in arriving at the decision. * The criterion that was relied upon in making the adverse health care treatment decision, provide either: * The specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol, or * Other similar criterion that was relied upon in making the adverse decision; * Explain that a copy will be provided free of charge to the covered person upon request. * Notice of any subsequent appeal rights, and the procedure and time limitation for exercising those rights: * Notice of external review rights must be provided to the enrollee as required by 24‑A M.R.S.A. §4312(3). * A description of the process for submitting a written request for second level appeal must include the rights specified in Rule 850 subsection G-1. * Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act. * Notice of the covered person’s right to contact the Superintendent’s office. The notice shall contain the toll free telephone number, website address, and mailing address of the Bureau of Insurance.   Any other information required pursuant to the federal Affordable Care Act.  **Adverse Benefit Determinations not Involving Adverse Health Care Treatment Decisions**  **Notice of Adverse Benefit Determinations not Involving Health Care Treatment Decisions:**   * Any adverse benefit determination that does not involve medical issues, the carrier shall provide written notice that includes: * Principal reason or reasons for the determination; * Reference to the specific plan provisions on which the determination is based; * Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount if applicable), and * A statement that the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, will be provided upon request; * Description of any additional material or information necessary for the covered person to perfect the claim and an explanation as to why such material or information is necessary; * Instructions and time limits for initiating an appeal or reconsideration of the determination; * Notice of the right to file a complaint with the Bureau of Insurance after exhausting any appeals under a carrier’s internal review process. In addition, an explanation of benefits (EOB) must comply with the requirements of 24‑A M.R.S.A. §4303(13) and any rules adopted pursuant thereto. * Provide the criterion that was relied upon in making the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement referring to the rule, guideline, protocol and explain that a copy will be provided free of charge to the covered person upon request; * Phone number the covered person may call for information on and assistance with initiating an appeal or reconsideration or requesting review criteria; * Description of the expedited review process applicable to claims involving urgent care; * Availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act; and * Any other information required pursuant to the federal Affordable Care Act.   **First Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions:**   * A grievance concerning any matter may be submitted by a covered person or a covered person’s representative. * The carrier shall make these rights known to the covered person within 3 working days after receiving a grievance. * The health carrier shall provide the covered person the name, address and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. * A covered person does not have the right to attend, or to have a representative in attendance, at the first level grievance review, but is entitled to submit written material to the reviewer. * The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. * Carrier shall issue a written decision to the covered person within 30 days after receiving a grievance. * Additional time is permitted where the carrier can establish the 30-day time frame cannot reasonably be met due to the carrier’s inability to obtain necessary information from a person or entity not affiliated with or under contract with the carrier. * The carrier shall provide written notice of the delay to the covered person. The notice shall explain the reasons for the delay. * In such instances, decisions must be issued within 30 days after the carrier’s receipt of all necessary information.   **An Adverse Benefit Determination Decision Notice shall contain:**   * The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process. * Statement of the reviewers’ understanding of the covered person’s grievance and all pertinent facts. * Reference to the specific plan provisions on which the benefit determination is based. * The reviewers’ decision in clear terms, including the specific reason or reasons for the adverse benefit determination. * Reference to the evidence or documentation used as the basis for the decision. * The decision shall include instructions for requesting copies, free of charge, of all documents, records and other information relevant to the claim, including any referenced evidence or documentation not previously provided to the covered person. * What criterion was relied upon in making the adverse benefit determination, provide either: * The specific rule, guideline, protocol, or other similar criterion, or * A statement referring to the rule, guideline, protocol, or * Other similar criterion that was relied upon in making the adverse determination; and * Explain that a copy will be provided free of charge to the covered person upon request; * Description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the rights specified in subparagraph C(3)(c). * Notice to the enrollee describing any subsequent external review rights, if required by 24-A M.R.S.A. §4312(3). * Notice of the availability of any applicable office of health insurance consumer assistance or ombudsman established under the federal Affordable Care Act. * Notice of the covered person’s right to contact the Superintendent’s office. The notice shall contain the toll-free telephone number, website address, and mailing address of the Bureau of Insurance. * Any other information required pursuant to the federal Affordable Care Act.   **Second Level Review of Adverse Benefit Determinations not Involving Health Care Treatment Decisions:**   * The carrier shall provide a second level grievance review process to covered persons who are dissatisfied with a first level grievance review determination under subsection B. * The covered person has the right to appear in person before authorized representatives of the health carrier and shall be provided adequate notice of that option by the carrier. * The carrier shall appoint a second level grievance review panel for each grievance subject to review under this subsection. A majority of the panel shall consist of employees or representatives of the health carrier who were not previously involved in the grievance. * Whenever a covered person has requested the opportunity to appear in person before authorized representatives of the health carrier, a health carrier’s procedures for conducting a second level panel review shall include the following: * The review panel shall schedule and hold a review meeting within 45 days after receiving a request from a covered person for a second level review. * The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person. * The carrier shall offer the covered person the opportunity to communicate with the review panel, at the health carrier’s expense, by conference call, video conferencing, or other appropriate technology. * The covered person shall be notified in writing at least 15 days in advance of the review date. The health carrier shall not unreasonably deny a request for postponement of the review made by a covered person. * Upon the request of a covered person, a health carrier shall provide to the covered person, free of charge, all relevant information that is not confidential and privileged from disclosure to the covered person. * A covered person has the right to: * Attend the second level review; * Present his or her case to the review panel; * Submit supporting material both before and at the review meeting; * Ask questions of any representative of the health carrier; and * Be assisted or represented by a person of his or her choice. * If the carrier will have an attorney present to argue its case against the covered person, the carrier shall so notify the covered person at least 15 days in advance of the review, and shall advise the covered person of his or her right to obtain legal representation. * The covered person’s right to a fair review shall not be made conditional on the covered person’s appearance at the review.   The review panel shall issue a written decision to the covered person within 5 working days after completing the review meeting. A decision adverse to the covered person shall include the information specified in Rule 850 subparagraph B(2)(b). | ☐ |  |
| Right to waive the right to a second level appeal/grievance | [24-A M.R.S.A. §4312](http://www.mainelegislature.org/legis/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 | [24-A M.R.S.A. §4303(4)](http://legislature.maine.gov/statutes/24-A/title24-Asec4303.html)  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc) | Decisions for second level grievance reviews must be issued within 30 calendar days. If the insured has requested to appear in person before authorized representatives of the health carrier the decision must be issued within 45 calendar days. | ☐ |  |
| **Providers/Networks** | | | | |
| Acupuncture services | 24-A M.R.S.A. [§2837-B](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-B.html) | Benefits must be made available for the services of acupuncturist if comparable services would be covered if performed by a physician. | ☐ |  |
| Certified nurse practitioners, certified midwives, and certified nurse midwives (aka: Advanced Practice Registered Nurse) | [Title 24-A § 2847-H](https://legislature.maine.gov/statutes/24-A/title24-Asec2847-H.html) (as amended by [P.L. 2021, ch. 79](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=76860))  [Title 24-A § 4303(5)](https://legislature.maine.gov/statutes/24-A/title24-Asec4303.html) | Coverage for services provided by nurse practitioners, certified midwives, and certified nurse midwives and allows nurse practitioners to serve as primary care providers. | ☐ |  |
| Coverage for Services Provided by Certified Registered Nurse Anesthetists | [P.L. 2021, ch. 39](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=74819) | Coverage for services provided by certified registered nurse anesthetists (CRNA) is required. | ☐ |  |
| Chiropractic Services | 24-A M.R.S.A. [§2840-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2840-A.html) | Provide benefits for care by chiropractors at least equal to benefit paid to other providers treating similar neuro-musculoskeletal conditions. Therapeutic, adjustive and manipulative services shall be covered whether performed by an allopathic, osteopathic or chiropractic doctor. | ☐ |  |
| Clinical professional counselors | [24-A M.R.S.A. §2835](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2835.html) | Must include benefits for licensed clinical professional counselor services to the extent that the same services would be covered if performed by a physician. | ☐ |  |
| Dentists (except for HMO’s) | 24-A M.R.S.A. [§2437](http://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. | ☐ |  |
| Enrollee choice of PCP | [24-A M.R.S.A. §4306](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4306.html) | A carrier offering or renewing a managed care plan shall allow enrollees to choose their own primary care providers, as allowed under the managed care plan's rules, from among the panel of participating providers made available to enrollees under the managed care plan's rules. A carrier shall allow physicians, including, but not limited to, pediatricians and physicians who specialize in obstetrics and gynecology, and certified nurse practitioners who have been approved by the State Board of Nursing to practice advanced practice registered nursing without the supervision of a physician pursuant to [Title 32, section 2102, subsection 2-A](http://www.mainelegislature.org/legis/statutes/32/title32sec2102.html) to serve as primary care providers for managed care plans. | ☐ |  |
| Essential Health Care Providers (Rural health clinics) | [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc)(7) | Benefits must be made available for outpatient health care services of certified rural health clinics. | ☐ |  |
| Independent Practice Dental Hygienists | [24-A M.R.S.A.](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-Q.html)  [§2847-Q](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-Q.html) | 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. | ☐ |  |
| Network adequacy | 24-A M.R.S.A. [§2673-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2673-A.html)  [§4303(1](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html))  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc)(7)  [Rule 360](http://www.maine.gov/sos/cec/rules/02/031/031c360.doc) | All managed care arrangements except MEWA’s must be filed for adequacy and compliance with Rule 850 and Rule 360 access standards.  If the policy uses a network, the network(s) need to have been approved by the Bureau for adequacy and access standards (i.e. physician, hospital, and ancillary service networks).  Must provide a copy of network approval. | ☐ |  |
| Optional coverage for optometric services | 24-A M.R.S.A. [§2841](http://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 a physician. | ☐ |  |
| Pastoral counselors and marriage and family therapists | [24-A M.R.S.A. §2835](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2835.html) | Must include benefits for licensed pastoral counselors and marriage and family therapists for mental health services to the extent that the same services would be covered if performed by a physician. | ☐ |  |
| Pharmacy Providers – “Any Willing Pharmacy” | [24-A M.R.S.A. §4317](http://www.maine.gov/pfr/insurance/review_checklists/life_health.htm) | A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers. | ☐ |  |
| PPOs – Payment for Non-preferred Providers | 24-A M.R.S.A. [§2677-A(2)](http://legislature.maine.gov/statutes/24-A/title24-Asec2677-A.html) | The benefit level differential between services rendered by preferred providers and non-preferred providers may not exceed 20% of the allowable charge for the service rendered. | ☐ |  |
| Provider directories | [24-A M.R.S.A. §4303-D](http://www.mainelegislature.org/legis/bills/getPDF.asp?paper=HP1073&item=3&snum=128) | Requirements for a plan’s provider directories. | ☐ |  |
| Psychologists’ services | 24-A M.R.S.A. [§2835](http://legislature.maine.gov/statutes/24-A/title24-Asec2835.html) | Must include benefits for psychologists’ services to the extent that the same services would be covered if performed by a physician. | ☐ |  |
| Registered nurse first assistants | [24-A M.R.S.A. §2847-I](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-I.html) | 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. | ☐ |  |
| Social workers/Psychiatric nurses | 24-A M.R.S.A. [§2835](http://legislature.maine.gov/statutes/24-A/title24-Asec2835.html) | Benefits must be included for the services of social workers and psychiatric nurses to the extent that the same services would be covered if performed by a physician. | ☐ |  |
| **MANDATED BENEFITS/SERVICES: Carriers must include all state mandates listed below when providing coverage of deductible, coinsurance, or copays.**  **Consideration as an excepted benefit under the ACA (42 U.S.C. § 300gg-91(c)(4) “coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan”) does not exempt these policies from state mandates. See federal Department of Labor Field Assistance Bulletin 2007-04.**  **Carriers must also provide an explanation as to why certain benefits are not being covered in the space provided (e.g., do not provide dependent coverage, do not provide dental, no RX coverage unless group purchases, etc.).** | | | | |
| Abortion services | [24-A M.R.S. §4320-M](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-M-1.html) | Applicable only if maternity coverage provided. Must provide coverage of abortion services in accordance with the following:   * The plan may contain provisions for maximum benefits and coinsurance and reasonable limitations, deductibles, and exclusions to the extent that these provisions are not inconsistent with the requirements of this law. * The requirements of this law apply to all policies or contracts executed, delivered, issued for delivery, continued, or renewed in this State, and all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.   **Applicable to group plans - exclusion for religious employer:**   * A religious employer may request and a carrier shall grant an exclusion under the policy or contract for the coverage required by this section if the required coverage conflicts with the religious employer's bona fide religious beliefs and practices. * A religious employer that obtains an exclusion shall provide prospective enrollees and those individuals insured under its policy written notice of the exclusion. * This section may not be construed as authorizing a carrier to exclude coverage for abortion services that are necessary to preserve the life or health of a covered enrollee. * For the purposes of this section, "religious employer" means an employer that is a church, a convention or association of churches or an elementary or secondary school that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 United States Code, Section 3121(w)(3)(A) and that qualifies as a tax-exempt organization under 26 United States Code, Section 501(c)(3). | ☐ |  |
| Abuse-deterrent opioid analgesic drug products | [24-A M.R.S.A. §4320-J](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-J.html) | A carrier offering a health plan in this State shall provide coverage for abuse-deterrent opioid analgesic drug products listed on any formulary, preferred drug list or other list of drugs used by the carrier on a basis not less favorable than that for opioid analgesic drug products that are not abuse-deterrent and are covered by the health plan.  An increase in enrollee cost sharing to achieve compliance with this section may not be implemented.  Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.    A. "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration with abuse-deterrent labeling claims that indicate the drug product is expected to result in a meaningful reduction in abuse.    B. "Cost sharing" means any coverage limit, copayment, coinsurance, deductible or other out-of-pocket expense associated with a health plan.    C. "Opioid analgesic drug product" means a drug product in the opioid analgesic drug class prescribed to treat moderate to severe pain or other conditions, whether in immediate release or extended release, long-acting form and whether or not combined with other drug substances to form a single drug product or dosage form. | ☐ |  |
| Anesthesia for Dentistry | 24-A M.R.S.A.  [§2847-K](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-K.html) | Anesthesia & associated facility charges for dental procedures are mandated benefits for certain vulnerable persons. | ☐ |  |
| Autism Spectrum Disorders | [24-A M.R.S.A. §2847-T](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-T.html) | All group health insurance policies, contracts and certificates must provide coverage for autism spectrum disorders for an individual covered under a policy, contract or certificate in accordance with the following.  **1. Definitions.** As used in this section, unless the context otherwise indicates, the following terms have the following meanings.  A. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.  B. "Autism spectrum disorders" means any of the pervasive developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th edition, published by the American Psychiatric Association, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.  C. "Treatment of autism spectrum disorders" includes the following types of care prescribed, provided or ordered for an individual diagnosed with an autism spectrum disorder:  (1) Habilitative or rehabilitative services, including applied behavior analysis or other professional or counseling services necessary to develop, maintain and restore the functioning of an individual to the extent possible. To be eligible for coverage, applied behavior analysis must be provided by a person professionally certified by a national board of behavior analysts or performed under the supervision of a person professionally certified by a national board of behavior analysts;  (2) Counseling services provided by a licensed psychiatrist, psychologist, clinical professional counselor or clinical social worker; and  (3) Therapy services provided by a licensed or certified speech therapist, occupational therapist or physical therapist.  **2. Required Coverage.**   1. The policy, contract or certificate must provide coverage for any assessments, evaluations or tests by a licensed physician or licensed psychologist to diagnose whether an individual has an autism spectrum disorder. 2. The policy, contract or certificate must provide coverage for the treatment of autism spectrum disorders when it is determined by a licensed physician or licensed psychologist that the treatment is medically necessary. 3. The policy, contract or certificate may limit coverage for applied behavior analysis to the actuarial equivalent of $36,000 worth of visits/services per year.  An insurer may not apply payments for coverage unrelated to autism spectrum disorders to any maximum benefit established under this paragraph. 4. Coverage for prescription drugs for the treatment of autism spectrum disorders must be determined in the same manner as coverage for prescription drugs for the treatment of any other illness or condition. | ☐ |  |
| Breast cancer treatment | [24-A M.R.S.A. §2837-C](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2837-C.html) | Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. | ☐ |  |
| Breast reduction and symptomatic varicose vein surgery | [24-A M.R.S.A. §2847-L](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-L.html) | Coverage must be offered for breast reduction surgery and symptomatic varicose vein surgery determined to be medically necessary. | ☐ |  |
| Chiropractic Services/Manipulative Therapy | [24-A M.R.S.A. §2748](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2748.html) | Must provide clarification how physical therapy, occupational therapy and osteopathic benefits are applied when chiropractic services are provided. | ☐ |  |
| Clinical Trials | [24-A M.R.S.A. §4310](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4310.html) | Provide access to clinical trials pursuant to:  1. Qualified enrollee**.**  An enrollee is eligible for coverage for participation in an approved clinical trial if the enrollee meets the following conditions:  A. The enrollee has a life-threatening illness for which no standard treatment is effective;  B. The enrollee is eligible to participate according to the clinical trial protocol with respect to treatment of such illness;  C. The enrollee's participation in the trial offers meaningful potential for significant clinical benefit to the enrollee; and  D. The enrollee's referring physician has concluded that the enrollee's participation in such a trial would be appropriate based upon the satisfaction of the conditions in paragraphs A, B and C.  2. Coverage.  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. For the purposes of this section, "routine patient costs" does not include the costs of the tests or measurements conducted primarily for the purpose of the clinical trial involved.  3. Payment.  A carrier shall provide payment for routine patient costs but is not required to pay for costs of items and services that are reasonably expected to be paid for by the sponsors of an approved clinical trial. In the case of covered items and services, the carrier shall pay participating providers at the agreed upon rate and pay nonparticipating providers at the same rate the carrier would pay for comparable services performed by participating providers.  4. Approved clinical trial.  For the purposes of this section, "approved clinical trial" means a clinical research study or clinical investigation approved and funded by the federal Department of Health and Human Services, National Institutes of Health or a cooperative group or center of the National Institutes of Health.  5. Application.  The requirements of this section apply to all individual and group policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State. For purposes of this section, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.  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 | [24-A M.R.S.A. §2847-N](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-N.html)   [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html) | 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 as the colorectal cancer screening and a lesion is discovered and removed during the colonoscopy benefits must be paid for the screening colonoscopy as the primary procedure. | ☐ |  |
| Continuity of Prescription Drugs | [24-A M.R.S.A.](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html)  [§4303(7)(A)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html) | 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 | 24-A M.R.S.A. [§2847-G](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-G.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)   [24-A M.R.S.A. §2847-G(4)](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-G.html) | All contracts that provide coverage for prescription drugs or outpatient medical services must provide coverage for all prescription contraceptives or for outpatient contraceptive services, respectively, to the same extent that coverage is provided for other prescription drugs or outpatient medical services.  Coverage required under this section must include coverage for contraceptive supplies in accordance with the following requirements. For purposes of this section, "contraceptive supplies" means all contraceptive drugs, devices and products approved by the federal Food and Drug Administration to prevent an unwanted pregnancy.    A. Coverage must be provided without any deductible, coinsurance, copayment or other cost-sharing requirement for at least one contraceptive supply within each method of contraception that is identified by the federal Food and Drug Administration to prevent an unwanted pregnancy and prescribed by a health care provider.    B. If there is a therapeutic equivalent of a contraceptive supply within a contraceptive method approved by the federal Food and Drug Administration, an insurer may provide coverage for more than one contraceptive supply and may impose cost-sharing requirements as long as at least one contraceptive supply within that method is available without cost sharing.    C. If an individual's health care provider recommends a particular contraceptive supply approved by the federal Food and Drug Administration for the individual based on a determination of medical necessity, the insurer shall defer to the provider's determination and judgment and shall provide coverage without cost sharing for the prescribed contraceptive supply.    D. Coverage must be provided for the furnishing or dispensing of prescribed contraceptive supplies intended to last for a 12-month period, which may be furnished or dispensed all at once or over the course of the 12 months at the discretion of the health care provider. | ☐ |  |
| Coverage for breast cancer treatment | [24-A M.R.S.A. §2837-C](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2837-C.html) | Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes. | ☐ |  |
| Coverage for HIV Prevention Drugs | Title 24-A § 4317-D (as established by [P.L. 2021, ch. 265](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78669)) | 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 | 24-A M.R.S.A. [§2847-E](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-E.html) | Benefits must be provided for medically necessary equipment and supplies used to treat diabetes (insulin, oral hypoglycemic agents, monitors, test strips, syringes and lancets) and approved self-management and education training authorized by the State's Diabetes Control Project within the Maine Bureau of Health. | ☐ |  |
| Drug Mail Order Opt Out | 45 CFR §156.122(e) | A health plan that provides an essential health benefits (EHB) package cannot have a mail-order only prescription drug benefit. | ☐ |  |
| Early Childhood Intervention | [24-A M.R.S.A. §2847-S](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2847-S.html) | All group health insurance policies, contracts and certificates must provide coverage for children's early intervention services in accordance with this subsection.  A referral from the child's primary care provider is required.  The policy or contract may limit coverage to the actuarial equivalent of $3,200 worth of visits/services per year for each child not to exceed the actuarial equivalent of $9,600 worth of visits/services by the child's 3rd birthday. **If visits/services are limited it must be actuarially equivalent to $3,200 and you must provide actuarial justification with the filing.**    “Children's early intervention services” means services provided by licensed occupational therapists, physical therapists, speech-language pathologists or clinical social workers working with children from birth to 36 months of age with an identified developmental disability or delay as described in the federal Individuals with Disabilities Education Act, Part C, 20, United States Code, Section 1432 at <http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title20-section1432&num=0&edition=prelim>. The following federal definition is provided for your information and is not required to be included in the policy/certificate:  **(4) Early intervention services**  The term “early intervention services” means developmental services that-  (A) are provided under public supervision;  (B) are provided at no cost except where Federal or State law provides for a system of payments by families, including a schedule of sliding fees;  (C) are designed to meet the developmental needs of an infant or toddler with a disability, as identified by the individualized family service plan team, in any 1 or more of the following areas:  (i) physical development;  (ii) cognitive development;  (iii) communication development;  (iv) social or emotional development; or  (v) adaptive development;  (D) meet the standards of the State in which the services are provided, including the requirements of this subchapter;  (E) include-  (i) family training, counseling, and home visits;  (ii) special instruction;  (iii) speech-language pathology and audiology services, and sign language and cued language services;  (iv) occupational therapy;  (v) physical therapy;  (vi) psychological services;  (vii) service coordination services;  (viii) medical services only for diagnostic or evaluation purposes;  (ix) early identification, screening, and assessment services;  (x) health services necessary to enable the infant or toddler to benefit from the other early intervention services;  (xi) social work services;  (xii) vision services;  (xiii) assistive technology devices and assistive technology services; and  (xiv) transportation and related costs that are necessary to enable an infant or toddler and the infant's or toddler's family to receive another service described in this paragraph;  (F) are provided by qualified personnel, including-  (i) special educators;  (ii) speech-language pathologists and audiologists;  (iii) occupational therapists;  (iv) physical therapists;  (v) psychologists;  (vi) social workers;  (vii) nurses;  (viii) registered dietitians;  (ix) family therapists;  (x) vision specialists, including ophthalmologists and optometrists;  (xi) orientation and mobility specialists; and  (xii) pediatricians and other physicians;  (G) to the maximum extent appropriate, are provided in natural environments, including the home, and community settings in which children without disabilities participate; and  (H) are provided in conformity with an individualized family service plan adopted in accordance with section 1436 of this title. | ☐ |  |
| Early refills of prescription eye drops | [24-A M.R.S.A. §4314-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4314-A.html) | A carrier offering a health plan in this State shall provide coverage for one early refill of a prescription for eye drops if the following criteria are met:    A. The enrollee requests the refill no earlier than the date on which 70% of the days of use authorized by the prescribing health care provider have elapsed;    B. The prescribing health care provider indicated on the original prescription that a specific number of refills are authorized;    C. The refill requested by the enrollee does not exceed the number of refills indicated on the original prescription;    D. The prescription has not been refilled more than once during the period authorized by the prescribing health care provider prior to the request for an early refill; and    E. The prescription eye drops are a covered benefit under the enrollee's health plan.    2.  Cost sharing. A carrier may impose a deductible, copayment or coinsurance requirement for an early refill under this section as permitted under the health plan. | ☐ |  |
| Electronic transmission of prior authorization requests for prescription drugs | [Title 24-A § 4304(2-B)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)  [Title 24-A § 4304(2)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html)  (as amended by [P.L. 2021, ch. 73](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=76852)) | If a health plan provides coverage for prescription drugs, the carrier must accept and respond to prior authorization requests through a secure electronic transmission using standards recommended by a national institute for the development of fair standards and adopted by a national council for prescription drug programs for electronic prescribing transactions. Transmission of a facsimile through a proprietary payer portal or by use of an electronic form is not considered electronic transmission.  A carrier's electronic transmission system for prior authorization requests for prescription drugs must comply with the requirements of the statute.  (For 2022, a carrier is only required to have one electronic benefit tool, which does not have to integrate with every provider’s system. For 2023 and beyond, a carrier’s electronic benefit tool(s) must integrate with all of its providers’ systems.) Upon request, the superintendent may grant a waiver from the requirements on a demonstration of good cause. The prescription drug and prior authorization standards used must be clear and readily available to enrollees, participating providers, pharmacists and other providers. | ☐ |  |
| Emergency Services | [24-A M.R.S. §4320-C](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-C.html)  [24-A M.R.S. § 4301-A(4-A) & (4-B)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4301-A.html)  [24-A M.R.S. §4304(5)](http://legislature.maine.gov/statutes/24-A/title24-Asec4304.html) | The plan must cover emergency services without prior authorization.  Cost-sharing requirements, expressed as a 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.  **“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 health care service. | ☐ |  |
| Eye Care Services | 24-A M.R.S.A. [§4314](http://legislature.maine.gov/statutes/24-A/title24-Asec4314.html) | Patient access to eye care providers when the plan provides eye care services. | ☐ |  |
| Hearing aids | [24-A M.R.S.A. §2847-O](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-O.html) | 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. | ☐ |  |
| HIV/AIDS | 24-A M.R.S.A. [§2846](http://legislature.maine.gov/statutes/24-A/title24-Asec2846.html) | May not provide more restrictive benefits for expenses resulting from Acquired Immune Deficiency Syndrome (AIDS) or related illness. | ☐ |  |
| Home health care coverage | 24-A M.R.S.A. [§2837](http://legislature.maine.gov/statutes/24-A/title24-Asec2837.html) | Every insurer which issues or issues for delivery in this State individual health policies, which provide coverage on an expense incurred basis for inpatient hospital care, shall make available such coverage for home health care services by a home health care provider. | ☐ |  |
| Hospice Care Services | 24-A M.R.S.A. [§2847-J](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-J.html) | 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. | ☐ |  |
| Infant Formula | [24-A M.R.S.A. §2847-P](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-P.html) | Coverage of amino acid-based elemental infant formula must be provided when a physician has diagnosed and documented one of the following:   1. Symptomatic allergic colitis or proctitis; 2. Laboratory- or biopsy-proven allergic or eosinophilic gastroenteritis; 3. A history of anaphylaxis 4. Gastroesophageal reflux disease that is nonresponsive to standard medical therapies 5. Severe vomiting or diarrhea resulting in clinically significant dehydration requiring treatment by a medical provider 6. Cystic fibrosis; or 7. 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. | ☐ |  |
| Information about prescription drugs | [24-A MRSA §4303, sub-§20](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4303.html) | Consistent with the requirements of the federal Affordable Care Act, a carrier offering a health plan in this State shall provide the following information to prospective enrollees and enrollees with respect to prescription drug coverage on its publicly accessible website.    A. A carrier shall post each prescription drug formulary for each health plan offered by the carrier. The prescription drug formularies must be posted in a manner that allows prospective enrollees and enrollees to search the formularies and compare formularies to determine whether a particular prescription drug is covered under a formulary. When a change is made to a formulary, the updated formulary must be posted on the website within 72 hours.    B. A carrier shall provide an explanation of:    (1) The requirements for utilization review, prior authorization or step therapy for each category of prescription drug covered under a health plan;    (2) The cost-sharing requirements for prescription drug coverage, including a description of how the costs of prescription drugs will specifically be applied or not applied to any deductible or out-of-pocket maximum required under a health plan;    (3) The exclusions from coverage under a health plan and any restrictions on use or quantity of covered health care services in each category of benefits; and    (4) The amount of coverage provided under a health plan for out-of-network providers or noncovered health care services and any right of appeal available to an enrollee when out-of-network providers or noncovered health care services are medically necessary. | ☐ |  |
| Leukocyte Antigen Testing To Establish Bone Marrow Donor | [24-A M.R.S.A. § 4320-I](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-I.html) | A carrier offering a health plan in this State shall provide coverage for laboratory fees up to $150 arising from human leukocyte antigen testing performed to establish bone marrow transplantation suitability in accordance with the following requirements:    A. The enrollee covered under the health plan must meet the criteria for testing established by the National Marrow Donor Program, or its successor organization;    B. The testing must be performed in a facility that is accredited by a national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists and is certified under the federal Clinical Laboratories Improvement Act of 1967, 42 United States Code, Section 263a;    C. At the time of the testing, the enrollee covered under the health plan must complete and sign an informed consent form that authorizes the results of the test to be used for participation in the National Marrow Donor Program, or its successor organization, and acknowledges a willingness to be a bone marrow donor if a suitable match is found; and    D. The carrier may limit each enrollee to one test per lifetime.    Prohibition on cost-sharing. A carrier may not impose any deductible, copayment, coinsurance or other cost-sharing requirement on an enrollee for the coverage required under this section. | ☐ |  |
| Mammogram screening | 24-A M.R.S.A. [§2837-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-A.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html) | 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. | ☐ |  |
| Maternity and newborn care;  newborn children coverage | 24-A M.R.S.A. [§2834-A](http://legislature.maine.gov/statutes/24-A/title24-Asec2834-A.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html)  [24-A M.R.S.A. §2834](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2834.html) | 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; dependent children | 24-A M.R.S.A. [§2832](http://legislature.maine.gov/statutes/24-A/title24-Asec2832.html)  24-A M.R.S.A. [§2833](http://legislature.maine.gov/statutes/24-A/title24-Asec2833.html) | Applicable only if maternity and dependent child coverage provided: 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 to married policyholders or the wives of policyholders with maternity coverage.  Coverage issued in accordance with section 2832 (above) must provide unmarried women certificate holders with the option of coverage of their children from the date of birth, which coverage must be the same as that provided the children of married certificate holders with family or dependent coverage.  Financial dependency of dependent children may not be required as condition for coverage eligibility.  Coverage must also provide the same benefits to dependent children placed for adoption with the certificate holder or their spouse 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. | ☐ |  |
| Medical food coverage for inborn error of metabolism | 24-A M.R.S.A. [§2837-D](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-D.html) | Must provide coverage for metabolic formula and up to the actuarial equivalent of $3,000 per year for prescribed modified low-protein food products. | ☐ |  |
| Mental Health Coverage | 24-A M.R.S.A. [§2843](http://legislature.maine.gov/statutes/24-A/title24-Asec2843.html) | Must provide, at a minimum, the following benefits for a person suffering from a mental or nervous condition: inpatient services, day treatment services, outpatient services, and home health care services. For groups with more than 20 employees mental health benefits cannot be less extensive than for physical illnesses for the following mental illnesses: psychotic disorders (including schizophrenia), dissociative disorders, mood disorders, anxiety disorders, personality disorders, paraphilias, attention deficit ad disruptive behavior disorders, pervasive developmental disorders, tic disorders, eating disorders (including bulimia and anorexia), and substance abuse-related disorders. | ☐ |  |
| Mental health services provided by counseling professionals. | [24-A M.R.S.A. §2835(3)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2835.html) | Benefits must be made available for mental health services provided by licensed counselors. | ☐ |  |
| No Prior Authorization or step therapy for mental illness drugs | [Title 24-A § 4304(2-C)](https://legislature.maine.gov/statutes/24-A/title24-Asec4304.html) (as amended by [P.L 2021, ch. 345](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78789))  [24-A M.R.S. §4320-N](https://legislature.maine.gov/statutes/24-A/title24-Asec4320-N.html) (as amended by [P.L 2021, ch. 345](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78789)) | 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. | ☐ |  |
| Obstetrical and gynecological care | 24-A M.R.S.A. [§2847-F](http://legislature.maine.gov/statutes/24-A/title24-Asec2847-F.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html) | 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. | ☐ |  |
| Off-label use of prescription drugs for cancer and HIV or AIDS | 24-A M.R.S.A. [§2837-F](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-F.html)  [§2837-G](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-G.html) | Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS. | ☐ |  |
| Orally Administered Cancer Therapy | [24-A M.R.S.A. §4317-B](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4317-B.html) | 1. Coverage. A carrier that provides coverage for cancer chemotherapy treatment shall provide coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells that is equivalent to the coverage provided for intravenously administered or injected anticancer medications. An increase in patient cost sharing for anticancer medications may not be used to achieve compliance with this section.  2. Construction. This section may not be construed to prohibit or limit a carrier's ability to establish a prescription drug formulary or to require a carrier to cover an orally administered anticancer medication on the sole basis that it is an alternative to an intravenously administered or injected anticancer medication.  Sec. 2. Application. This Act applies to all policies, contracts and certificates executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2015. For purposes of this Act, all contracts are deemed to be renewed no later than the next yearly anniversary of the contract date. | ☐ |  |
| Pap tests | 24-A M.R.S.A. [§2837-E](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-E.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html) | Benefits must be provided for cervical cancer screening tests. | ☐ |  |
| Pediatric Dental | 45 CFR §155.1065 (a)(3) | Please demonstrate compliance with dental benefits pursuant to the FEDVIP plan by completing the Benchmark Pediatric Dental checklist using the FEDVIP Benchmark Plan Benefits Chart for specific coverage information. | ☐ |  |
| Pediatric Services | 45 CFR §156.115(a)(6) | Coverage for pediatric services should continue until the end of the plan year in which the enrollee turns 19 years of age. Issuers are encouraged to cover services under the pediatric services EHB category beyond the 19th birthday month if non-coverage of those services after that time would negatively affect care. | ☐ |  |
| Prescription Drug Access | 24-A M.R.S.A. [§4311](http://legislature.maine.gov/statutes/24-A/title24-Asec4311.html) | Access to prescription drugs for contracts that provide coverage for prescription drugs and medical devices. | ☐ |  |
| Prescription Drug Coverage | [Rule 755, Sec. 6(F)(1)(i)](http://www.maine.gov/sos/cec/rules/02/031/031c755.doc) | Must provide coverage for out-of-hospital prescription drugs and medications. Cost sharing for the drug benefit shall not exceed 50% on average. If there is a separate maximum for this benefit, it shall be at least $1,500 per year. | ☐ |  |
| Prescription drug exception process | [24-A M.R.S. §4311(1-A)(A)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4311.html) | **Decision within 72 hours or 2 business days, whichever is less:**   * The carrier must notify the enrollee, the enrollee's designee if applicable, and the person who has issued a valid prescription for the enrollee of its coverage decision within 72 hours or 2 business days, whichever is less, following receipt of the request. * A carrier that grants coverage must provide coverage of the drug for the duration of the prescription, including refills. | ☐ |  |
| Prescription synchronization | [24-A M.R.S.A. §2769](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec2769.html) | If a health plan provides coverage for prescription drugs, a carrier:    A. Shall permit and apply a prorated daily cost-sharing rate to a prescription that is dispensed by a pharmacist in the carrier's network for less than a 30-day supply if the prescriber or pharmacist determines that filling or refilling the prescription for less than a 30-day supply is in the best interest of the patient and the patient requests or agrees to less than a 30-day supply in order to synchronize the refilling of that prescription with the patient's other prescriptions;    B. May not deny coverage for the dispensing of a medication prescribed for the treatment of a chronic illness that is made in accordance with a plan developed by the carrier, the insured, the prescriber and a pharmacist to synchronize the filling or refilling of multiple prescriptions for the insured. The carrier shall allow a pharmacy to override any denial codes indicating that a prescription is being refilled too soon in order to synchronize the patient's prescriptions; and    C. May not use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions must be paid in full for each prescription dispensed, regardless of any prorated copay for the insured or fee paid for alignment services.    2.  Application; exclusion. The requirements of this section do not apply to a prescription for:    A. Solid oral doses of antibiotics; or    B. Solid oral doses that are dispensed in their original container as indicated in the federal Food and Drug Administration Prescribing Information or are customarily dispensed in their original packaging to assist a patient with compliance. | ☐ |  |
| Prior authorization of medication-assisted treatment for opioid use disorder | [24-A M.R.S. §4304(2-A)](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4304.html) | A carrier may not require prior authorization for medication-assisted treatment for opioid use disorder for the prescription of at least one drug for each therapeutic class of medication used in medication-assisted treatment, except that a carrier may not impose *any* prior authorization requirements on a pregnant woman for medication-assisted treatment for opioid use disorder.  "Medication-assisted treatment" means an evidence-based practice that combines pharmacological interventions with substance use disorder counseling. | ☐ |  |
| Prior authorization of nonemergency services; exigent circumstances | [24-A M.R.S. §4304](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4304.html)  [Rule 850](http://www.maine.gov/sos/cec/rules/02/031/031c850.doc)(8) | **Prior authorization of nonemergency services**  Except for a request in exigent circumstances, a request by a provider for prior authorization of a nonemergency service must be answered by a carrier within 72 hours or 2 business days, whichever is less, in accordance with the following:   * Both the provider and the enrollee on whose behalf the authorization was requested must be notified by the carrier of its determination. * If the carrier responds to a request with a request for additional information, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, after receiving the requested information. * If the carrier responds that outside consultation is necessary before making a decision, the carrier shall make a decision within 72 hours or 2 business days, whichever is less, from the time of the carrier’s initial response. * The prior authorization standards used by a carrier must be clear and readily available. * A provider must make best efforts to provide all information necessary to evaluate a request, and the carrier must make best efforts to limit requests for additional information. * If a carrier does not grant or deny a request for prior authorization within these timeframes, the request is granted.   **Expedited review in exigent circumstances**  When exigent circumstances exist, a carrier must answer a prior authorization request no more than 24 hours after receiving the request.   * Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug. * The carrier must notify the enrollee, the enrollee’s designee if applicable, and the provider of its coverage decision.   **Concurrent review determinations**:  “Concurrent review” means utilization review conducted during a patient’s hospital stay or course of treatment. Determination shall be within 1 working day after obtaining all necessary information.  Certification of Extended stay or additional services: Shall notify the covered person and the provider rendering the service within 1 working day. Written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.  Adverse benefit determination of concurrent review the carrier shall:  Notify the covered person and the provider rendering the service within 1 working day. Continue the service without liability to the covered person until the covered person has been notified of the determination. | ☐ |  |
| Prostate cancer screening | 24-A M.R.S.A. [§2837-H](http://legislature.maine.gov/statutes/24-A/title24-Asec2837-H.html)  [§4320-A](http://legislature.maine.gov/statutes/24-A/title24-Asec4320-A.html) | 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. | ☐ |  |
| Prosthetic devices to replace an arm or leg | [24-A M.R.S.A. §4315](http://legislature.maine.gov/statutes/24-A/title24-Asec4315.html) | 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—  (i) the actual charge for the item; or  (ii) 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%. | ☐ |  |
| Reconstructive surgery after mastectomy | PHSA §2727 | If covers mastectomy, then must also cover reconstructive surgery in a manner determined in consultation with provider and patient. Coverage must include:   * Reconstruction of the breast on which the mastectomy was performed (all stages); * Surgery and reconstruction of the other breast to produce symmetrical appearance; * Prostheses; and * Treatment of physical complications at all stages of mastectomy.   **Does not limit mastectomy to cancer diagnosis.** | ☐ |  |
| Specialty tiered drugs - Adjustment of out-of-pocket limits | [24-A M.R.S.A. §4317-A](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4317-A.html) | A carrier may adjust an out-of-pocket limit, as long as any limit for prescription drugs for coinsurance does not exceed $3,500, to minimize any premium increase that might otherwise result from the requirements of this section. Any adjustment made by a carrier pursuant to this subsection is considered a minor modification under section 2850-B. | ☐ |  |
| Step therapy requirements | [24-A M.R.S. §4320-N](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4320-N.html) | Step therapy requirements when a carrier provides prescription drug coverage, and coverage of a prescription drug is restricted through the use of a step therapy protocol. | ☐ |  |
| Substance Abuse | 24-A M.R.S.A. [§2842](http://legislature.maine.gov/statutes/24-A/title24-Asec2842.html) | Every insurer which issues group health care contracts providing coverage for hospital care to residents of this State shall provide benefits as required in this section to any subscriber or other person covered under those contracts for the treatment of alcoholism and other drug dependency pursuant to a treatment plan. | ☐ |  |
| Telehealth Services | [Title 24-A § 4316](https://legislature.maine.gov/statutes/24-A/title24-Asec4316.html) (as amended by [P.L. 2021 ch. 291](https://legislature.maine.gov/ros/LawsOfMaine/breeze/Law/getDocById/?docId=78725)) | 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. | ☐ |  |
| Third Party Prescription Act (Any Willing Pharmacy) | [32 M.R.S.A. §13771](http://www.mainelegislature.org/legis/statutes/32/title32sec13771.html)  [24-A M.R.S.A. §4317](http://www.mainelegislature.org/legis/statutes/24-A/title24-Asec4317.html)  [Bulletin 377](https://www.maine.gov/pfr/insurance/themes/insurance/pdf/377.pdf) | A carrier that provides coverage for prescription drugs as part of a health plan may not refuse to contract with a pharmacy provider that is qualified and is willing to meet the terms and conditions of the carrier's criteria for pharmacy participation as stipulated in the carrier's contractual agreement with its pharmacy providers. | ☐ |  |
| Treatment of alcoholism | 24-A M.R.S.A. [§2842](http://legislature.maine.gov/statutes/24-A/title24-Asec2842.html) | Benefits must be made available for treatment of alcoholism by licensed or certified treatment facilities subject "reasonable limitations". | ☐ |  |